Large Group Underwriting Guidelines for Brokers

(Groups of 51+ and non-SEH Groups)

AmeriHealth Underwriting Department

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Large group underwriting guidelines
(Groups of 51+ and non-SEH groups)

Please note: These guidelines are applicable to new and renewing customers. AHNJ reserves the right to apply rate adjustments for new business customers not in compliance with the Underwriting Guidelines. Renewing customers not in compliance with the Underwriting Guidelines may also be subject to rating adjustments or possible termination of the group contract. This applies to pre or post sale and renewal business.

Eligibility and enrollment requirements

Guaranteed Availability	Guaranteed Availability, also known as Guaranteed Issue, requires that health insurance issuers must offer to and accept any individual or employer who applies for coverage. In addition, issuers cannot deny coverage to employers for failing to satisfy minimum participation or contribution requirements, subject to a few exceptions, including fraud and nonpayment of premiums.
Definition of large groups/non-SEH groups	• Group size will be determined based on the total number of full time equivalent employees using the calculation method prescribed by the Employer Shared Responsibility Act for determining the employee count. • Groups with a minimum of 51 active eligible lives as defined above on the effective date of coverage. • Groups with less than 51 enrolled may be eligible. • Groups that only reach a level of 51+ employees on a seasonal basis are not eligible.

Determining group size	• AHNJ will use the calculation method prescribed by the Employer Shared Responsibility Act for determining the employee count.
	• The employee count, as provided by the employer, is used when determining the group size and rating methodology.
	• **Employee count calculation**:
	  – Number of full-time employees (30 or more hours per week); ***plus***
	  – Number of full-time equivalents (FTE's)
	  (FTE calculation = Number of hours worked in a calendar month by non-full-time employees divided by 120)
	• **Eligible employees:** All employees that the employer considers to be eligible for coverage
	• **Enrolled employees**: The number of eligible employees that are actually being enrolled in the group health coverage.
	Note: The calculation for determining group size will be based on the number of FTE's on business days during the preceding calendar year. Employers should refer to their tax advisor or legal counsel when determining group size to ensure the employee count was calculated correctly.

AHNJ service area (network options)	• **National network:** Expands the Preferred network to include access to the PHCS national provider network.
	  – Access to the National network may be offered to all employees of a group or to a closed class of employees; it may not be offered as an option to employees
	• **Regional Preferred network:**
	  – New Jersey (all counties); and,
	  – Pennsylvania: The five-county Greater Philadelphia area (Bucks, Chester, Delaware, Montgomery and Philadelphia counties) and the four contiguous counties of Berks,

	Lancaster, Lehigh and Northampton; and, – Delaware (all counties). • **Local Value network:** Access to a sub-set of providers, located in the State of New Jersey, within the Preferred network (does not include any providers in Pennsylvania and Delaware) – not available in Hunterdon County. • **AmeriHealth Advantage network:** – Tier 1 consists of all Cooper Health System, Shore Medical Center and Meridian Health, Cape Regional Medical Center facilities and affiliated professional providers. – Tier 2 consists of all other providers in the Value network. – Available in Monmouth, Camden, Burlington, and Gloucester, Atlantic, Cape May and Ocean counties.
Group location requirements	• The group must have their corporate headquarters, or a local entity, located in the state of New Jersey — and it must be a physical site location. A New Jersey post office box does **not** fulfill the New Jersey location requirement. – Group members enrolling in HMO, HMO Plus, or POS coverage must reside within the AHNJ service area.
Participation requirements (eligible employees)	• Minimum 75 percent participation (including valid waivers) • Minimum 50 percent participation (excluding valid waivers) • Valid waivers: – Employees with group coverage elsewhere through AmeriHealth and/or its affiliated parent companies or subsidiaries (coverage through an individual “direct pay” plan is not a valid waiver) , Medicare or Medicaid; Tricare, Veteran or other government issued coverage – Employees covered through their spouse; – Employees covered as an eligible dependent to age 26--including employees covered as an eligible dependent under the employer’s plan (situations where the employee’s parent is also an employee of the employer), in accordance with the federal Patient Protection and Affordable Care Act. – Advanced Premium Tax Credit (APTC) waivers from the individual federal Exchange • For groups covering retirees: – 100 percent participation is required for retired employees and the group must consist of a minimum of 75 percent active employees; – Retiree-only groups will not be accepted; – Coverage for self-pay retirees is subject to underwriting approval. • AHNJ reserves the right to apply rate adjustments for new business customers not in compliance with this Underwriting Guideline.
Out-of-area employees	• Definition: Employees located outside of the AHNJ proprietary service area.

Coverage Classes	• Definition: Distinct categories (classes) within the group, where these classes will receive different levels of health care coverage. • Classes must be determined by conditions relating to employment; must be clearly identifiable; and must exist for purposes other than insurance risk (for example, union/non-union, salaried/hourly, full time/part time). • Excluding a class within a group from coverage is **not** permitted, except for certain groups with coverage through a collective bargaining agreement. Brokers or customers should contact their AHNJ sales representative to discuss groups with coverage through a collective bargaining agreement that want to exclude a class within a group from coverage. • Qualifier: Subject to the above conditions, AHNJ will comply with the coverage classifications requested by the employer, but approval of such request is not a representation by AHNJ to the employer that the requested classifications comply with applicable laws/regulations. The employer should consult with its own legal counsel or tax advisor to determine if the coverage classification is permissible under applicable laws/regulations.
Employer contribution requirement	• For contributory plan offerings, the employer must contribute a minimum of 50 percent of the calculated gross monthly premium for each plan offered. • AHNJ reserves the right to apply rate adjustments for new business customers not in compliance with the Underwriting Guidelines.
Employee eligibility	• Eligible employees include all active employees and owners or partners actively engaged in the business who meet **all** of the following criteria: − are deemed benefit-eligible according to the employer; − meet all requirements as defined in the carrier's plan documents and fulfilled any authorized waiting period requirements; − work at least 25 hours per week; and − for HMO products, reside or work in the HMO's defined service area. • An established employer/employee relationship must exist. • ***Ineligible employees include, but are not limited to:*** temporary, seasonal (AHNJ defines a seasonal employee as an employee who is hired with the understanding that he/she is not a permanent, year-round employee and who is employed for fewer than 120 days working tax year), substitute, uncompensated employees; volunteers, silent partners, board members, shareholders or investors only; owners, officers or managing members who are not active, permanent, full-time employees.
Changes in employee or dependent eligibility criteria	• Definition: Employer-initiated requests to change group's eligibility criteria. For example, changing minimum hours worked requirement for eligibility (must meet guidelines listed for minimum hours worked requirement); changing dependent eligibility from age 26 to age 30, etc. • Changes in eligibility criteria may only be made on group's anniversary date and with at least 120 days prior notification to underwriting. (Please note that changes to eligibility may affect premiums.) • Requests for off-anniversary changes will require Underwriting review and approval. • Changes may not be made on a retroactive basis.
Independent Contractor Eligibility	• Upon the employer's request, and at AHNJ's underwriting discretion, independent contractors may be eligible for coverage to the extent that each independent contractor: − Is performing a service for the employer pursuant to a written contract for monetary or other legal consideration; − Works at least 25 hours per week for the employer; − Works on other than a temporary or substitute basis; − The independent contractor relationship has been established to serve a substantial business need of the employer and is not intended primary to obtain insurance

	coverage; − Is not considered to be an employee by the New Jersey Department of Labor and Workforce Development pursuant to N.J.S.A. 43:21-19 and applicable law. • Independent contractors are not counted toward eligibility participation requirements. • Independent contractors cannot represent more than 10 percent of the total enrolled population.
Dependent eligibility	• Employee's spouse or civil-union partner; if both employee and spouse work for the same company, they may enroll together or separately. • Dependent children of the employee (natural, adopted, under legal guardianship or court-ordered custody), as defined in plan documents and in accordance with state and federal laws, are eligible for coverage up to age 26. • Medical coverage for dependent children may be extended to age 31 (New Jersey Law Chapter 375 - Dependents to 31), if the dependent child meets the following criteria: − Has aged-out or is about to age-out of a parent's group health benefits plan issued in New Jersey; and, − is younger than 31 years old, unmarried and has no dependents, and must be beyond the limiting age for eligible dependents under the parent's group health plan; and, − is a resident of New Jersey or is enrolled as a full-time student in an institution of higher education; and, − is not provided coverage under any other group or individual health plan, including eligibility for any government health care benefits program; and, − the adult child's parent must be covered under a group health benefits plan issued in New Jersey. • Overage handicapped dependent children who, in the judgment of AHNJ, are incapable of self-support due to mental or physical incapacitation. (Coverage will terminate upon marriage of the dependent.) • Individuals cannot be covered as an employee and dependent under the same plan, nor may children be eligible for coverage through both parents and be covered by both under the same plan. • Domestic partners, only if the employer elects this designation at contract effective or renewal date. (See domestic partner coverage criteria below.) • Dependents must enroll in the same benefit options as the employee.

Domestic partner (DP) coverage	• Includes opposite or same sex couples for partnerships established prior to the February 19, 2007 effective date of the New Jersey Civil Union Act. • Groups may choose to offer Domestic Partner Coverage to: − Same sex couples only − Opposite and same sex couples ***Note***: Groups may not choose to offer Domestic Partnership coverage to opposite sex partners only. NJ Dept. of Health and Senior Services documentation (Certificate of Domestic Partnership or Affidavit of Domestic Partnership) will be required. • For an AHNJ member who resides in a state other than New Jersey, the domestic partnership law of the member's state of residence is applicable. • DP coverage may only be added or removed on group's anniversary date. • Must be offered by all in-force carriers in order to add to the AHNJ coverage. • Must be added to all groups within an affiliation. • Must be added to all lines of business – separate group numbers not permitted. • Domestic partners cannot be covered retroactively. • COBRA coverage does not apply to domestic partnerships. If applicable, domestic partners are entitled to coverage under the New Jersey Small Group Continuation law. If the federal government (Department of Labor) issues further guidance on COBRA coverage for individuals with a domestic partner, these underwriting guidelines will be revised to reflect the guidance. As with New Jersey Small Group Continuation law, groups will determine the applicability of COBRA coverage, if applicable, for their employees with a domestic partner.
Civil Union partner coverage	• The New Jersey Civil Union Act, effective February 19, 2007, requires that civil unions must be treated the same as marriage and coverage for civil union partners is handled under the same provisions as eligible spouses. • For an AHNJ member who resides in a state other than New Jersey, the civil union law of the member's state of residence is applicable. • COBRA coverage does not apply to civil unions. If applicable, civil union partners are entitled to coverage under the New Jersey Small Group Continuation law. If the federal government (Department of Labor) issues further guidance on COBRA coverage for individuals with a civil union, these underwriting guidelines will be revised to reflect the guidance. As with New Jersey Small Group Continuation law, groups will determine the applicability of COBRA coverage, if applicable, for their employees with a civil union.
Same-sex spouse coverage	• The state of New Jersey legally recognized same-sex marriages effective October 21, 2013 requiring that same sex couples be treated the same as opposite-sex married couples. • Underwriting guidelines and eligibility applicable to an opposite-sex dependent spouse will also apply to a same-sex dependent spouse.
COBRA	• COBRA coverage will be extended in accordance with the federal law. • Employers with 20 or more employees (full- or part-time) are eligible to offer COBRA coverage. • The number of enrollees in COBRA is limited to 10 percent of the group enrollment. • COBRA members are not to be included for purpose of counting employees to determine the size of the group. Once the group size has been established, and it is confirmed that the law is applicable to the group, COBRA members can be included for coverage subject to the normal underwriting guidelines.

New Jersey State group continuation (NJSGC) right	• NJSGC coverage will be provided in accordance with state law. • NJSGC applies to employers with 2 to 50 employees, if the employer purchases a small group health benefits plan. Groups with 20 to 50 employees must comply with both COBRA and NJSGC. • Note: When determining the size of the group, former employees receiving coverage under NJSGC are not included in the group count. Once the size of the group has been determined, and it is determined that the law is applicable to the group, former employees receiving coverage under NJSGC will be included for coverage subject to the normal underwriting guidelines.
Employer eligibility	• An employer must employ on average at least 51 **full-time employees, including full-time equivalents (FTEs),** on business days during the preceding calendar year. • All persons treated as a single employer under specified sections of Section 414 of the Internal Revenue Service Code shall be treated as one employer. • New group applicants not meeting this definition of an employer are not eligible for coverage under the Large Group programs, but may be eligible for coverage under the New Jersey Small Employer Health Program (SEH) – refer to the AmeriHealth New Jersey SEH Underwriting Guidelines manual. • Employers with less than 51 eligible employees who do not meet the definition and requirements for the NJ SEH Program may be considered eligible for coverage under the large group programs, but certain limitations may apply, as noted throughout these guidelines. • ***Ineligible groups include, but are not limited to:*** Fraternal organizations, clubs, professional associations, volunteer organizations, or any organization formed solely for the purpose of obtaining health coverage.
Common ownership affiliation (two or more companies affiliated or associated)	• Employers who have more than one business with different tax identification numbers (TINs) may enroll as one group if the following criteria are met (combined arrangements will not be quoted until sufficient proof of ownership is provided, as outlined below): − One owner, either a single person or business entity, has controlling interest (greater than 50 percent interest) of all businesses to be included. − Provides proof of ownership (acceptable proof includes copies of IRS Forms 851, 1065 - Schedule K-1, or SS4 – Application for Employer ID, and/or a copy of latest federal tax return — all businesses filed under one combined tax return must be enrolled as one group). − Provides WR30 Employer Report of Wages Paid for each entity and combined census with all eligible from all entities. − Must have common policymaker legally authorized to make benefits decisions for the combined business. − All companies must be in a common or related industry. − Letter from group indicating desire to combine the commonly owned entities. • Subject to underwriting review and approval on case-specific basis. • Also applies to existing groups wishing to add new businesses under common ownership arrangement (i.e., acquisitions, mergers). • Once common ownership is established and premium rates are provided, the rates must be accepted as presented. • Common ownership groups may later be separated for group coverage ***only*** when based on verifiable legitimate business reasons. **Note:** Employers should refer to their tax advisor or legal counsel to confirm eligibility for common ownership.
Prior AHNJ coverage	• Groups that have been terminated for non-payment by AHNJ will not be eligible to reapply for coverage until **all** of the following requirements are met: − Must wait until 12 months after the termination date;

- The group makes payment of six months of premium in advance of issuance of health benefits plan; and,
- all outstanding financial balances are paid in full.

- Both other carrier and AHNJ medical claims information (medical loss ratio) subject to review along with information provided on the employee application and included in the overall assessment of the group.
- For former AHNJ groups reapplying for coverage, determination of group status will be based on the following criteria:
  - Groups returning within 12 months of termination will be deemed “renewal” business;
  - Groups returning more than 12 months following termination will be deemed “new business.”
- AHNJ reserves the right to assess a reinstatement fee to returning groups that have been terminated due to non-payment.
- Upon satisfaction of the above conditions, AHNJ Underwriting will review the case and make a final determination on whether or not to approve the reinstatement and applicable rate level.

Product offerings – Groups of 51 or more*(and non-SEH Groups of less than 51*)

*New Business: eligible enrollees; existing business: enrolled contracts)

Benefit plans	• Medical plans: HMO, HMO Plus, POS, PPO, EPO, ICPOS and CMM. • Supplemental ancillary benefits: − Prescription drug and vision.
Quoting policy – maximum number of plan options	• Employers may select up to three total benefit packages. (Note: National products for out-of-area employees and Medicare products will not be counted toward the maximum number of benefit levels.) • Requests for more than three total benefit packages will require underwriting approval. • All benefit levels may be within one product line or multiple product lines. • CMM plans may only be offered for out-of-area or retiree contracts, when part of a larger group, and may not exceed 10% of the total enrolled contracts. • When two or more HMO and/or POS plans are offered alongside each other, there must be a significant difference in the member cost-sharing levels between each of the plans (in-network deductibles, copayments, coinsurance amounts). • If multiple plans are offered, they must all include or all exclude prescription drug coverage. (Exception: when one option is an HSA-qualified HDHP with integrated drug, other non-HSA-qualified plans may either include or exclude drug coverage.) • Groups may not offer the same medical plan with different drug and/or vision options.
Ancillary products (Prescription drug plans, vision riders, and dental plans)	• Ancillary products must be offered in conjunction with a medical plan (not on a standalone basis). • Only one option for each of the ancillary products may be offered (one prescription drug plan, one dental plan and/or one vision plan). • Surcharge for cancellation of prescription drug coverage from a package offering: A two-percent surcharge will be applied to the medical line of coverage immediately upon termination of the prescription drug coverage. • For groups of 51-99, medical only coverage is not permitted. Prescription drug must be purchased with the medical benefit (this requirement does not apply to Public Sector groups). • Ancillary products may only be added or dropped on-anniversary (particularly in the case of vision coverage, this avoids the situation where a group pays for the vision rider, the group members get their eyeglasses, and then the rider is dropped).
Mandated benefits	• AHNJ benefit plans comply with all applicable federal and New Jersey State mandates.
Off anniversary plan changes	• Off-anniversary downgrades are permitted using the following guidelines: − All changes must be completed 180 days prior to anniversary. − Upgrades are only allowed on anniversary − Limit of one off-anniversary and one on-anniversary downgrade per contract year. − Requests for off-anniversary changes must be sent to AHNJ Underwriting 75 days (or more) in advance to ensure our customers receive an updated summary of benefits and coverage as required by the Affordable Care Act at least 60 days prior to the effective date of the off-anniversary change. − All requests subject to underwriting approval.
High deductible health plans (HDHPs), including HSA-qualified HDHPs	• Definition: − HDHP: Any plan with an in-network deductible of $500 Single/$1,000 Family or higher. − HSA-qualified HDHP: Plans must follow prescribed federal guidelines and requirements, which are updated annually by the IRS. • Guidelines for funding deductibles. Employers are not permitted to: − fund more than 50% of the employee/family deductible costs in an HRA or HSA, unless

approved and priced accordingly by AHNJ underwriting;
  - provide a supplemental benefits plan that augments the core health insurance plan;
  - pay more than 50 percent of employee/family deductible costs through an allowance or claims payment;
  - provide any combination of the above that causes the total amount funded to be greater than 50 percent of the employee/family deductible.
- If offered off-cycle, the full annual deductible will apply to the shortened period — there is no deductible carryover to the next contract year.
- An HDHP or HSA-qualified HDHP may be offered along with other products, as long as the maximum number of product offerings is not exceeded.
- HSA-qualified HDHPs: Health Savings Account (HSA) regulations have distinct requirements for prescription drug coverage. Federal requirements for HSA-qualified HDHPs do not allow a separate prescription drug program (or rider) to provide benefits before the HDHP annual deductible is satisfied; therefore, if a plan provides any prescription drug benefit before the annual deductible is met (except in the case of preventive drugs), it is not a qualifying HDHP for a Health Savings Account. If the employer group has a prescription drug program through another carrier, the group may request AHNJ to combine the Rx claims with the AHNJ medical plan claims. Such requests are subject to underwriting review, and if approved, an additional administrative fee will apply for this service.
- An HDHP may be sold without being paired with an HRA, HSA or FSA.

Commit2Wellness Rewards	• Program effective January 1, 2012, for all commercial groups, provided at no additional cost to employer • Incentive-based program allows members to earn points for healthy behaviors and redeem them for gift cards. • Eligible members include all enrolled commercial group members, their covered spouses and dependents age 18 or older.
AHNJ Guest Advantage (GA)	**<u>Overview</u>:** • Guest Advantage is a courtesy service to members on plans without national access, at no additional cost to the employer or member, for fully insured groups. Self-insured groups must pay for the service. • Currently offered to: − Dependents actively enrolled full-time in college or university outside of the network service area. − An employee (*subscriber only*) traveling outside of the network service area for more than 90 days (3 months) but less than 180 days (6 months). − Dependents living apart from the primary subscriber, when medical coverage is required to be provided by court order. Although this is a filed criterion it is not to be promoted or encouraged. If enrolled, it should be considered a temporary solution for up to 12 months and not renewable. **<u>Guidelines</u>:** • Guest Advantage services are designed as a short-term solution, not a permanent alternative to national access. • If the member is part of a group plan that offers a plan with national access, then the member will be denied enrollment into Guest Advantage. An exception to this rule is, if the member wants to enroll into Guest Advantage off anniversary, then we will allow enrollment, since the member can't make an off anniversary plan change. We will allow them to enroll in Guest Advantage until their anniversary date. Upon anniversary, the member will be removed from the Guest Advantage program and should move into the national access option. • Members on individual coverage will not be offered Guest Advantage. • College students should only be given Guest Advantage services during the academic school year. They must be required to show proof of enrollment from school every year. If they require summer coverage, they must show proof of their continued enrollment or temporary work arrangement for the summer. • For members traveling for work purposes, this is meant as a short-term coverage. Members should provide a start date and end date for their Guest Advantage services, along with a letter from their employer validating their travel time. All contracts must be for members traveling more 90 days (3 months) but less than 180 days (6 months). The short-term worker category is only applicable to the subscriber. • Long-term traveler and seasonal residency are not valid criteria for Guest Advantage. • AHNJ Underwriting must approve all applications for enrollment in Guest Advantage. • Guest Advantage services are only available within a 45-mile radius of the Guest Advantage enrollee's residence for which they were approved.

AmeriHealth+ Health Reimbursement Account (HRA Account)	• May be offered with any medical plan. • May be offered with an HSA qualified plan, but must be a limited-purpose HRA (reimbursement limited to specific types of benefits). • Groups adding or changing to an HRA plan with a non-calendar year contract year benefit period may change to a calendar year anniversary date, which would apply to all products for that group. • An HRA plan option can be offered along with other products, as long as the maximum number of permitted product offerings is not exceeded. • Employer funding to the HRA cannot exceed 50 percent of annual deductibles. • Only one HRA option is allowed per employer.
AmeriHealth+ Flexible Spending Account (FSA Account)	• May be offered with any medical plan. • If offered with an HSA-qualified HDHP, the FSA must be a limited-purpose health FSA (under a limited purpose FSA, only eligible vision and dental expenses are reimbursable-- general medical expenses **are not** eligible for reimbursement). • May only be offered on group's anniversary date. • Not available as a stand-alone product.
AmeriHealth+ Health Savings Account (HSA Account)	• Available only with a federally qualified high deductible health plan (HDHP). • Adult vision plans are not offered with this product. • Groups adding or changing to an HSA-qualified plan with a non-calendar year contract year benefit period may change to a calendar year anniversary date, which would apply to all products for that group (HSA and non-HSA products)

Network options:

National Network Access	• Available only as a rider to PPO, EPO, and POS Plus products. • Access to the National Network may be offered to all employees of a group or to a closed class (out-of-area) of employees; it may not be offered as an option to employees. • Not available on slice business (slice business is defined as a case where there is more than one health benefits carrier insuring the group). • Requests for National Network Access on groups within affiliations will be reviewed by AHNJ Underwriting on a case-by-case basis. • **Quoting Scenarios:** − **Quote National Network to all employees:** (all employees, regardless of whether they are local or out-of-area, require National Network access) • Only PPO, EPO or POS Plus products could be quoted • One rate would be charged to all employees for each benefit design. − **Quote National Network to out-of-area employees only**: • The local employees would have a separate rate from those needing National access and the **local** employees may be offered HMO, HMO Plus and POS products. • Different rates would be charged for the local versus OOA population: • ***Rating option 1:*** Apply no load to the local population and apply 100 percent of the National Network load to the out-of-area contracts. • ***Rating option 2:*** If the employer wants to reduce the rate spread between the local and out-of-area employees, apply a small load to the rating for the local population to subsidize a reduced load to the out-of-area contracts – however, there must ALWAYS be a rate differential between a product with the National Network rider compared to that same product without the National rider.
Regional Preferred Network	**Overview:** • Offers greatest provider access • Preferred Network covers the entire state of New Jersey • Pennsylvania and Delaware: Includes 9 counties in Pennsylvania the entire state of Delaware. • National Network access may be added as a rider on the following benefits offered in the preferred network: PPO, EPO, and POS Plus products • Network downgrade is allowed at any time. Please refer to the Off-Anniversary Plan Changes section on page 12 for additional requirements related to off-anniversary plan changes. **Available products:** • HMO, HMO Plus, HMO Coinsurance; • POS, POS Plus, IC POS, POS Coinsurance, POS Plus Coinsurance, IC POS Coinsurance HMO Plus Coinsurance; • EPO, EPO H.S.A.; • PPO HSA. **Group Availability:** • **New business**: May be sold on all available products outlined above, subject to plan offering limitations outlined in "Multiple Plan Option" section below. • **Existing groups:** • May move from lowest-cost Preferred Network option (currently, HMO Coinsurance Option 3 or IC POS Coinsurance Option 3 or HMO Plus Coinsurance Option 3or EPO 1250/50%) to Value Network; • If a plan change is made from the Preferred Network to the Value Network in combination with other benefits changes, the overall result (network plus benefit changes) must be a premium decrease.

Local Value Network	**Overview:**
	• Access to a subset of providers within the Preferred Network.
	• Pennsylvania and Delaware access: Does not include any providers in Pennsylvania (if a PA or DE member is enrolled in a Value Network product, only those NJ-based Value Network providers will be considered in network.)
	• Not available in Hunterdon County.
	• National Network Access is **not** available with the Value Network.
	Available products:
	• HMO, HMO Plus, HMO Coinsurance;
	• POS, POS Plus, IC POS, POS Coinsurance, POS Plus Coinsurance, IC POS Coinsurance HMO Plus Coinsurance;
	• EPO, EPO H.S.A.;
	• PPO HSA.
	Group Availability:
	• **New business:** May be sold on all available products outlined above, subject to plan offering limitations outlined in "Multiple Plan Option" section below.
	• **Existing groups**:
	  o May move to Value Network from lowest-cost Preferred Network option If group does not have any enrollment in the lowest cost option available.
	  o If plan change is made from the Preferred or national Network to the Value Network in combination with other benefits changes, the overall result (network plus benefit changes) must be a premium decrease. Please refer to the Off-Anniversary Plan Changes section on page 12 for additional requirements related to off-anniversary plan changes.
	
	Multiple plan options: Groups may offer both Value Network and Preferred Network as either:
	• Class-carve-out option (subject to state and federal requirements); or
	• Core/buy-up option – there must be a significant in-network benefit design difference consisting of:
	  o a minimum coinsurance difference of 10%; **and,**
	  o a minimum copay difference of $10; **and,**
	  o a minimum deductible difference of $500.
	• In a dual-option scenario, Underwriting reserves the right to re-price if there is a 10% or greater change in enrollment (as a result of plan design enrollment or enrollment by tier).
	Network changes:
	• Network downgrade (Preferred to Value) is allowed at any time.
	• Groups in the Preferred network may move to the Value Network only from the lowest Preferred Network plans,
	• Network upgrade (Value to Preferred) is allowed only on anniversary.
	• Groups must maintain most recently purchased network option for at least 12 months.
	Groups that are currently not at the lowest Preferred Network plan cannot first make an off-anniversary benefit change to the lowest Preferred Network plan and then change to the Value Network on anniversary.

AmeriHealth Advantage Network	**Overview:**
	• **Tier 1**
	  o Access to all of Cooper Health System, Shore Medical Center, Meridian Health, Cape Regional Medical Center facilities and affiliated professional providers.
	  o Only available to members residing in and groups headquartered in Ocean and Monmouth counties, Camden, Burlington and Gloucester.
	• **Tier 2:** Access to providers in the Value Network
	
	Available Products: EPO Plans and EPO HSA *only No benefit exceptions are allowed.*

	Group Availability:
	• May be sold on any AH Advantage EPO design, subject to plan offering limitations outlined in "Multiple Plan Option" section below.
	
	Multiple plan options:
	Groups may offer both AmeriHealth Advantage Network and Preferred Network as either:
	• Class-carve-out option (subject to state and federal requirements); or
	• Core/buy-up option – there should be a significant in-network benefit design difference, the following examples:
	  ○ a minimum coinsurance difference of 10%; **and,**
	  ○ a minimum copay difference of $10; **and,**
	  ○ a minimum deductible difference of $500.
	• In a dual-option scenario, Underwriting reserves the right to re-price if there is a 10% or greater change in enrollment (as a result of plan design enrollment or enrollment by tier).

Tier 1 Network	**Overview**
	New Jersey statewide availability except for Hunterdon. ***Note*:** This is a facility only network.
	Available Products: EPO Plans and EPO HSA *only. No benefit exceptions are allowed.*
	
	Group Availability:
	• May be sold on any Tier 1 EPO design, subject to plan offering limitations outlined in "Multiple Plan Option" section below.
	
	Multiple plan options:
	Groups may offer both Tier 1 Network and Preferred Network as either:
	• Class-carve-out option (subject to state and federal requirements); or
	• Core/buy-up option – there should be a significant in-network benefit design difference, the following examples:
	  ○ a minimum coinsurance difference of 10%; **and,**
	  ○ a minimum copay difference of $10; **and,**
	  ○ a minimum deductible difference of $500.
	• In a dual-option scenario, Underwriting reserves the right to re-price if there is a 10% or greater change in enrollment (as a result of plan design enrollment or enrollment by tier).

Rating information

Experience rating programs – fully-insured

Prospective rating

Description	• Fully-insured program • Employer pays a fixed premium rate to AHNJ, and AHNJ assumes the entire claim risk for the covered services. No surplus/deficit determination
Eligibility for Prospective Rating Methodology	• Standard rating method for groups of 51 or more: − Based on total number of employees for new business; − Renewing groups will retain their current rating method.)

Affiliation groups

Definition and requirements

Any request to combine groups to form an affiliation is subject to Underwriting review and approval. Following is some basic, general information regarding affiliations:

- Definition of an affiliation: Two or more groups combining for experience-rating purposes:
  - Groups having common ownership (refer to the common ownership section for details on common ownership requirements and definition); or,
  - Groups not having common ownership but with other valid evidence for combination — for example, common industry classification or common union affiliation (e.g., carpenters locals).
- Typically, all groups in the affiliation pay the same rates for the same benefits.
- The corporate headquarters of each member group must be located in the AHNJ service area.
- Must be affiliated for all lines of business.
- Important: All requests to form a new affiliation, as well as the continuation of existing affiliations, are subject to AHNJ Underwriting review and approval.

Please Note: A CPA or lawyer may be required to attest to the fact that groups are affiliated.

Union groups

Union groups may be eligible for large group coverage subject to review and approval by Underwriting management.

- One or more of the following union documents may be required as proof that the organization is formed as a valid union group:
  - Collective Bargaining Agreement (signed by the union president)
  - Copy of the union Constitution and Bylaws (signed and dated)
  - Current copy of the annual union financial reports (LM-2, LM-3, or LM-4)
  - Department of Labor filing number
  - Other information and/or proof not listed above may be required.

Note: Multiple Employer Welfare Arrangements (MEWA's) are not eligible for AmeriHealth large group health coverage.

Rate quote submission

Documentation needed when submitting a rate quote request

Incomplete submissions may impact our ability to evaluate the group application and provide a competitive proposal. Subject to applicable state and federal laws, AHNJ reserves the right to decline or pend quote requests. Such a decision will not be based in any way on the medical condition of the group's members.

Existing business:

- Requested plan design;
- Marketing strategy and group/broker expectations (if applicable);
- Note: If adding new contracts totaling more than 10 percent of existing population, refer to "new business group" requirements outlined below.

New business: (including existing business adding new contracts totaling more than 10 percent of existing population)

- **Background information**:
  - Marketing strategy and group/broker expectations
  - Is prospect a previous AHNJ customer (if so, provide details)
  - Name of existing insurance carrier
  - Broker and/or consultant information
  - Carrier history (five-year history preferred, if available).
  - Length of time with current carrier
  - Summary of current plan design
  - Detailed current benefit description (source documentation)
  - Employee contribution schedule (percentage or dollar value) by plan design and by tier (for example, 100% single, 50% family)
  - A certification letter is required for all renewing groups with less than 150 enrolled
- **Claims information:**
  - Twelve to 24 months of prior claims data (minimum of 12 months experience) or
  - Underwriting may accept an upcoming renewal (corresponding with the effective date of the quote request) if the claims data is not available or
  - Five years of renewal history
  - For first-year groups, a minimum of 7 months of claims data will be accepted.
  - For State Health Benefit Plans, at least 12 months of prior claims data is required.
  - Newly formed groups with no prior claims data or renewal information, may be required to complete individual health questionnaires.
  - Claims data should not be more than 6 months older than rate quote submission date.
  - Source documentation for upcoming renewal
  - Process claims renewal calculation
  - Experience period should be defined (specify incurred and paid periods) [i]

Please note: *If the underwriter is unable to determine the experience period based on the information provided, the group must define the experience period.*

  - Specify any benefit changes made within each experience period provided
  - Medical claims broken out by inpatient, outpatient, and professional claim categories, if available

- Medical claims broken out by facility and zip code, if available
- Enrollment for the claims period (breakdown of contracts by month preferred).
- Shock claims information (individual claims in excess of $50,000)
- Diagnosis and prognosis for the shock claims (excess claims)
- Prescription drug claims data, to include the following information, if available:
- Script count
- Break-out by generic, brand and non-formulary, as well as retail and mail order
- Prescription drug claims data must also include: Script count and break-out by generic, brand and non-formulary, as well as retail and mail order.

- **Background and Claims information required for Self-Insured Groups requesting a fully-insured quote:**
  - Self-insured groups requesting a fully-insured quote must provide documentation that the group has been self-insured for at least three years.
  - For groups that are currently self-insured requesting a fully-insured quote, or space for State Health Benefit Plans, at least 12 months of prior claims data is required.

Please note: *Claims data provided cannot be more than 6 months older than the quote submission date.*

  - Shock claims in excess of ½ of the customers pooling point are required for self-insured groups requesting a fully insured quote,
  - For self-insured groups requesting a fully insured quote, diagnosis and prognosis for excess claims is required.
  - State Health Benefit Plans are excluded from the shock claims and diagnosis and prognosis claims requirements listed above.

Please Note: *Unless specifically stated in this section, other requirements listed in this document apply to self-insured groups requesting a fully-insured quote (e.g. enrollment, experience period, rate and census information etc.).*

- **Rate information:**
  - Current and renewal rates (source documents)
  - Historical final rate increases for last three-year period
  - Current financial arrangement
  - - Commission level requested for current quote (applies to groups of 100 or more)- Current broker commissions with current carrier (if applicable)
- **Census information** – in spreadsheet format -- must include:
  - Employee name
  - Date of birth (MM/DD/YYYY)
  - Current plan design indicator (for example, employee John Doe is enrolled in HMO high option plan)
  - Zip code of current residence
  - Employee gender
  - Hours worked for each employee
  - Coverage status (enrollment by coverage tier)
  - Total number of eligible employees versus enrollees
  - Waivers – eligible employees not electing coverage because they are covered under another plan
  - Opt-outs – eligible employees not electing coverage and who are not covered under another plan
  - New hire information: date hired or date eligible for coverage if employees are

in a probationary period
- COBRA subscribers and expiration date
- Dependent information is required

- **Additional information needed:** (where applicable):
    - Request for proposal (RFP) with all attachments
    - Competing carrier information (if available)
    - Documentation reflecting proof of valid labor agreement

Newly formed business:

- Business license (not a professional license). If not available, a copy of partnership agreement, articles or organization or articles of incorporation; and
- Employer identification number/federal tax ID number; and
- Quarterly Wage and Tax Statement. If not available, when will one be filed; or,
- If the above listed documents are not available for a newly formed business, Underwriting may accept a letter from Certified Public Accountant or an attorney listing the names of all employees (full- and part-time), number of hours worked each week, dates of hire, weekly salary, and confirmation of establishment of payroll records.

Please note: The letter provided must be on a CPA or attorney letterhead to include the employer identification number/federal tax ID.

Right to decline to quote	Subject to applicable state and federal laws, in compliance with any guarantee issue requirements, AHNJ reserves the right to decline to quote any group not meeting our minimum requirements. Such a decision will not be based in any way on the medical condition of the group's members.

Benefit customization requests:

- Any requests to customize standard benefits (e.g., cost sharing changes, add/exclude benefits, alter visit limits) are defined as "benefit exceptions".
- For groups of 51-99 employees, benefit customization is strictly on an exception-only basis and subject to AHNJ Underwriting and Product Management approval.
- Collectively bargained and public sector account may be quoted "equal to or better" benefits, subject to AHNJ Underwriting and Product Management approval.
- Requested benefit exceptions require Product Management review to ensure AHNJ product filings support the requested alterations.
- Some benefit exceptions require full operational review to determine AHNJ's ability to meet customer requirements.
- AHNJ Underwriting will not release a rate quote until confirmation of Product Management review and operational review (when necessary) is complete and all required approvals are received.

NEED MORE HELP?	Questions regarding benefit customization requests should be directed to the appropriate AHNJ product manager for the customer segment.

Post-sale submission requirements

Post-sale enrollment requirements	• Rates quoted are conditional pending receipt, review and acceptance of the standard submission requirements. • Rates are based on final enrollment – AHNJ reserves the right to re-evaluate rates quoted if final enrolled contracts vary by ten percent, plus or minus, or if there is a material change in the age/sex calculation.

Group terminations and reinstatements

Termination process	• Any terminations will be in compliance with the federal Patient Protection and Affordable Care Act. • Group may terminate coverage on contract anniversary date, with at least 30 days' advance written notice to AHNJ. • For ASC/self-funded groups, AHNJ may terminate the agreement immediately upon prior written notice for nonpayment. Either party may terminate the agreement for any reason, upon 90 days' prior written notice. • AHNJ may terminate the group's coverage for nonpayment of premium, upon written notice, effective the last day of the 30-day grace period. • AHNJ reserves the right to terminate a group's coverage off-anniversary if the group fails to meet AHNJ's underwriting guidelines. Per the New Jersey Department of Banking and Insurance, N.J.S.A. 17B:27-66b permits non-renewal only for noncompliance with contribution or participation rules. Group products are guaranteed renewable at the policyholder's option.
Terms and conditions upon termination of coverage	• The group is responsible for all due but unpaid premiums and any accrued deficits. • Payment of deficits: Any historical deficits are due and payable at time of termination; any deficit from the current policy period is due and payable at point of final financial settlement. • When active group is terminated, all dependent to 31 groups, all COBRA groups, retiree groups, and Medicare groups (including Medicare Advantage groups) must also be terminated – COBRA-only, retiree-only, or Medicare-only groups are not allowed. • If group cancels medical coverage, all riders must also be cancelled. AHNJ does not offer standalone prescription drug, dental or vision coverage.
Reinstatement of coverage	• Applies to groups terminated from coverage due to nonpayment of premium. • Reinstatement must occur within 60 days of the effective date of cancellation. • Must be retroactive to the cancellation date. • All outstanding financial balances must be paid in full prior to reinstatement. • AHNJ reserves the right to assess a reinstatement fee for administrative services. • Upon satisfaction of the above conditions, AHNJ Underwriting will review the case and make a final determination whether or not to approve reinstatement and applicable rate level. • Limit of one reinstatement per year.

Defined Contribution Products

Overview

- Defined Contribution allows an employer to fund a specific dollar amount for each employee to use to purchase health care benefits.
- The defined contribution products are available to new and existing groups.
- The AHNJ defined contribution products consist of predetermined packages of health plans, with multiple health plan options within each package (hereafter referred to as the “package” or “package of plans”). Refer to the defined contribution benefit plan chart for details about each package.
- Each employee can then make a health plan selection within this package that best meets his/her health care and financial needs. The employee is responsible for funding the balance of any premium cost above the employer’s contribution.
- Employers will be allowed to select 5 defined contribution products from the predetermined defined contribution offerings (see defined contribution benefit plan chart).

Employer Contribution:
The employer must contribute a minimum of 50 percent of the cost of the highest cost plan within a selected package.

Benefit Changes *(adding a new plan or changing an existing plan)*:

- All benefit change requests must be submitted to AHNJ at least 45 business days prior to the effective date of the change. Requests for effective dates with less than 45 days advance notice must be approved by Sales and underwriting management review.
- There will be no benefit exceptions for the Defined Contribution plans.
- Benefit changes will only be allowed on anniversary.

Product Offerings:

- National Access defined contribution products can only be offered on Plan A or Plan C. National access plans must be offered to all employees.
- Prescription plans must be selected based on the prescription suite associated with the medical benefit selected (see product grid).
- If a value plan is offered, all plans must be selected must be from the value package of plans.
- If vision is offered, it must be offered on all eligible health plans within the selected package.
- Defined contribution products cannot be offered to employees alongside non-defined contribution product offerings.

***Note:** Other than the specific guidelines for defined contribution products described in this section, the AHNJ Underwriting Guidelines generally apply to defined contribution products*.