Large Group Underwriting Guidelines for Brokers

(Groups of 51+ and non-SEH groups)

AmeriHealth Underwriting Department

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Eligibility and enrollment requirements

Definition of large groups/non-SEH groups	• Groups with a minimum of 51 active eligible lives on the effective date of coverage; or, • Groups with less than 51 eligible lives that do not meet the definition and requirements for Small Employer Health (SEH) groups. • Groups that only reach a level of 51+ employees on a seasonal basis are not eligible.

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); and,
	• **Value Network:** New Jersey (all counties except Hunterdon County).

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.

Participation requirements (eligible employees)	• Minimum 75 percent participation.
	• Valid waivers:
	  • Employees with group coverage elsewhere through AmeriHealth New Jersey and/or its affiliated parent companies or subsidiaries (coverage through an individual "direct pay" plan is not a valid waiver) , Medicare or Medicaid;
	  • Employees covered through their spouse;
	  • Employees covered as an eligible dependent to age 26, in accordance with federal health care reform regulations.
	• Minimum 50 percent participation level must be met exclusive of valid waivers.
	• Non-SEH employer groups with less than 51 eligible employees must meet the 75% participation requirement and must have a minimum of 15 enrolled contracts or 50% participation exclusive of valid waivers (whichever is greater).
	• 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.

Out-of-area employees	• Definition: Employees located outside of the AHNJ service area. • Enrollment limits: Out-of-area employees cannot exceed 30% of the total enrolled contracts

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. Contact your 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.

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, 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.

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 primarily 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 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 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 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- or part-time) are eligible to offer COBRA coverage. • 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 who employed at least 51 employees on business days during the preceding calendar year and who employs at least 51 employees on the first day of the plan 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. • 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. • An employer must be in business for at least six months before applying for coverage. • **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. *continued on next page*

Common ownership affiliation (two or more companies affiliated or associated), continued	• 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 all of the following requirements are met:
	  ◦ Must wait until 12 months after the termination date;
	  ◦ payment of two months of premium in advance of issuance of health benefits; and,
	  ◦ all premium and financial settlement monies (if applicable) still owed on the prior AHNJ plan 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.

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

Benefit plans	• Plans sold through AmeriHealth HMO, Inc.:
	  • Medical plans: HMO, HMO Plus, and POS
	  • Supplemental benefits: Prescription drug and vision riders.
	• Plans sold through AmeriHealth Insurance Company of NJ:
	  • Medical plans: Open access products including POS Plus, PPO, National PPO, ICPOS, and CMM.
	  • Supplemental benefits: Prescription drug and vision plans.

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.
Mandated benefits	• AHNJ benefit plans comply with all federal and New Jersey State mandates.

Downgrading benefit plans off anniversary date	• Off-anniversary downgrades are permitted using the following guidelines:
	  • All changes must be completed 180 days prior to anniversary.
	  • Limit of one off-anniversary and one on-anniversary downgrade per contract year.
	  • All requests subject to underwriting approval.

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

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 an HDHP product is 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.
	• An HDHP may be sold without being paired with an HRA, HSA or FSA.

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.
AmeriHealth+ Health Reimbursement Account (HRA)	• 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). • May only be offered on group's anniversary date. • 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. • The 75 percent participation guideline is enforced for employers offering an HRA plan. • Only one HRA option is allowed per employer.
AmeriHealth+ Flexible Spending Account (FSA)	• 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)	• Available only with a federally qualified high deductible health plan (HDHP). • Groups adding or changing to an HSA-qualified plan with a contract year benefit period may change anniversary date, which would apply to all products.
Consumer-driven health care tool kit	• For more information on HRAs, FSAs, and HSAs, connect to the consumer-driven health care tool kit on the AHNJ website; or, • Click on link: http://www.amerihealth.com/health_plans/why_amerihealth/consumer_driven_health/index.html

Network options:

National Network Access	• Available to groups with 51 or more enrolled contracts. • Available only as a rider to PPO, 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. • Out-of-area employees cannot exceed 30% of the total enrolled contracts. • 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.

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.)
	• 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, IC POS Coinsurance;
	• 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 to Value Network from lowest-cost Preferred Network option (currently, HMO Coinsurance Option 3 or IC POS Coinsurance Option 3 or HMO Plus Coinsurance Option 3);
	  ◦ If group does not have any enrollment in HMO Coinsurance Option 3 or HMO Plus Coinsurance Option 3, the Value Network is not available.
	  ◦ If 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.
	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:
	    – 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).
	continued on next page

Value Network, *continued*

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 (currently, HMO Coinsurance Option 3 or IC POS Coinsurance Option 3);
- 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.
- **First-year exception**: For this first year only, a onetime exception is granted for groups with renewal dates prior to April 1, 2011. These groups can move from the Preferred Network to the Value network off anniversary and still be allowed to make additional benefit downgrade changes on anniversary (lifting the 12-month restriction).

Rating information*

Community rating programs	
Community rating by class (CRC) program	• Rating method for non-SEH groups with less than 51 enrolled contracts. 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.
Prospective rating	
Definition/Description	• Standard rating method for groups of 51 or more enrolled contracts • Fully-insured program • No surplus/deficit determination
Risk share retrospective funding	**(effective July 1, 2012)**
Definition/Description	• Fully-insured arrangement • Claims risk is shared by the employer and carrier; the employer pays a fixed premium during the contract year. • A financial settlement is completed after each annual contract period to determine the premium payable based on the terms of the funding arrangement. • AHNJ will establish a premium stabilization reserve account for the customer, that may carry forward surpluses and deficits (see premium stabilization reserve account guidelines below). • A retrospective rating charge is assessed, which is the risk charge applicable to this rating arrangement.

*Note: Availability of rating method will be based on number of eligible employees for new groups and on group's current enrollment for existing groups, unless otherwise stated.

Employer eligibility for available retrospective funding arrangements	• Applicable only to medical and Rx lines of business • AHNJ must be the sole carrier of medical benefits for the customer • Available retrospective funding arrangements - eligibility based on actual enrolled contracts for both new business and existing business: - +/- 5% risk share retrospective funding: - Claims risk share is a 95-105 percent corridor. - Available for new and renewal customers with 250 or more contracts. - +/- 10% risk share retrospective funding: - Claims risk share is a 90-110 percent corridor. - Available for new and renewing customers with 250 or more contracts. • Groups cannot combine different funding arrangements except in the case of a self-funded Rx alongside a retrospectively rated medical plan. • Claims experience is an aggregation of medical and Rx (if applicable) lines of business rated under the retrospective risk share arrangement, over the contract year. • Customers are subject to initial and ongoing credit risk checks. • Existing customers must have a history of timely payment of all monies due AHNJ.
Employers changing funding arrangements	• Customers may only change to a different funding arrangement once in a three-year period. • Customers with an existing risk-share retrospective funding arrangement may only change to an alternate risk-share retrospective funding arrangement to decrease their risk exposure once in a three year period. • Customers with an existing risk-share retrospective funding arrangement may change to an alternate retrospective funding arrangement that increases the risk exposure annually, upon the policy renewal date. • All changes in funding arrangements must be made via written notice to AHNJ at least 90 days prior to the affected policy renewal date. No retroactive funding changes. • Groups will be reviewed at time of their annual rate renewal to make sure they continue to meet the minimum enrollment requirements for the retrospective risk share arrangement. Groups that no longer qualify will be removed from this financial arrangement. The process for transitioning these groups to another rating arrangement will be determined by AHNJ Underwriting on a customer-specific basis.
Financial settlement provisions	• Definition: At the end of each contract period, the actual claims expense is compared with expected claims expense. Actual claims expense at the end of the contract period is calculated as explained in the contract. The variance between the expected claims expense and the actual claims (surplus or deficit) is placed in a Premium Stabilization Reserve Account (PSR) and subject to the terms of payment as described in the PSR provisions below. • Prepared within 180 days after completion of the run out period, using the appropriate claims paid-through dates, and the completion and pooling factors as specified in the contract. • Surplus and deficit recovery rules: - Cross-application of deficits and surpluses apply to common retrospectively funded lines of business (i.e., Medical and Rx). - Under the provisions of the PSR account, surplus funds must be used to offset previous years' deficits, or current contract year deficits must be offset by an existing surplus fund balance. • Deficit carry-forward rules - see Premium Stabilization Reserve Account (below).

Premium Stabilization Reserve Account (PSR)	• Definition: Monetary funds that are maintained by the insurance carrier (AHNJ) under a group insurance contract. • Funds may only be used for the purpose of paying medical claims for covered beneficiaries of the plan in accordance with applicable laws and regulations. • A three-year commitment is required, unless the customer is moving to a self-funded arrangement with AHNJ. • Surplus funds must be used to offset previous years' deficits, or current contract year deficits must be offset by an existing surplus fund balance. The following PSR account balance limits and requirements apply: - If the PSR account **surplus** balance: - Exceeds 5 percent of the annual premium in the current contract year, up to 50 percent of surplus funds but no more than 7.5 percent of estimated annual premium in the affected future contract year may be used as a pre-payment and offset against future policy period premiums provided AHNJ receives 45 days written notice prior to the affected contract period. No interest credit applies. - Exceeds 25 percent of the projected annual premium in the current contract year as calculated during the annual settlement, AHNJ will provide a refund for the estimated amount in excess of the 25 percent within 30 days of the issuance date of the settlement. No interest credit applies. - If the cumulative PSR account **deficit** balance: - Exceeds 15 percent of the projected annual premium in the current contract year, AHNJ may apply an upward adjustment to future contract periods' premiums of up to 3 percent of billed premium. If the upward adjustment to billed premium generates a surplus, then the group will be entitled to an interest credit on the surplus funds. - Exceeds 25 percent of the projected annual premium in the current contract year, AHNJ will be obligated to apply an upward adjustment of up to 3 percent but not more than 7.5 percent of billed premium. If the upward adjustment to billed premium generates a surplus, then the group will be entitled to an interest credit on the surplus funds. • In the event of termination from the risk-share retrospective funding arrangement for any reason (on or off anniversary), the following provisions will apply: - Cumulative surplus will be refunded and cumulative deficits are due within 30 days of the issuance date of the final settlement. - AHNJ and the customer are subject to interest penalties for respective balances not paid within 30 days of the issuance date of the final settlement. - No interest will be credited or charged for surpluses or deficits held in the PSR account while the customer is actively participating in the retrospective arrangement.

ASC self-funded/self-insured

Definition/Description	• Available rating method for groups with 300 or more total enrolled contracts in the product being considered for self-funding (for example, HMO or PPO).
	• If multiple medical products are offered, they must all be rated under the self-funded program (group cannot have both self-funded and fully-insured medical products)
	• Self-funded program employers assume all risks for the cost of the program.
	• Payment method: Claims reimbursement basis — employer is billed weekly or monthly based on claims paid (including capitation, if applicable) plus retention and broker commission (if applicable).
	• Upfront financial requirements:
	  • Advance deposit required — amount will be reviewed annually.
	  • Bank letter of credit (BLOC) also required if group elects to hold its own reserves for claims incurred but not reported.
	  • Escrow account may be considered in lieu of BLOC, upon Underwriting review and approval.

Rate quote submission

Documentation required when submitting a rate quote request	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 and 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)
	• Shock claims information (individual claims in excess of $50,000)
	• Diagnosis and prognosis for the shock claims (excess claims)
	• Other claims information — required for all self-funded groups and for fully-insured groups of 100 or more (and preferred for fully-insured groups of 51+, if available):
	  • Twelve to 24 months of prior claims data (minimum of 12 months mature experience)
	  • Experience period should be defined (specify incurred and paid periods)
	  • 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
	  • 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
	  • Enrollment for the claims period (breakdown of contracts by month preferred).
	• Rate information:
	  • Current and renewal rates (source documents)
	  • Historical rate increases for last three-year period
	  • Current financial arrangement
	  • Broker commissions (if applicable) — both current commission and desired commission

continued on next page

Documentation required when submitting a rate quote request continued	• 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
	  • Coverage status (enrollment by coverage tier)
	  • 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
	• Information needed to re-price prescription drug claims: (to provide comparison between gross cost with current PBM versus estimated cost with FutureScripts)
	  • Twelve months of claims data, if available (minimum of three months), to include:
	    – Eleven-digit NDC
	    – Fill date
	    – Mail/retail indicator
	    – Brand/generic indicator
	    – Quantity dispensed
	    – Ingredient cost
	    – Dispensing fees
	    – Any applicable taxes
	    – Member liability information (copays, coinsurance, deductibles), if net plan cost comparison needed
	• Additional required information (where applicable):
	  • Request for proposal (RFP) with all attachments
	  • Competing carrier information (if available)
	  • Union agreement

Right to decline to quote	• Subject to applicable state and federal laws, AHNJ reserves the right to decline to quote any group deemed to be an unsatisfactory risk. Such a decision will not be based in any way on the medical condition of the group's members.

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, including but not limited to minimum participation requirements. 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 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. • Groups terminating to purchase individual coverage will not be eligible for group coverage for 12 months from the date of termination of group 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. • 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. • Limit of one reinstatement per year.

AmeriHealth HMO, Inc.
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12-0243 (06/12)