How to Sell AmeriHealth
Underwriting and Administrative Guidelines

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New Jersey Small employer Health Market Segment

Products Offered

AHNJ is filed to offer CMM, PPO, POS, POS Plus, IC POS, HDHP HSA, HMO Plus and HMO standard plans for all SEH groups. These products have filed base rates by quarter. These are filed based on age/sex factors by contract type (single, family, etc.) and area factors by county that are applied to those quarterly base rates. Rates can only be offered on a standard four-tiered basis.

There is no limit to the number of Lines of Business (LOBs) an SEH group can have (as long as there is enrollment in each).

Participation and Employer Contribution Requirements

Participation Requirements are mandated in the NJSEH market. As allowed by the regulations, AmeriHealth requires a minimum participation of 75% of eligible employees for all products. Classed out employees do not count towards the participation requirement; however they will count towards TEFRA status. Per the regulations, the following are considered valid waivers for the purposes of meeting the 75% requirement:

- coverage as a dependent under a spouse's health plan
- coverage under any other health plan offered by the small employer
- federal coverage through Medicare or Medicaid
- coverage through the military

The employer must pay at least 10% of the cost of the health benefits.

Pre-Existing Condition Exclusions:

A "Pre-existing condition" is a medical condition which manifests itself within six months prior to a person's enrollment date and which was diagnosed or treated during that six-month period. Pregnancy is not considered a pre-existing condition. If a group consists of 2-5 eligible employees, we may refuse to

cover pre-existing conditions for persons covered under the plan for the first six months the coverage is in effect, unless the group provides proof of prior coverage to waive pre-existing conditions.

If a group consists of 6-50 eligible employees, we do not impose a pre-existing condition exclusion on any member of that group, with the exception of an employee who requests for enrollment in the group's health benefits plan following the initial 30- day enrollment period, who may be required to satisfy a pre-existing condition exclusion for up to six months.

TEFRA:

TEFRA status is determined by the total number of employees a group has. If a group has fewer than 20 employees, the 65 and older employees are rated as TEFRA-No in which Medicare is the primary carrier and AHNJ is the secondary carrier.

For retention business, the TEFRA status is determined based on the number of employees reported on the group's annual NJSEH certification form.

If a group has 20 or more total employees, 65 and older employees are rated as TEFRA-Yes in which AHNJ is primary and Medicare is secondary.

Independent Contractors:

A small employer may elect either to cover all independent contractors or not to cover independent contractors. A person is an independent contractor if he/she: (1) is performing a service for the employer pursuant to a written contract for monetary or other legal consideration; (2) is working exclusively for the employer; (3) works 25 or more hours per week for the employer; (4) works on other than a temporary or substitute basis; and (5) 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.

Union Employees:

Union employees participating in an employee welfare arrangement pursuant to a collective bargaining agreement are not eligible for coverage under SEH.

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Rating Procedures:

Benefit changes (adding a new plan or changing an existing plan) may not occur until the most recently purchased health benefit plan or rider has been in effect for at least 12 months (12-month rule). Exceptions to this include on-anniversary changes/adds and Total Takeovers. Also, requests for a plan to be added for new hires will be looked at on a case-to-case basis. Once the most recently purchased health benefit plan or rider has been in effect for 12 months, a group may upgrade, downgrade or add a plan off-anniversary. Only on-anniversary can a group add or make changes to vision and domestic partner coverage (SSDP). However, unlike domestic partnerships, normal husband/wife guidelines apply to members of a civil union as well. Additional plan designs may be added off anniversary if a group has existing coverage with both AHNJ and another carrier and wishes to roll their current coverage with the other carrier into AHNJ (total takeover). The group must show proof of coverage with the other carrier, and both applications and waivers must be submitted for all eligible employees.

Census rules Because all SEH rates are based on an employee's age, sex, location and contract type, it is important to have a consistent set of rules on whom to include as part of the group when determining rates, and how those rates are calculated.

- For new business, rates should be based on actual enrollment as of the effective date coverage begins.

- If employees are married and each work for the same company, rates should be based on how their member applications are completed. For example, if under their current coverage they each have single coverage, then they would be entered as two single contracts. If on the other hand, the female spouse has the husband/wife contract and the male spouse waives coverage, then they would be entered as one husband/wife contract and the female's date of birth would be used.

- If more than one AHNJ product is to be offered, all employees, regardless of their current product choice, must be entered for all products. For example, if a group of 40 offers PPO and HMO, all 40 employees would be used to the age/sex factor for both PPO and HMO.

Additional rating procedures:

On-anniversary: the renewal census will always be used unless it is a Total Takeover situation. Groups are allowed to make changes or adds regardless of the 12-month rule.

Off-anniversary must adhere to the 12-month rule. The general rule is that everything will be re-rated unless the only change is to enrollment or tier selection. The most current census will be used for effective dates greater than 60 days from renewal, including any new enrollees. Effective dates within 60 days after renewal, the renewal census will be used. Further instruction:

- When a group adds a plan off-anniversary, the group's current plan(s) will also be re-rated.
- Adding a plan more than 60 days from the renewal date, the Midpoint will be used as the rate date.
- For changes more than 60 days from the renewal date, the rate date for downgrades will be the previous anniversary date. The Midpoint will be used when upgrading to a plan with richer benefits.
- If a group has multiple benefits and changes one, the other benefit(s) will be re-rated consistently with the benefit being changed.
- If a change or add is within 150 days prior to the renewal, rates for the following plan year may need to be calculated and signed-off on because it may be too close to the anniversary date for the renewal to reflect the changes being made. If the plan sells, renewal underwriting must be made aware of the change.

Total Takeover Quotes (TT): Anniversary date will not change. The quote will always end with the upcoming anniversary date. If the TT date is within 150 days prior to the renewal, renewal rates will need to be calculated for the following plan year. If the TT is occurring off-anniversary, the Rate Date will be the midpoint of the previous anniversary date and the effective date of the TT. On-anniversary TTs will use the anniversary date as the rate date. The most up-to-date census will be used for all total takeovers, not the renewal census snapshot. The group's current plan(s) must also be re-rated so that all plans are rated consistently.

Administrative topics

Groups requesting an address change: The group's business address should always be the address of the actual physical location of the business and not a separate billing address, P.O. Box or TPA (third party administrator) address. The only time the business address should change is if the group specifically states that the business has relocated. Requests to use a PO Box as an address will require a PO Box letter. Requests to use a TPA address will require a TPA letter to be completed.

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Annual Underwriting review of addresses: For retention business, Underwriting will review NJSEH group addresses and make changes to the address in the rating system and/or recommend address changes to the Marketing Operations area when Certification mail is "returned to sender".

The **Employment Verification form** is used for small SEH groups (usually under 5 eligible employees) where the owner and his/her spouse works for the company but does not have payroll or tax documentation to verify employment. For any group with five or fewer eligible employees, AHNJ requires proof of business and also proof of employment for each employee. Acceptable documentation would be: a Schedule C, Certificate of Formation, or Articles of Incorporation. It is usually not difficult for these groups to provide these for the owner. However, groups often do not have documentation for the spouse even is he/she works, this is because they do not actually get paid a salary and just take a draw, or when the owner takes a draw it is shared between the two. In cases such as these the Employment Verification Form is required. It is important to note that a CPA letter stating the owner and/or spouse works for the company on a full-time basis will be accepted as proof of employment in lieu of the Employment Verification form.

Domestic Partner (SSDP) includes all same-sex couples and opposite-sex couples age 62 or older. Domestic partner coverage can only be set up on anniversary. A NJ Dept of Health & Senior Services Certificate of Domestic Partnership or a NJ Dept of Health & Senior Services Affidavit of Domestic Partnership will be required when members are being added. There is no additional paperwork required for members of civil union, who may be added/removed from coverage in the same manner as spouses. There is no effect on the rates when either domestic partners or civil union members are added.

Termination of Coverage: AHNJ may terminate a NJSEH group coverage for non-compliance or non-response to the required annual small employer certification form effective on the group's anniversary date. NJSEH terminations for non-response or non-compliance to NJSEH criteria are processed via the certification system.

Reinstatement of Coverage: A NJSEH group seeking reinstatement must prove the group continues to meet the NJSEH eligibility criteria via a completed and accurate NJSEH certification form and additional verification, i.e. WR30 tax information, if needed.

NJSEH groups that are terminated for non-response to the Certification process, may be reinstated with the following approvals:

- If an acceptable cert form is received w/in 15 days of the group's cancellation date, underwriting can reinstate without management review/approval.

- If an acceptable cert form is received after 15 days of the group's cancellation date, the reinstatement request would need to be submitted to marketing management by the sales rep and then marketing management will forward to underwriting management for a decision.

What is needed to Sell/Enroll a New Group in the NJSEH Market Segment?

- Application for SEH Benefits Policy
- New Jersey Small Employer Certification
- Copy of ROAM quote, census & demographics
- Signed Enrollment form for each enrolling employee
- Waivers (as applicable)
- First month's premium – must be a corporate check
- WR-30 / Proof of Business (groups under 6 eligible employees)

Large Group Market Segment

AHNJ Service Area A group must have their corporate headquarters, or a local entity, located in the state of New Jersey.

Ineligible Groups A Natural Group that does not meet all of the criteria and basic requirements outlined in this section will not be eligible for group coverage. Some examples are fraternal organizations, clubs, lodges, etc.

Employer Contribution Requirements AHNJ requires that an employer contribute a minimum of 50% to total premium towards the cost of healthcare premiums for its employees. This is to ensure that coverage is reasonably affordable for employees so that a greater percentage will take coverage and therefore ensure a spread the risk.

Participation Requirements Open Access Products such as PPO and CMM products have the richest benefit designs and so a minimum participation level of 75% is required for all Open Access Products. (Other Open Access Products are POS Plus and HMO Plus.) With the introduction of high cost share benefit designs across various product platforms (HDHPs for example), a guideline based solely on product can be too restrictive. The 75% participation requirement may be waived, subject to underwriter discretion, if the underwriter determines that a lower participation requirement will not generate inappropriate risk.

When calculating the participation level on a group, credit will be given for those eligible subscribers who opt out because they have coverage elsewhere through AHNJ and/or its affiliations, parents or subsidiaries, or who are covered through their spouse. Only these types of opt-outs, or waivers, are excluded from the calculation to determine if a group meets the participation requirement.

Participation Requirements for Slice Business For customers where AHNJ is not the sole carrier for their Medical Insurance, participation requirements are 10% of total eligible employees or a minimum of 50 enrolled contracts.

Participation Audits AHNJ reserves the right to conduct an audit at any time, in order to determine the accuracy of the count of eligible subscribers, as well as to assure that the eligibility percentage requirements are being met by the account.

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With ongoing additions and deletions to the group roster throughout the year, there is a potential for the group to drop below the minimum participation requirement. Such a review may result in a change in products offered to the group or cancellation.

Eligible Employees

All individuals who are active employees are eligible to apply for coverage, provided they have fulfilled the waiting periods. An **eligible employee** is defined as someone who meets the following criteria:

- is benefit eligible according to the employer;
- meets all requirements as defined in each carrier's plan document; and
- for HMO products, resides or works in the HMO's defined service area.

AHNJ considers all active employees as eligible for coverage and uses this number as the basis for determining participation criteria. An enrolled contract is defined as an eligible employee who has coverage in force within a particular line of business within AHNJ and/or it's affiliated parents or subsidiaries.

General Size Requirements

Non-SEH employer groups with less than 50 enrolled contracts

- This segment is CRC rated, including Rx, Dental and Vision riders in accordance with our rate filing with the NJDOI.
- To be considered for a quote, a minimum of 5 enrolled contracts is required.
- A standard four-tiered rating structure is used.
- Groups may offer dual options, one from each product line, along with one Drug plan. The combination of offerings should be limited to **two** total packages of combined medical and drug options.
- Rates are adjusted annually on the anniversary date of the group.
- All lines of coverage must have the same anniversary dates.

Groups with 50-99 enrolled contracts

- For new business opportunities, groups will be considered to be experience-rated based on AHNJ's filed rating methodology with the NJDOI (New Jersey Consolidated Experience Rated Formula), providing additional rating flexibility in the Underwriting and Rating.

- Employer groups under a self-funded arrangement with their current carrier will be required to provide claims experience, including High Level Claimant information in order to be provided a fully insured quote.
- A standard four-tiered rating structure is preferred, but other rating structures may be available in competitive situations. The tiered rating structure must be consistent between products.
- Groups may offer dual options, one from each product line, along with one Drug plan. The preferred risk would limit the combination of offerings to **two** total packages of combined medical and drug options. A third offering is allowed, but should be discouraged. No more than three medical plans are allowed for any group.
- Neither National PPO nor Medicare products will be counted toward the maximum number of benefit levels.
- Rates are adjusted annually on the anniversary date of the group.
- All lines of coverage must have the same anniversary dates.

100+ enrolled contracts

- Employer groups with 100+ enrolled contracts are required to provide claims experience including High Level Claimant information in order to be provided a fully insured quote.
- A standard four-tiered rating structure is preferred, but other rating structures may be available in competitive situations. The tiered rating structure must be consistent between products.
- Groups may offer dual options, one from each product line, along with one Drug plan. The preferred risk would limit the combination of offerings to **two** total packages of combined medical and drug options. A third offering is allowed, but should be discouraged. No more than three medical plans are allowed for any group.
- Neither National PPO nor Medicare products will be counted toward the maximum number of benefit levels.
- Rates are adjusted annually on the anniversary date of the group.

Product Regulations

Off-anniversary Changes

- Benefits may not be upgraded off anniversary. This regulation applies to Medical as well as Pharmacy, Vision and Dental coverages.
- Downgrades off anniversary are permitted using the following guidelines:
    - Downgrade the customer's existing plan by increasing their co/pays and/or deductible within a product.

- Richer programs can be changed to less-rich programs. (i.e. PPO plan may be downgraded to a less rich POS or HMO).

HMO and POS Products

- Participation requirements are set by the Underwriter based on the individual characteristics of the group and an assessment of the selection risk, account structure, product offerings and number of carriers involved.

- HMO and POS products may be offered alongside each other, but the in-network benefits of the POS Product offering may not be equal to the HMO benefits.

HMO Plus, POS Plus, PPO, NPPO and CMM (Open Access Products)

- Open Access Products (with the exception of High Deductible Health Plans or HDHP's) require a minimum participation level of 75%. HDHPs may be sold without being paired with an HRA, HSA or FSA.

- CMM coverage may only be offered as needed for out of area or retiree contracts as part of a larger group and may not exceed 10% of the total enrolled contracts.

- A PPO or CMM Carveout option may be offered as needed for in-area retiree contracts as a part of a larger group and may not exceed 10% of the total enrolled contracts.

Underwriting Guidelines for Ancillary Products

- Ancillary only offerings are not permitted. All Ancillary coverage must be offered in conjunction with a Medical program.

- To decrease the selection risk within a group with multiple medical options, all ancillary coverages must be the same for all options. W*henever multiple plans are offered within a group, selection will occur to some degree. This applies to medical coverage as well as Rx, but is most evident with Rx coverage where it is easier for an individual employee to predict their future costs and then choose the plan that is most advantageous to them.*

- 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, everyone within the group gets their prescription lenses and then the rider is dropped.)*

If Vision, Dental or Prescription Drug rider benefits are offered, they must be offered with *all* medical products.

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Health Reimbursement Account (HRA):

The HRA product will be available to the **"51+ (Eligibles)" market segment only**. It is not available for NJSEH groups, but may be offered to Non-SEH groups with less than 50 enrolled contracts. This product must be offered in conjunction with an approved High Deductible plan or POS/POS Plus designs that contain an In Network deductible and coinsurance. It cannot be sold as a stand-alone product.

The HRA/Medical plan may be offered along with other products as long as the customer does not exceed the three-plan maximum offering. For example, a customer can offer a standard HMO, a standard POS/POS+ and an HRA/High Deductible PPO plan.

The HRA product can only be offered on the customer's anniversary date.

Multiple options within the HRA are not permitted. The customer is limited to one choice with regard to debit card, auto rollover and the benefits that will be applied to the HRA. This includes the newly created Incentive based designs.

For Fully-Insured Accounts, the maximum employer contribution to the HRA will be 50% of the annual employee deductible. Self-Funded customers may alter the contribution percentage upon Underwriting approval.

Flexible Spending Account (FSA):

The FSA product will be available to the **"50+ (Eligibles)" market segment only**. It can be offered in conjunction with any medical plan, but it cannot be sold as a stand-alone product.

The FSA product can only be offered on the customer's anniversary date.

Multiple options within the FSA product are not permitted. The customer is limited to one choice with regard to debit card, auto rollover and the benefits will be applied to the FSA.

Health Savings Account (HSA) Solution:

New Business: 2+ (eligibles)

Existing Business: 2+ (enrolled by line of business)

The HSA must be offered with a federally qualified high deductible health plan (HDHP).

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HSA-Qualified HDHP products will be considered downgrades from all current product offerings, and can be offered off-cycle. The HSA-Qualified HDHP product will renew upon the customer's current renewal date with any other product offerings.

The HSA-Qualified HDHP may be offered along with other medical products as long as the customer does not exceed the maximum number of product offerings. For example, a customer can offer a standard HMO, a standard PPO and an HSA-Qualified HDHP.

Vision Riders may NOT be attached to the HSA-Qualified HDHP medical plans.

Subject to benefit exception approval, prior carrier deductible credit may be given to an HSA-Qualified High Deductible Health Plan when prior group coverage was also an HSA-Qualified HDHP. Prior carrier deductible credit will not be permitted when prior group coverage was not an HSA-qualified HDHP.

Fourth-quarter deductible carryover credit is not available with HSA-Qualified HDHP offerings.

What documentation is required for a quote?

- Name of existing insurance carrier
- 5 year carrier history
- 3 year rate history
- Claims Experience data
    - Required if greater than 100 enrolled contracts. If not available, it should be noted that it was requested and the reason why it is not available
    - Required for groups currently in a self-funded arrangement.
    - Three years of claim data is preferred.
    - Experience exhibit should:
        - Include the number of insured lives during experience period
        - Be segregated by product (e.g., PPO vs. POS vs. Indemnity)
        - Distinguish between paid or incurred claims
        - Identify whether claims represent charges or payments
        - Include shock claim information (individual claims in excess of $50,000) with diagnosis and prognosis

- Summary of current plan design (source documentation, include effective date of benefits) and proposed benefit design if different
- Current renewal including premium rates (source documentation)
- For groups currently in a self-funded arrangement, provide Administrative fees and Stop/Loss premium
- Employee contribution (the amount of premium contributed by the employee toward their benefit program; it can be expressed as a percentage or dollar value)
- Detailed census - Excel formatted. The census must include the following:
    - employee name
    - date of birth
    - current program enrollment (i.e., HMO, PPO, Rx)
    - zip code of current residence
    - employee gender
    - coverage status (i.e., enrollment by coverage tier)
    - waivers – eligible employees not electing coverage because they are covered under another plan (i.e., – spouse's coverage)
    - opt-outs – eligible employees not electing coverage and who are not covered under another plan
    - date eligible for coverage if employees are in a probationary period
- Additional required information, where applicable would include:
    - Request for Proposal (RFP) request and attachments
    - Union agreement

Right not to Quote

Subject to applicable law, Underwriting reserves the right to decline to quote any group deemed to be an unsatisfactory risk. However, such a decision will not be based in any way on the health status of the group's members.

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What is needed to Sell/Enroll a New Group in the Large Group Market Segment?

- Signed Group Enrollment Form
- Signed Enrollment form for each enrolling employee
- Waivers (required if Open Access Plans are offered)
- Broker of Record Letter
- Signed Rate Sheets
- First month's premium – must be a corporate check