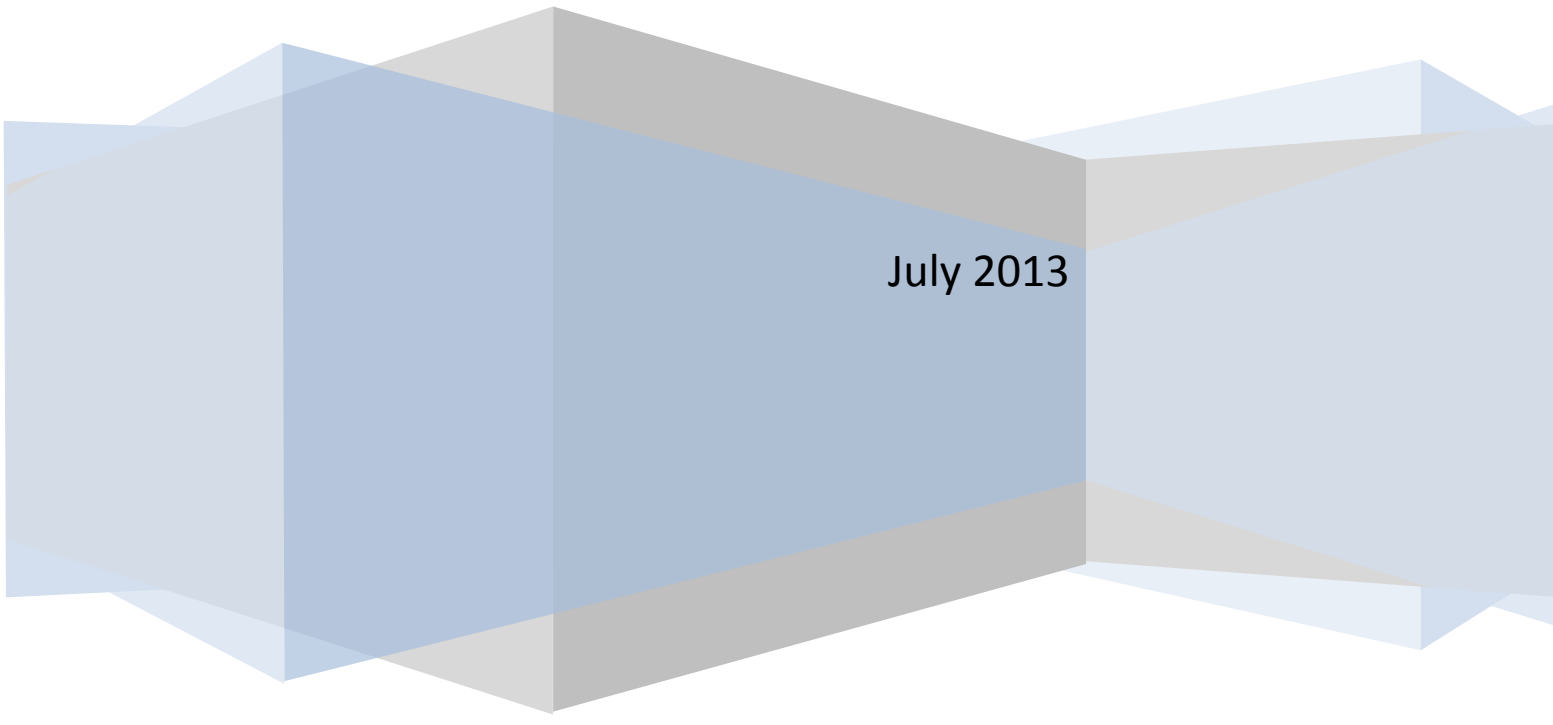
AmeriHealth NEW JERSEY

New Jersey Small Employer Health (SEH) Underwriting Guidelines for Brokers

(Groups of 2 to 50)

AmeriHealth New Jersey Underwriting Department



July 2013

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New Jersey Small Employer Health (Groups of 2-50)

Underwriting Guidelines

This document is for informational purposes only and is not intended to be all-inclusive. AmeriHealth HMO, Inc. and AmeriHealth Insurance Company of New Jersey [collectively, AmeriHealth New Jersey (AHNJ)] reserves the right to change these underwriting guidelines without notice as AHNJ, within its sole discretion, believes necessary or to comply with federal and/or state law or as required by federal and/or state regulatory agencies. AHNJ has the sole discretion and final authority to interpret the scope and application of the underwriting guidelines. These guidelines supersede any previously released guidelines.

New Jersey Small Employer Health Reform (SEH)

Overview	▪ The Small Employer Health Reform (SEH) is a state law in New Jersey that mandates how insurance companies offer coverage to groups of 2-50 eligible employees within the state. ▪ For detailed information, please visit the New Jersey Department of Banking and Insurance (NJDOBI) webpage: http://www.state.nj.us/dobi/division_insurance/ihcseh/sehmain.htm

Eligibility and Enrollment Requirements

Definition of a small employer health plan (SEH) [the "group"]	▪ A "small employer", in connection with a group health plan with respect to a calendar year and a plan year, must meet **all** of the following requirements: – any person, firm, corporation, partnership, or political subdivision that is actively engaged in business that employed an average of at least 2 eligible employees but not more than 50 eligible employees on business days during the preceding calendar year; – who employs at least two eligible employees on the first day of the plan year — independent contractors do not count toward meeting this minimum requirement. – the majority (51 percent or more) of the eligible employees are employed in New Jersey; – must have a physical site location in New Jersey — a New Jersey post office box does **not** fulfill the New Jersey location requirement.
AHNJ service area	▪ **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). ▪ **Value network:** New Jersey (all counties except Hunterdon County).
Participation requirements – primary carrier (eligible employees)	▪ **Minimum 75 percent participation applies to all coverage.** ▪ **Valid waivers:** – Employees with group coverage through a plan offered by AmeriHealth New Jersey or NJ FamilyCare; Medicare or Medicaid; or TRICARE (military coverage). Coverage through an individual "direct pay" plan is not a valid waiver. – Employees covered through their spouse. – Employees covered as an eligible dependent to age 26, in accordance with federal health care reform regulations. ▪ Independent contractors do not count toward meeting the minimum participation requirements. ▪ Classed-out employees count towards the participation requirement **and** TEFRA status.

Employer contribution requirement	▪ For contributory plan offerings, the employer must contribute a minimum of 10 percent of the cost of the health benefits.
Employee eligibility	▪ Eligible employees include all active employees and owners or partners actively engaged in the business who: – Are deemed benefit-eligible according to the employer; and – meet all requirements as defined in the carriers' plan documents; and work at least 25 hours per week. ▪ A small employer may elect to cover all eligible independent contractors, subject to the requirements outlined in the "Independent Contractor Eligibility" section below. ▪ ***Ineligible employees include, but not limited to***: temporary, seasonal, substitute, uncompensated employees; volunteers, silent partners, shareholders or investors only; owners, officers or managing members who are not active, permanent, full-time employees; and employees participating in an employee welfare agreement pursuant to a collective bargaining agreement.
Independent Contractor Eligibility	▪ Independent contractors are 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 primarily to obtain insurance coverage; and, – 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 or participation requirements.
Dependent eligibility	▪ Employee's spouse or civil union partner (see "Civil Union" section below.); if both husband and wife 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. ▪ At employer's request, 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 both same-sex couples and opposite-sex couples age 62 or older. ▪ Same sex couples under age 62, only for partnerships established prior to effective date of New Jersey Civil Union Act. ▪ 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 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. However, domestic partners are entitled to coverage under the New Jersey Small Group Continuation law (NJSGC), if applicable to the employer group (see NJSGC section below).
Civil unions	▪ 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 does not apply to civil unions. However, civil union partners are entitled to coverage under the New Jersey Small Group Continuation law (NJSGC), if applicable to the employer group (see NJSGC section below).
COBRA	▪ COBRA coverage will be extended in accordance with the federal law. ▪ Employers with 20 or more employees (full- and part-time) for more than 50 percent of the preceding calendar year are eligible to offer COBRA coverage. ▪ Note: COBRA members are not to be included for the purpose of counting employees to determine the size of the group. Once the size of the group has been determined, and it is determined 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, including employers to whom COBRA does not apply, 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.
TEFRA	▪ TEFRA status is determined by the total number of employees in a group: – If a group has fewer than 20 total employees, the 65 and older employees are rated as Medicare is the primary carrier and AHNJ is the secondary carrier. – If a group has 20 or more total employees, the 65 and older employees are rated as Medicare is the secondary payer and AHNJ is the primary payer. – For retention business, the TEFRA status is based on the number of employees reported by the group on their annual NJSEH certification form.

Common ownership affiliation (two or more companies affiliated or associated)	Employers who have more than one business with different tax identification numbers (TINs) must 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. ▪ If group later fails to meet the above criteria or elects to cover one or more of its businesses through another carrier, the entire group will be subject to cancellation.
Prior AHNJ coverage	▪ Groups that have been terminated for non-payment by AHNJ will not be eligible to reapply until payment of six months of premium in advance of issuance of health benefits plan.
Annual SEH certification process	▪ The State of NJ requires all employers with 2-50 eligible employees offering a group health insurance plan to certify annually that they continue to qualify for SEH benefits. ▪ Notification Process: – AHNJ sends notification and certification form to SEH employer groups approximately 120 days prior to the renewal date. – Groups must complete the form provided and return it to AHNJ via email, fax or mail (fax number, email and mailing addresses shown on the form). – AHNJ will issue a series of communications to groups not responding or providing incomplete information (including a reminder notice, follow-up, and possibly, termination notification). – Fully executed form must be received by AHNJ at least two weeks prior to the group's anniversary date or the group will be terminated on their anniversary date. ▪ Termination Process: – AHNJ may terminate a group for non-compliance or non-response to the required certification form, effective on the group's anniversary date. – Groups that no longer qualify to be a Small Employer according to NJSEH criteria will be so notified by AHNJ and: – will be reviewed for possible large group conversion or non-SEH health insurance; and, – if not eligible for other AHNJ group coverage, groups will be terminated on their anniversary date. ▪ Reinstatement Process: – All requests for reinstatement are subject to AHNJ underwriting approval. – Groups seeking reinstatement must prove they continue to meet the NJ SEH eligibility criteria via an acceptable certification form and provide additional verification (WR30 tax information), if needed. – Groups terminated for non-response may be reinstated if the group submits an

acceptable certification form within 15 days of the group cancellation date.
  - If an acceptable certification form is received after 15 days of the group's cancellation date, reinstatement is subject to underwriting and marketing management approval.
- Customers and brokers may inquire about the status of the certification form by calling the certification hotline (215-640-7573).
- Note: At time of the certification process, AHNJ Underwriting may, at their discretion, require groups to provide acceptable proof of business and/or proof of employment for all employees – see *Pre-sale documentation required* section of these guidelines for details.

Rating Information

Community rating by class (CRC) program	▪ Definition: Community-based rates are adjusted for factors such as age, gender, area, and contract mix, using enrolled contracts for existing groups and eligible contracts for new groups. ▪ Group Size: Applies to SEH customers with 2 to 50 total contracts
Rate Quote Submission	Most rate quote requests can be submitted through the ROAM system, but there are situations requiring submission through the AHNJ account executive.
Situations requiring rate quote submission through AHNJ account executive	▪ A change in anniversary date: – Documentation Required: Letter from group (on customer letterhead). ▪ A material change in the census (for example, purchasing a new entity): – Documentation Required: Proof of common ownership (see "Common Ownership" rules under Eligibility Requirements section of this document). – Requires approval by Underwriting. ▪ All benefit change requests ▪ Non-standard requests not viewable as alternatives to renewals on ROAM.
Documentation required when submitting a rate quote request	**Existing Business:** ▪ Requested plan design ▪ NJ SEH Certification must be received and in good standing. ▪ If adding new contracts totaling more than 10 percent of existing population, refer to New Business requirements outlined below. **New Business – Groups of 2 to 50:** ▪ Name of existing insurance carrier ▪ Length of time with current carrier ▪ Employer contribution (percentage) ▪ Detailed census – in spreadsheet format – must include the following: – Employee name – Date of birth (MM/DD/YYYY) – Zip code – Employee gender – Coverage status (enrollment by coverage tier) – Waivers (valid waivers are listed in the *Participation Requirements* section of these guidelines) – Opt-outs (eligible employees not electing coverage and who are not covered under another plan) – Date eligible for coverage for employees who are in a probationary period
Benefit changes (adding a new plan or changing an existing plan)	**All benefit change requests must be submitted to AHNJ at least five business days prior to the effective date of the change**. In addition, the following provisions apply: **Twelve-month rule:** ▪ Benefit changes may not occur until the most recently purchased health benefit plan or rider has been in effect for at least 12 months. ▪ Exceptions: – On-anniversary changes/adds; – Total takeovers (see section below) – Requests to add a plan for new hires reviewed on a case-by-case basis **On- anniversary benefit changes:** ▪ Renewal census will be used (exception: A total takeover quote -- see section below). **Off-anniversary benefit changes:** (subject to the provisions of the 12-month rule) ▪ Groups may upgrade, downgrade or add a plan off-anniversary ▪ All plans will be re-rated unless the only change is to enrollment or tier selection. ▪ Applicable census: For requests greater than 60 days from renewal, the most recent census, including any new enrollees, will be used; for requests within 60 days after renewal, the renewal census will be used.

	▪ Adding a new plan: If adding a plan more than 60 days from the renewal date, the midpoint will be used as the rate date. ▪ Changing an existing plan: For changes more than 60 days from the renewal date, the previous anniversary date will be the rate date. The mid-point will be used when upgrading to a plan with richer benefits. ▪ Note: If the add/change is within 150 days prior to the renewal, rates for the following plan year may need to be calculated and approved.
Total takeovers	▪ Definition: A group that has existing coverage with both AHNJ and another carrier and wishes to roll their other-carrier coverage into AHNJ. ▪ The anniversary date of the group will not change. ▪ The end date of the total takeover quote will be the upcoming anniversary date of the group. ▪ If the total takeover date is within 150 days prior to the renewal, renewal rates will be calculated for the following plan year. ▪ If the total takeover occurs: – Off anniversary: the rate date will be the mid-point from the previous anniversary date and the effective date of the total takeover. – On anniversary: the anniversary date is used as the rate date. ▪ The most recent census is used for all total takeovers. ▪ The group's current plan(s) will be re-rated for consistency.
Census rules	▪ For new business, the rates are based on the actual enrollment as of the effective date of coverage. ▪ If employees are married and work for the same company, rates are based on how their member applications are completed. ▪ All employees, regardless of their current product choice, are used in the determination of all product rates; the same age/gender factor applies to all products.
Right to decline to quote	▪ Subject to applicable state and federal laws, AHNJ reserves the right to decline to quote any group. Such a decision will not be based in any way on the medical condition of the group's members.

Product offerings

Benefit plans	▪ Benefit plans for SEH groups are mandated by the State of New Jersey. Plans include: ▪ Medical benefits: PPO, HMO, POS, EPO, and HSA Plans ▪ Supplemental benefits: Vision and pharmacy riders
Quoting policy – maximum number of plan options	**Multiple plan options:** ▪ Employers may select up to four AmeriHealth medical plan options, exclusive of "class carve-out" options. ▪ Options cannot differ solely by any one, or combination of, the following variations: Prescription drug plan design, network, referral option, vision, or out-of-network benefits. ▪ Employers may not offer the same medical plan with different pharmacy or vision benefits. ▪ All medical plan options must either include or exclude vision services. ▪ The number of plan options must be less than the number of enrolled employees. ▪ There must be enrollment in each plan offered. **Class carve-out options:** ▪ Qualifications: – The distinction must be by one of the following specific classes or categories of employees (subject to state and federal requirements): Salary versus hourly employees; full-time versus part-time employees; management versus non-management; union versus non-union; owners versus non-owners; or, New Jersey versus out-of-state employees. – Underwriting reserves the right to request any documentation necessary to verify employee classifications. – If EPO and/or Value Network options are selected, then the specific underwriting guidelines defined for those options would apply. – Groups of two enrolled employees cannot have a class out option (see Multiple Plan Option criteria above.) ▪ Maximum of two classes – with up to four options per class.
High-deductible health plans (HDHP) and 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. ▪ Employers are not allowed to: – Fund more than 50 percent of the annual employee/family deductible costs to an HSA ; – Provide a supplemental benefits plan that augments the core health insurance plan; – Pay more than 50 percent of annual employee/family deductible costs through an allowance or claims payment, or; – Provide any combination of the above that causes the total amount funded to be greater than 50 percent of the annual employee/family deductible. ▪ For groups adding an HSA-qualified HDHP for the first time, it will be considered a downgrade from all current product offerings and can be offered off-cycle as of January 1, 2011 on a contract-year-basis only. When offered off-cycle, the full annual deductible will apply to the shortened period — there is no deductible carryover to the next contract year. ▪ An HSA-qualified HDHP may be offered along with other products.

Commit2Wellness Rewards	▪ New program effective January 1, 2012 for all commercial groups 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.
EPO (Exclusive Provider Organization) product	▪ **Description:** In-network only, non-gated plans using the PPO network — HSA and non-HSA plans available beginning with October 1, 2011, effective dates. ▪ **Network:** – Available with either the Preferred or Value provider networks; – Pennsylvania and Delaware access available only when sold with Preferred network. ▪ **National access –** National network access rider available if: – the EPO is sold with Preferred network; and, – the National access rider is offered to either the out-of-area employees only, or the entire group; the same EPO **cannot** be offered with and without National access as an employee choice within the same employee class ▪ **Group availability:** – EPO (HSA or non-HSA) may be sold subject to plan offering limitations outlined in "Multiple Plan Option" section below. – EPO HSA: Available as a replacement or plan offering with any allowable plan combination with the limit of four plans per class of employees. ▪ **Multiple plan options:** – Core/buy-up option: – Plan differential guidelines apply (plans must differ in design other than national access, Rx benefit, out-of-network benefit, network platform and/or gatekeeper/referral option). – The number of plan options must be less than the number of enrolled employees. – There must be enrollment in each plan offered. – Class carve-out option: – SEH groups may offer an EPO as a class carve-out option, if the distinction is by a specific class or category of employees (subject to state and federal requirements). If sold with the Value network, the Value network underwriting guidelines would apply. (Please refer to Value Network section below.) – The number of class out options must be less than the number of enrolled employees (no class out for groups of two enrolled.) – There must be enrollment in each class offered. – Underwriting reserves the right to request any documentation necessary to verify employee classifications.

Network options:	
National Network Access	▪ Available only on EPO and POS Plus products. ▪ 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. ▪ Not available with the Value Network.
Value Network	**Overview:** ▪ Access to a subset of providers within the Preferred Network. ▪ Pennsylvania (PA) and Delaware (DE) 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.) ▪ National Access rider is not available with the Value Network. **Available products:** ▪ HMO, HMO Plus, HMO Split Copay, HMO Split Copay Plus, HMO Coinsurance, HMO Plus Coinsurance; ▪ POS, POS Plus, POS Split Copay, POS Plus Coinsurance; ▪ PPO HSA ▪ EPO, EPO HSA **Group Availability:** ▪ May be sold on all available products outlined above, subject to plan offering limitations outlined in "Multiple Plan Option" section below. **Multiple plan options:** ▪ Core/buy-up option – not available to SEH groups. Groups must offer all available products in the Value Network or in the Preferred Network, but may not offer both. ▪ Class **carve-out option** (Value Network versus Preferred Network): – Available, if the distinction is by one of the following specific classes or categories of employees (subject to state and federal requirements): Salary versus hourly employees; full-time versus part-time employees; management versus non-management; union versus non-union; owners versus non-owners; or, New Jersey versus out-of-state employees. – If group has employees located outside of New Jersey, class carve-out by site location permitted, with Value Network offered to NJ employees and Preferred Network with National Network Access offered to the out-of-state employees. – The number of class out options must be less than the number of enrolled employees (no class out for groups of two enrolled.) – There must be enrollment in each class offered. – Underwriting reserves the right to request any documentation necessary to verify employee classifications. **Network changes:** ▪ Changes to the initial network option purchased may not occur until the network plan has been in place for at least 12 months. ▪ Network changes may be made on anniversary or at any time during the year, contingent upon the 12-month rule stated above.

Pre and 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 10 percent, plus or minus, or if the enrolled group census differs from census used in development of quoted rates.
- Rates are not guaranteed for 12 months. AHNJ reserves the right to re-evaluate the premium rates for changes which may affect the underwriting risk. These changes include but are not limited to:
  - Changes in enrollment after the inception of the policy period; or
  - Adding or deleting enrollees retroactive to the effective date of the policy.

Pre-sale - new business documentation required

New business:

- For groups with less than five enrollees, employers must provide both proof of business and proof of employment for all employees.
- For groups with five or more, proof of business and/or proof of employment for all employees may be requested, at Underwriting discretion.

Existing business: Proof of business and/or proof of employment may be requested at time of certification, at Underwriting's discretion. Please see *Annual SEH certification process* section of these guidelines for more information.

Following are acceptable forms of proof of business and proof of employment:

Proof of Business:

- Schedule C, Schedule K-1 or Schedule F
- IRS Form 1065 (Partnership Income)
- IRS Form 1120 (Corporate Income)
- IRS Form 990 (Tax-exempt return)
- IRS Form 941 (Non-profit)
- Business license
- CPA letter or letter from an attorney (on exception basis only, subject to underwriting approval)
- For newly formed business only:
  - Articles of Incorporation, Certificate of Formation, Certificate of Incorporation (signed and completed with a stamp or receipt with issuing date)
  - Partnership agreement (stamped by state or notarized)

Proof of Employment:

- New Jersey WR-30 – Employer Report of Wages Paid
- W-2 (if recent)
- W-4 (for new hires only)
- IRS Form 1099 (for independent contractors) or written contract
- Payroll documents showing taxes taken out
- Schedule C, Schedule K-1 or Schedule F (for owners only)
- IRS Form 2106 (Employee Business Expense)
- CPA letter or letter from an attorney (on exception basis only, subject to underwriting approval)

Group terminations and reinstatements

Termination process	▪ Any terminations will be in compliance with federal health care reform legislation ▪ Group may terminate coverage on contract anniversary date, with at least 30 days' advance written notice to AHNJ. ▪ 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, including but not limited to minimum participation requirements. ▪ AHNJ may terminate NJSEH group coverage for non-compliance or non-response to the required annual small employer certification form. In such instances, termination will be effective on the group's Anniversary date.
Terms and conditions upon termination of coverage	▪ The group is responsible for all due but unpaid premiums. ▪ When active group is terminated, all COBRA groups and overage-dependent groups must also be terminated.
Reinstatement of coverage	▪ A NJSEH group seeking reinstatement must recertify they continue to meet the eligibility criteria for SEH benefits. ▪ The group must complete and return the NJSEH certification form and provide additional verification, if needed. This provision applies to groups terminated from coverage due to nonpayment of premium or non-response to the certification form. ▪ Reinstatement must occur within 60 days of the effective date of cancellation ▪ Must be retroactive to the cancellation date ▪ Any past-due premium must be paid prior to reinstatement ▪ 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. ▪ Limited to 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 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. – The employer selects a predetermined package of plans to offer their employees. – 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. – The defined contribution products are available to new and existing groups in the New Jersey Small Employer Health (SEH) market effective August 1, 2013. – Employers will be allowed to select one (1) defined contribution product (one package of plans) from the predetermined defined contribution offerings (see defined contribution benefit plan chart). ▪ **Employer Contribution:** – The employer must contribute a minimum of 10 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 15 business days prior to the effective date of the change. ▪ **Off-Anniversary Benefit Changes:** – Groups currently enrolled with AHNJ can move into a defined contribution product off anniversary. – Groups are permitted to change package selection off anniversary. – Employees are not permitted to change plans within their group's selected package off-anniversary. – Request for off anniversary changes must be sent to 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. *Off-anniversary changes are subject to the provision of the 12-month rule (refer to the Benefit Change provisions outlined in the Rating Information section of the AHNJ Underwriting Guidelines).* ▪ **Product Offerings:** – The defined contribution product (package of plans) may include some combination of the following AHNJ medical plan products, dependent upon the package of plans selected: HMO, POS, HMO plus, POS plus, EPO, and HSA plans. All products listed are not available in all defined contribution packages (see defined contribution benefit plan chart). – Select defined contribution health plan options may differ solely by any one or a combination of the following variations: Prescription drug plan design, network, referral option, or out-of-network benefits within the predefined health plan options contained in the selected package of plans. – If vision is offered, it must be offered on all eligible health plans within the selected package. – Groups with defined contribution products have the option to offer Value network

	products in conjunction with Preferred Network products for packages 1-4 (see defined contribution product chart). – All plan options within the selected package are available to all employees regardless of the number of employees enrolled in each plan. For example, a group of two (2) can enroll in a package that offers four (4) plan options but enrollment is not required in each plan. – Defined contribution products cannot be offered to employees alongside non-defined contribution product offerings. *Please refer to the defined contribution product chart for more details on networks and products offerings available.* ▪ **Class Carve-out** – Each group may have a maximum of two (2) classes with one (1) defined contribution package of plans per class. Please see the SEH guidelines for class carve-out qualifications in the Product Offerings section of the AHNJ Underwriting Guidelines. – An employer group enrolled in defined contribution must have all classes enrolled within the defined contribution packages. ***Note:*** *Other than the specific guidelines for defined contribution products described in this section, the Small Employer Health AHNJ Underwriting Guidelines generally apply to defined contribution products*.

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My AHNJ Plans & Packages

	Health Plan Package 1	Health Plan Package 2	Health Plan Package 3	Health Plan Package 4	Health Plan Package 5	Health Plan Package 6
Health Plan 1	EPO HSA $2,500 deductible 50% coins w/ integrated 50% Rx	EPO HSA $2,500 deductible 50% coins w/ integrated 50% Rx	EPO HSA $1,500 deductible 70% coins w/ integrated 50%/$125 max Rx	EPO HSA $1,500 deductible 70% coins w/ integrated $7/50%/$125 max Rx	EPO $30/50% $2,500 deductible 50% coins – National Access $250 ded $7/50%/$125 max Rx	EPO HSA $1,250 deductible 80% coins w/ integrated $7/50%/$125 max Rx – National Access
Health Plan 2	EPO HSA $1,500 deductible 70% coins w/ integrated 50%/$125 max Rx	EPO $30/50% $2,500 deductible 50% coins 50%/$125 max Rx	HMO+ $30/$50 $2,500 deductible 50% coins – Opt 3 $100 ded $10/$40/$60 Rx	HMO $25/$50 $500/day $250 ded $7/50%/$125 max Rx	EPO HSA $1,500 deductible 70% coins w/ integrated 50%/$125 max Rx – National Access	EPO $30/$50 $2,500 deductible 80% coins – National Access $7/50%/$125 max Rx
Health Plan 3	HMO $30/$50 $2,500 deductible 50% coins – Opt 3 $7/50%/$125 max Rx	HMO $30/$50 $1,500 deductible 70% coins – Opt 6 $250 ded $7/50%/$125 max Rx	POS $30/$50; OON $5,000 deductible 50% coins – Opt 2 $7/50%/$125 max Rx	POS $30/$50; OON $5,000 deductible 50% coins – Opt 2 $7/50%/$125 max Rx	POS+ $30/$50; OON $5,000 deductible 50% coins – Opt 2 – National Access $10/$40/$60 Rx	POS+ $25/$50 $500/day; OON $2,500 deductible 60% coins – National Access $100 ded $10/$40/$60 Rx
Health Plan 4	HMO+ $25/$50 $500/day $100 ded $10/$40/$60 Rx	POS $25/$50 $500/day; OON $2,500 deductible 60% coins $7/50%/$125 max Rx	POS+ $25/$50 $500/day; OON $2,500 deductible 60% coins $250 ded $10/$40/$60 Rx	POS+ $30/$50; OON $5,000 deductible 50% coins – Opt 2 $100 ded $10/$40/$60 R	POS + $25/$50 $500/day; OON $2,500 deductible 60% coins – National Access $250 ded $10/$40/$60 Rx	POS+ $30/$50; OON $2,000 deductible 60% coins – Opt 3 – National Access $10/$40/$60 Rx
Network	Option A: All Value or All Preferred Option B: Plans 1 & 2 Value Plans 3 & 4 Preferred	Option A: All Value or All Preferred Option B: Plans 1 & 2 Value Plans 3 & 4 Preferred	Option A: All Value or All Preferred Option B: Plans 1 & 2 Value Plans 3 & 4 Preferred	Option A: All Value or All Preferred Option B: Plans 1 & 2 Value Plans 3 & 4 Preferred	National Access	National Access