

STATE OF NEW JERSEY

Department of Banking and Insurance

SCA ANNUAL REPORT

Name of Carrier

December 31, 2011
Year Ending

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Name of Carrier _____

A. ADMINISTRATIVE INFORMATION

NAIC #: _____ **TAX ID #:** _____

Date Carrier Incorporated or Organized: _____

Date Carrier Commenced Business: _____

Date Carrier Certified as a SCA: _____

Statutory Home Office: _____
(Street) (City, State & Zip Code)

Main Administrative Office: _____
(Street) (City, State & Zip Code)

Contact Person: _____
(Name) (Area Code & Telephone Number)

(E-Mail) (FAX)

CERTIFICATION BY OFFICER

As an Officer of the carrier, I certify that for the reporting period stated above, all information and statements made in this Annual Report are true, complete and current to the best of my knowledge and belief.

Name President Signature

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B. NETWORK INFORMATION

Please identify the network used in the Selective Contracting Arrangement. If there is no SCA, please mark N/A. Designate whether the network is provided through an ODS, PPO in the case of a Prescription Drug Benefit, or through a direct contract with providers. Identify the principal contact person, if different from the person identified in Section A.

I Hospital/Medical: _____

(Name of Network)

____ Certified ODS ____ Licensed ODS ____ Direct Contract

Contact Person: _____, _____

(Name)

(Area code & Telephone Number)

_____, _____

(E-mail)

(Fax)

II Dental: _____

(Name of network)

____ Certified ODS ____ Licensed ODS ____ Direct Contract

Contact Person: _____, _____

(Name)

(Area code & Telephone Number)

_____, _____

(E-mail)

(Fax)

III Vision: _____

(Name of network)

____ Certified ODS ____ Licensed ODS ____ Direct Contract

Contact Person: _____, _____

(Name)

(Area code & Telephone Number)

_____, _____

(E-mail)

(Fax)

IV Prescription Drug Benefit: _____

(Name of network)

____ PPO ____ Direct Contract

Contact Person: _____, _____

(Name)

(Area code & Telephone Number)

_____, _____

(E-mail)

(Fax)

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V Behavior Health (Mental Health and Substance Abuse):

(Name of Network)

____ Certified ODS ____ Licensed ODS ____ Direct Contract

Contact Person: _____, _____
(Name) (Area code & Telephone Number)

_____, _____
(E-mail) (Fax)

VI Other: _____

(Name of network)

Contact Person: _____, _____
(Name) (Area code & Telephone Number)

_____, _____
(E-mail) (Fax)

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C. Membership

1. Please provide Membership by Rating Status

MEMBERSHIP BY RATING STATUS

YEAR ENDING	December 31, 2011	December 31, 2010
SINGLE EES *		
EE & SPOUSE *		
EE & CHILD *		
FAMILY *		
TOTAL	0	0

* Indicate the number of **employees** that are enrolled in each category.

2. Please complete the table for the number of employer contracts by products:

Number of Employer Contracts by Products

Year Ending	Hospital/ Medical*	Prescription	Vision	Dental	Total
2011					0
2010					0

* Which may include prescription, vision and or dental on a non-stand alone basis

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3. Please complete the Plan Experience table for the SCA Line of Business for 2010 and 2011 calendar years. If any products are stand-alone, complete a separate table.

PLAN EXPERIENCE

Calendar Year	2011	2010
Premium		
Incurred Claims In Network	\$	\$
Incurred Claims Out of Network	\$	\$
# Of Claims In Network		
# Of Claims Out of Network		

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4. Please provide Membership by County or by zip code (first three digits only) for the previous calendar year.
(Complete a separate table for each PPO/HMO)

Membership by County as of December 31, 2011

	# Single	# Employee & Spouse	# Employee & Child	# Family	Total Employees
Atlantic				0	
Bergen				0	
Burlington				0	
Camden				0	
Cape May				0	
Cumberland				0	
Essex				0	
Gloucester				0	
Hudson				0	
Hunterdon				0	
Mercer				0	
Middlesex				0	
Monmouth				0	
Morris				0	
Ocean				0	
Passaic				0	
Salem				0	
Somerset				0	
Sussex				0	
Union				0	
Warren				0	
Out of State				0	
Unknown				0	
TOTAL Employees Enrolled	0	0	0	0	

The use of twenty (20) three digit zip codes can be used as an alternative to counties. # Indicate the number of Employees that are enrolled in each category.

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5. Subscribers and members by type of payment

a. Total member months for the year: _____

b. Average monthly change: _____

(Dec. 31 current year minus Dec. 31 prior year membership divided by 12)

Type of Payment	Subscribers* at End of Year		Total Members** at Year End
	Subscriber Total	Average Members Per Subscribers	Actual
	(a)	(b)	(c)
A. Group Contracts (Non-Government)			
1. SEH Standard Group Plans (2-50 Employees)		#DIV/0!	
2. Non-Standard Plans (2-30 Employees)		#DIV/0!	
3. Large Group		#DIV/0!	
4. Student***		#DIV/0!	
B. Individual Contracts		#DIV/0!	
C. Government Plans			
1. FEHBP		#DIV/0!	
2 Other/Local		#DIV/0!	
		#DIV/0!	
D. Medicare****		#DIV/0!	
E. Other (Specify)*****		#DIV/0!	
TOTAL	0	#DIV/0!	0

Notes:

* Subscriber means, in the case of a group contract, an individual whose employment or other status, except family status, is the basis for eligibility for enrollment or, in the case of an individual contract, the person in whose name the contract is issued.

** Total Member means the total number of covered persons.

*** Student means anyone who is covered under a Student Health Plan.

**** Medicare relates only to members enrolled in programs complementary to Title XVIII, or under direct cost contracts or risk contracts with the Social Security Administration. Excludes Medicare eligible in other categories.

***** COBRA extension, small group extensions, etc. not reported in other categories.

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6. Has the carrier withdrawn from any market in which it was previously approved?
If yes, please identify the market and date of withdrawal.

7. Identify any affiliated companies associated with the SCA.

D. Vendor Oversight

Please submit a copy of the 2011 vendor performance reports upon which carriers evaluated the quality of care and services provided to covered persons.