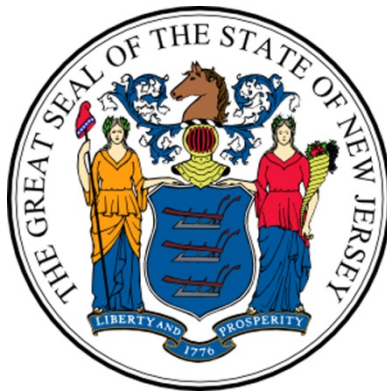


The New Jersey Small Employer Health Benefits Program BUYER'S GUIDE



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Introduction

Purpose of this Buyer's Guide

This Buyer's Guide provides explanations of the basic rules governing the purchase of health coverage by small employers in New Jersey. The Buyer's Guide includes frequently asked questions along with responses to the questions.

The Buyer's Guide can help you determine if your business qualifies for coverage in the New Jersey small employer market. For those businesses that qualify for small employer coverage the Buyer's Guide offers some general descriptions of the many coverage options that are available to businesses that qualify as small employers in New Jersey.

Please note: The rules discussed in this Buyer's Guide apply to the purchase of small employer coverage in the state-regulated small employer market. For information regarding the Small Business Health Options Program (SHOP) visit getcovered.nj.gov.

Laws Governing Small Employer Health Benefits Plans

Enacted in 1992, the New Jersey Small Employer Health Benefits Program Act (SEH Act) (N.J.S.A. 17B:27A-17 et seq) has provided significant protections to New Jersey small employers since 1994. Through the years, the SEH Act has been amended by State laws as well as Federal laws. Since 1996, standards regarding privacy and security of health information have been governed by the federal Health Insurance Portability and Accountability Act (HIPAA). Various mandated requirements of the federal Patient Protection and Affordable Care Act (PPACA) became effective starting in 2010 with the most recent requirements becoming effective beginning in January 2014.

Overview of Small Employer Health Benefits Program

The Small Employer Health Benefits Program (SEH Program) defines a small employer as an employer with at least one but not more than 50 employees. The rules for counting employees are explained in the Eligibility section of this Buyer's Guide. Generally, small employers must satisfy participation and contribution requirements.

Although many businesses will qualify as small employers, some businesses will not. Businesses that do not qualify as small employers may purchase health coverage through the Individual Health Coverage Program. See getcovered.nj.gov for more information.

Eligibility

What is a Small Employer?

An employer that satisfies the requirements of the definition below is a small employer in New Jersey.

Small Employer means in connection with a Group Health Plan with respect to a Calendar Year and a Plan Year, an employer who employed an average of at least 1 but not more than 50 Employees on business days during the preceding Calendar Year and who employs at least 1 Employee on the first day of the Plan Year.

All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer.

In the case of an Employer which was not in existence throughout the preceding Calendar Year, the determination of whether such employer is a small or large employer shall be based on the average number of Employees that it is reasonably expected such Employer will employ on business days in the current Calendar Year.

Please note: Small Employer includes an employer that employs more than 50 full-time Employees if the employer's workforce exceeds 50 full-time employees for no more than 120 days during the calendar year and the Employees in excess of 50 who were employed during such 120-day or fewer period were seasonal workers.

The key elements?

- ✓ 1 – 50 employees on business days in the *preceding* calendar year
- ✓ At least 1 employee on the first day of the plan year

Who Counts as an Employee?

First, the technical definition

Employee means an Employee of the Policyholder under the common law standard as described in 26 CFR 31.3401(c)-1. An individual and his or her legal spouse when the business is owned by the individual or by the individual and his or her legal spouse, partners in a partnership, two percent shareholders in a Subchapter S corporation, sole proprietors and independent contractors are **not** employees of the Policyholder. Employee also excludes a leased employee.

Now, let's break it down.

The definition counts common law **employees**

Please note: Employees are paid and must be paid at least minimum wage. Carriers may ask for proof.

Pay attention to who is **NOT** an employee:

- Individual and spouse when one or both own the business
- Partners in a partnership
- 2% shareholders in S-corp
- Sole proprietors
- Independent contractors
- Leased employees

And note that employees who are members of a union and covered under a union welfare arrangement ARE employees and must be counted the same as any other employee.

What happens if the employer is just starting in business?

If an employer was not in existence during the preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of employees that it is reasonably expected that the employer will employ on business days in the current calendar year.

Redetermination of Eligibility

Once a health benefits plan has been issued to a small employer the size of a small employer will be reviewed annually. Please refer to the discussion of guaranteed renewability in [Advisory Bulletin 17-SEH-01](#).

Who can be covered under a Small Employer Plan?

Although the definition of Small Employer and Employee considers full-time to be 30 hours per week that definition of full-time is used solely for determining whether an employer is a Small Employer.

For purposes of determining which employees are eligible for insurance under a Small Employer plan and whether the Small Employer meets the participation requirement, **full-time is defined as 25 hours per week.**

Coverage tip 1: Although employee excludes an individual and spouse when one or both own the business, partners of partnerships, and a two percent shareholder in a Subchapter S corporation, and sole proprietors, such persons may be covered under a small employer plan provided they work at least 25 or more hours per week in the business and the employer has at least one but not more than 50 workers who qualify as employees and at least one employee will be covered under the plan. Under no circumstances may independent contractors and leased employees be covered under a small employer plan.

Coverage tip 2: While full time is defined as 25 hours per week for eligibility, if the employer has only one employee, that employee would have to work at least 30 hours per week in order for the employer to qualify as a small employer. Thus, businesses that employ only one employee can buy a small employer plan only if that employee works at least 30 hours per week. Additionally, unless that employee will be covered under the plan there can be no group plan.

Participation and Contribution Requirements

Participation Requirement

At least 75 percent of the full-time employees (25 hours per week) must be covered under the small employer health benefits plan the employer is offering or covered under one of the following:

1. any fully insured health benefits plan offered by the small employer;
2. Medicare;
3. Medicaid or NJ FamilyCare;
4. another group health benefits plan;
5. a spouse's group health benefits plan; or
6. Tricare.

Note that coverage under an individual health benefits plan does **not** count toward satisfaction of the 75% participation requirement.

Tip: When calculating participation consider employees only. Do not count anyone else.

A carrier is **not** required to give participation credit for those employees who are covered under another carrier's contract issued to the same employer.

A carrier must offer at least one policy to a small employer's group if the employer meets the participation requirements. A carrier may permit a small employer to offer more than one of the carrier's small group health benefits policies to employees; however, the carrier may limit the number of additional policies it will issue, based on the carrier's "underwriting guidelines" available on the SEH Board's website

(www.state.nj.us/dobi/division_insurance/ihcseh/shop_seh.htm). If a carrier has not provided underwriting guidelines to the SEH Board for posting, then the carrier does not limit the number of policies it will issue to a small employer's group.

Group Health Plan

A “group health plan” means an employee welfare benefit plan, as defined in Title I of section 3 of Pub.L.93-406, the “Employee Retirement Income Security Act of 1974” (29 U.S.C.s.1002(1)), to the extent that the plan provides medical care, including items and services paid for as medical care to employees or their dependents directly or through insurance, reimbursement or otherwise. Most plans offered by employers are considered group health plans, including small employer health benefits plans. However, for purposes of calculating participation, the term group health plan does not include the self-funded plans offered by the same employer, and is not required to include employees covered under policies issued by another carrier to the same employer (see the carrier’s underwriting guidelines, if any, available on the SEH Board’s website).

Classes of Employees and Participation

An employer is permitted to limit the offer of coverage to employees by class, subject to some limitations. Classes must be based on bona fide conditions of employment – for instance, hours worked per week, salary versus hourly wage, or union versus non-union.* But for purposes of meeting the participation requirement, all employees are considered in the count. For example, if an employer with 30 employees – 15 of whom work 35 hours per week and 15 of whom work 30 hours per week – wants to offer coverage only to employees working 35 hours per week, the employer may do so, but the group must meet the participation requirement based on 30 employees. Thus, at least 23 employees must be covered under the employer’s group health plans(s) or another group health plan, Medicare, Medicaid or NJFamilyCare or Tricare for the employer to meet the participation requirement.

*Please note: beginning in 2011, federal law makes most group health plans that unfairly discriminate in favor of highly compensated employees subject to tax and other potential penalties. However, the Internal Revenue Service has stated in Notice 2011-1 that it will not require employers to comply with the requirement until the agency has adopted regulations regarding nondiscrimination in favor of highly compensated individuals.

Changes in a Carrier’s Underwriting Guidelines

A carrier may change its underwriting guidelines. Any revisions will be posted on www.state.nj.us/dobi/division_insurance/ihcseh/shop_seh.htm, and will apply only to new business or renewals with plan changes occurring on or after the date the revisions to the guidelines are effective.

Exception to the 75% Participation Requirement

The 75% participation requirement does **not** apply to applications received during the Employer Open Enrollment Period which takes place from November 15 through December 15 each year.

Please Note: If a small employer carrier introduces a new plan that is first available after the beginning of a calendar year such that the new plan was not available for small employers to select during the preceding Employer Open Enrollment Period, the carrier cannot apply the 75% participation requirement to any small employer with respect to the newly offered plan at any time during the initial calendar year.

Contribution Requirement

A small employer is required to pay 10 percent of the **total** cost of a health benefits plan issued to the employer's group. A small employer may, of course, elect to pay a greater percentage – up to 100 percent – but a carrier may not require the employer to pay more than 10 percent as a condition of issuing the small employer a small group health benefits plan.

Note that the employer's contribution obligation is based on the total cost of the health benefits plan, not just the cost related to employees or a class of employees. For example, if the total cost of a plan for all employees and dependents is \$10,000 per year, the minimum employer contribution would be \$1,000 per year.

For purposes of insurance law, it is possible for an employer to limit its contributions to the group premium by class of employee or by employee coverage only (thus, requiring some classes of employees to pay more of the premium than other classes, or requiring employees to pay the full cost of dependent coverage, if offered). However, the employer's contribution obligation remains at least 10 percent of the total cost for the health benefits plan.

Exception to the 10% Contribution Requirement

The 10% contribution requirement does **not** apply to applications received during the Employer Open Enrollment Period which takes place from November 15 through December 15 each year.

Please Note: If a small employer carrier introduces a new plan that is first available after the beginning of a calendar year such that the new plan was not available for small employers to select during the preceding Employer Open Enrollment Period, the carrier cannot apply the 10% contribution requirement to any small employer with respect to the newly offered plan at any time during the initial calendar year.

Remember that New Jersey law defines an individual health benefits plan as including a certificate where the eligible person pays the premium. In order for the coverage to be considered group coverage the employer will need to contribute some amount toward the group premium.

Service Area

Since carriers selling network based small employer plans are **not** required to cover an employee that does not live, work, or reside in the small employer carrier's service area it is important for small employers to check whether the service area meets the needs of the employees and their dependents.

This means if a New Jersey small employer has a location in another state and several of the employees work at that location and live in the state of that location, those employees and their dependents can be covered under the small employer group plan provided that other state is part of the carrier's service area. If the other location is outside the carrier's service area employees and dependents in that location cannot be covered under the small employer plan.

Enrollment Periods for Employers and for Employees

Small Employer Coverage Maybe Purchased Throughout the Year

An employer may submit an application for small employer coverage at any time. If the employer qualifies as a small employer, as defined, and satisfies the 75% Participation Requirement and the 10% Contribution Requirement, the small employer plan will be issued with an effective date that will be determined based on the date the application and all supporting documentation is provided.

If the employer qualifies as a small employer but does not satisfy the participation and/or contribution requirements the employer can buy small employer coverage if the employer applies during the Employer Open Enrollment Period as discussed below.

Employer Open Enrollment Period

The Employer Open Enrollment Period is the period from November 15 through December 15 each year. During this period, employers that meet the definition of small employer but do not meet the 75% Participation Requirement or the 10% Contribution Requirement will be accepted for a small employer plan. The effective date of the small employer plan will be January 1 of the year immediately following the Employer Open Enrollment Period.

While the participation and contribution requirements are waived during the Employer Open Enrollment period, all other requirements associated with purchasing a small employer health benefits plan must be satisfied. For example, the business must qualify as a small employer, and at least one employee must be covered under the small employer plan. The Employer Open Enrollment Period is not an opportunity for employers without employees to secure coverage in the small employer market.

Initial Opportunity for Employees to Enroll

An employee has a 30-day opportunity to enroll for coverage measured from the date the employee is first eligible to enroll. New employees can enroll throughout the year, provided they enroll during the initial 30-day period.

Employee Open Enrollment Period

The Employee Open Enrollment Period is the 30-day period each year designated by the small employer. The 30-day Employee Open Enrollment Period is the **only** time during which employees and dependents who are eligible under the small employer's plan but who are *late enrollees*, see definition below, may enroll for coverage under the small employer's plan. It is also the time during which employees and dependents that are covered under the small employer's plan may elect coverage under a different policy, if any, offered by the small employer.

Special Enrollment Period

A special enrollment period follows a *triggering event* (triggering event is defined below) and provides an additional opportunity for late enrollees to enroll for coverage under the small employer's plan. In addition, employees and dependents that already have coverage are allowed to replace current coverage with a different plan, if any, offered by the small employer.

Late Enrollees, Triggering Events and Late Enrollee Exceptions

Late Enrollee

A Late Enrollee means an employee or dependent that requests enrollment in a small employer health benefits plan after the end of the 30-day enrollment period provided under the small employer's plan.

Triggering Events

The following dates qualify as triggering events. The Special Enrollment Period begins on the date of the event and lasts for either 30 or 60 days following the event, as stated below.

- 1) The date an employee or dependent loses eligibility for minimum essential coverage, including a loss of coverage resulting from the decertification of a qualified health plan by the marketplace. A loss of coverage resulting from nonpayment of premium, fraud or misrepresentation of material fact shall not be a Triggering Event. The Special Enrollment Period lasts for 30 days following this event.
- 2) The date an employee acquires a dependent or becomes a dependent due to marriage, birth, adoption, placement for adoption, or placement in foster care. The Special Enrollment Period lasts for 30 days following this event.

- 3) The date an employee's enrollment or non-enrollment in a qualified health plan is the result of error, misrepresentation or inaction by the exchange. The Special Enrollment Period lasts for 30 days following this event.
- 4) The date an employee or eligible dependent demonstrates to the exchange that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee. The Special Enrollment Period lasts for 30 days following this event.
- 5) The date the employee or dependent gains access to new qualified health plans as a result of a permanent move. The Special Enrollment Period lasts for 30 days following this event.
- 6) The date the employee or dependent loses or gains eligibility under Medicaid or NJFamilyCare. The Special Enrollment Period lasts for 60 days following this event.
- 7) The date of a court order that requires coverage of a dependent. The Special Enrollment Period lasts for 30 days following this event.
- 8) The date an Employee and/or his or her Dependent who are victims of domestic abuse or spousal abandonment need to enroll for coverage apart from the perpetrator of the abuse or abandonment. The Special Enrollment Period lasts for 30 days following this event.
- 9) The date the Employee or Dependent loses eligibility for Medicaid or NJ FamilyCare. The Special Enrollment Period lasts for 60 days following this event.
- 10) The date the Employee or Dependent becomes eligible for assistance under a Medicaid or NJ FamilyCare plan. The Special Enrollment Period lasts for 60 days following this event.
- 11) With respect to SHOP plans only, the date of confirmation of an Employee's or Spouse's pregnancy by a Practitioner. The Triggering Event allows the election of coverage for all the Employee's Dependents. The Special Enrollment Period lasts for 60 days following this event.

Late Enrollee Exceptions

If an employee initially waived coverage under the small employer's plan and stated at that time that such waiver was because he or she was covered under another group plan, and the employee subsequently loses that coverage and elects to enroll under the small employer's plan, the employee and his or her dependents will **not** be Late Enrollees.

The employee is not considered to be a Late Enrollee and may enroll under the small employer's plan within 90 days of the date any of the events described below occurs.

- 1) termination of employment or eligibility;
- 2) reduction in the number of hours of employment;
- 3) involuntary termination;
- 4) divorce or legal separation or dissolution of the civil union or termination of the domestic partnership;
- 5) death of the employee's spouse;
- 6) termination of the policyholder's contribution toward coverage; or
- 7) termination of the other plan's coverage.

Waiting Period

The waiting period is a period of time that must pass before coverage of an otherwise employee and his or her dependents, if any, will become effective. A small employer may request that a waiting period be applied to employees however; the waiting period cannot exceed **90 days**. Waiting periods may be applied by class of employee based upon conditions pertaining to employment (examples include number of hours the employees work, salaried v. hourly, union v. non-union).

Since the waiting period is a period of time that must pass, any breaks in service do not affect the satisfaction of the waiting period. Thus, if the employee continues to be an employee through the waiting period, the coverage will become effective once the waiting period ends.

If an employer wishes to apply a period during which performance of a new employee is evaluated, the employer may require that new employees satisfy an orientation period, as explained below. If an employer applies an orientation period, the waiting period begins on the first day after the orientation period ends.

Orientation Period

The orientation period is a period of no longer than **one month** during which the employer and employee determine whether the employment situation is satisfactory for each party and any necessary orientation and training processes commence. Generally, one month is determined by adding one calendar month and subtracting one calendar day, measured from an employee's start date in a position that is otherwise eligible for coverage.

SEH Program Features for Health Benefits Plans

All small group health benefits plans must meet certain minimum requirements that are “SEH Program features.” Small group health benefits plans must:

- Be guaranteed issue;
- Be guaranteed renewable;
- Comply with restrictions on rating criteria and standards;
- Include rights of coverage continuation for members of groups not governed by COBRA; and
- Be standard plans (*at the option of the employer*, such plans may include one or more riders offered by the carrier in the SEH market).

Guaranteed Issue

A carrier may not refuse to issue a small group health benefits plan to any small employer or any member of the group for which the small employer is purchasing coverage because of anyone’s health, prior claims experience, age, gender, occupation, nature of the business, or the location of the business in New Jersey.

Guaranteed Renewal

In general, a small employer may continue to renew a small group health benefits plan at the discretion of the small employer.

A carrier may nonrenew a small employer health benefits plan ONLY if:

- The employer fails to provide the completed Employer Certification as required (Note: the Employer Certification is required annually.);
- The employer ceases to be a small employer because it no longer has at least one employee;
- The employer was classified as a small employer at the time the health benefits plan was issued, but would not have been classified as a small employer had the current definition of small employer been in effect, and is not classified as a small employer using the definition of small employer in effect on the renewal date;
- The small employer is no longer eligible because it fails to meet contribution requirements or fails to meet participation requirements; or
- Following the approval of the Commissioner of the New Jersey Department of Banking and Insurance, the carrier withdraws the health benefits plan from the small employer market.

When a small employer grows to more than 50 employees, the carrier will renew the small employer policy at the employer's request, but the premiums *may* no longer be the carrier's SEH market rates. The small employer plan will be amended to include benefits for the treatment of infertility. The employer would have to continue to comply with the small employer participation and contribution requirements. If the employer changes the policy *in any way*, the employer loses the protections arising from small employer status entirely. The carrier may offer the employer the opportunity to buy a large group policy that would be subject to the guaranteed issue requirements of Federal law but that would use different rating methodologies and might apply different participation and different contribution requirements to the employer.

Of course, regardless of the employer's status, a carrier may terminate the coverage if the employer fails to pay premiums timely or has acted fraudulently or intentionally made material misrepresentations of information relevant to the issuance of the health benefits plan. In such cases, termination can occur immediately.

Rates

Carriers use modified community rates for small employer plans. Rates are not based upon the actual or expected claims history of any particular person or persons in the small employer group. In addition, carriers do not rate based on gender and there is no special rate for smokers versus non-smokers and there is no rate variation for Medicare.

Carriers use age and geography as a rating factor for small employer plans. Carriers must use a child rate for ages 0 through 20 years old, (the child rate is the same rate for each child ages 0 – 14, then increases each year from age 15 through age 20) and then incrementally increase rates every year from age 21 through 64. Each carrier must set its rates so that its highest rate is not more than 2 times its lowest adult rate for a specific individual plan. (This is referred to as a 2:1 rate band.)

Each person covered under a small employer plan is rated individually, except that a family is not charged for more than three children under the age of 21, even if they cover more than three children under the age of 21. If a family has two adults (one being 45 years old and the other being 42 years old) and four children under the age of 21, to determine the monthly cost of a plan to cover the entire family, the family would add the monthly premium for each adult and add the child premium, appropriate to age, for three children to get the total for the family's monthly premium, as follows:

45 year old premium + 42 year old premium + child premium + child premium + child premium = family premium

The rate for the small employer group is the sum of the rates for each person to be covered.

Small employer base rates along with a calculator that can be used to determine the actual rates for a small employer group are available at www.state.nj.us/dobi/division_insurance/ihcseh/sehrates.htm.

Rating Errors

If a carrier discovers that it has undercharged a small employer, the carrier must provide the small employer with notice of the error at least 60 days prior to charging the small employer group the corrected premium amount. The carrier is not permitted to try to collect or offset for the undercharges.

If a carrier discovers that it has overcharged a small employer, the carrier must stop doing so immediately, provide notice to the small employer about the overcharges as soon as possible, and refund or credit the full amount of the overcharges to the small employer within no more than 30 days after discovering the error. (See N.J.A.C. 11:21-9.6).

Continuation of Coverage

Small employer health benefits plans contain continuation of coverage provisions that may be exercised when certain covered persons lose eligibility. Some small employers will be subject to the continuation rights established by the federal law known as [COBRA](#). Many small employers will be subject to the continuation rights established by New Jersey law, referred to as the New Jersey State Group Continuation (NJSGC) right and sometimes called Mini-COBRA. The laws are similar, but there are some differences. In addition, New Jersey law has a special continuation right for certain employees that terminate employment due to total disability.

Brief comparison of COBRA and NJSGC

Both [COBRA](#) and NJSGC:

- Establish continuation rights for most of the same groups of qualified beneficiaries – employees, spouses and child dependents – if covered under the health benefits plan immediately preceding the qualifying event.
- Establish continuation rights as the result of most of the same types of qualifying events.
- Establish continuation periods of the same duration.
- Permit the employer to require that the person who elects to continue the coverage pay 100 percent of the cost of the coverage, plus a 2 percent administrative fee (that is, 102 percent of the cost).

NJSGC differs from [COBRA](#) in that:

- COBRA only applies to employers with 20 or more employees, with some exceptions (such as church plans).
- NJSGC applies to employers with one 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. In addition, church plans of employers with one to 50 employees must comply with NJSGC, even though they do not have to comply with COBRA at all. For more detail, refer to Advisory Bulletin 07-SEH-02, at www.state.nj.us/dobi/division_insurance/ihcseh/bulletins/sehblt07_02.pdf

The information that follows is specific to the NJSGC. For more information about COBRA, see “An Employee Guide to Health Benefits Under COBRA,” published by the Employee Benefits Security Administration of the U.S. Department of Labor (available online at: www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/an-employees-guide-to-health-benefits-under-cobra.pdf).

Continuation Tips for both NJSGC and COBRA:

For the employer:

Small employer group policies state that the Policyholder will notify the carrier of any event, including a change in eligibility, that causes termination of a covered person's coverage immediately, or in no event later than the last day of the month in which the event occurs.

Tip 1: When employee X terminates employment the employer should immediately notify the carrier that employee X terminated employment and provide the date of termination.

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Small employers must notify the potential continuee of the cost to continue coverage under the employer's group plan. Small employers have the opportunity to specify the due date for the payment of all premiums after the initial continuation premium. If the premium increases at group renewal while a person is on continuation the employer should advise all continuees of the new monthly continuation premium.

Tip 2: When setting a due date for continuation premiums consider the date the employer pays the group premium. Designate a date that is a week to 10 days prior to the group premium due date to allow time for the continuee's payment to clear the bank. When the group premium

changes at renewal be sure to notify the people on continuation of the new continuation premium

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Small employers must pay the group premium, as billed, even if the bill includes premium for one or more people who terminated. The carrier will adjust the payment on a subsequent invoice.

Tip 3: Pay the group premium, as billed. Assuming the employer has notified the carrier of the termination (see Tip 1 above) the carrier will provide the necessary credit. If the employer fails to provide notice of an employee termination the carrier will not know that a credit is due and the employer may not be able to get a refund.

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An employee request for continuation has two parts – the election and the premium payment. The timing for the initial premium payment differs for NJSGC and COBRA, but in both instances, can be weeks following the election notice. The request is not complete until both the election and payment have been provided.

Tip 4: Wait to notify the carrier that a person has elected continuation until both the election and payment have been provided.

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The continuee has a grace period for each premium after the first. If a continuee has not paid premium by the due date, the employer does not have an obligation to “front” the payment. However, the employer needs to pay the group premium as billed. (see Tip 3 above.)

Tip 5: If a continuee has not paid the premium by the due date notify the carrier that the continuation premium has not yet been paid. If it is never paid and continuation ends, this will ensure the premium for the continuee that was included when the invoice was paid as billed will be credited back to the employer.

For the continuee:

The continuee must make a timely election of continuation and is responsible to pay the premiums to the former employer or other entity designated by the employer. Coverage will be retroactive to the date insurance ended so there will be no gap in coverage. Although both NJSGC and COBRA allow time after the election to make the initial payment, delaying payment means an initial payment equal to two months of premium could be due.

Tip 1: People who intend to continue coverage can establish a manageable payment schedule by paying the initial premium either with or shortly after the election.

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An involuntary loss of coverage is a triggering event that provides a special enrollment period and the opportunity to buy an individual plan. However, once the person elects and pays for NJSGC or COBRA the person cannot switch to an individual plan until the annual open enrollment period.

Tip 2: Evaluate both the continuation option and the individual coverage option before making a decision. Consider benefits, provider networks and premiums.

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There is a 31-day grace period for all premiums after the initial premium. The grace period is additional time to pay the premium. If a continuee uses services during the grace period the continuee may have to pay for them out-of-pocket and submit for reimbursement after the grace period premium has been paid.

Tip3: Try to pay all premiums by the due date. Use the grace period only if absolutely necessary.

Employees, qualifying events and duration of continued coverage

The NJSGC requirement specifies that an employee be given the option to continue coverage when:

- the employee is terminated for reasons other than cause;
- the employee's hours are reduced, causing him or her to be ineligible for the small group coverage; or
- the employee ends employment.

An employee is entitled to continue the coverage he or she had immediately prior to his or her ineligibility, including covering dependents that were covered prior to the employee's ineligibility. An employee is entitled to continue coverage for 18 months, unless he or she is [disabled](#) within 60 days after the qualifying event, in which case, he or she may continue coverage for 29 months. The determination of disability is made by the Social Security Administration.

Dependents, qualifying events and duration of continued coverage

Only NJSGC specifies that a covered spouse, civil union partner or domestic partner be given the independent option to continue coverage when he or she would otherwise lose eligibility for coverage because of:

- Death of the covered employee; or
- Divorce or other legal action that results in termination of the marriage, or dissolution of the civil union or domestic partnership with the covered employee.

Note that an employee electing to be covered under Medicare is not a qualifying event. If an employee chooses to be covered under Medicare rather than the small employer plan, the spouse and dependent children may seek to enroll for individual coverage.

Only NJSGC specifies that a covered child dependent be given the independent option to continue coverage because of:

- Death of the covered employee;
- Divorce or other legal action that results in termination of the marriage, or dissolution of the civil union or domestic partnership with the covered employee; or
- The child ceases to be an eligible dependent (for instance, because s/he marries or attains the policy's limiting age for dependent children).

When a dependent makes a continuation election, he or she is entitled to continue coverage for up to 36 months.

Limits on the duration of coverage

Continued coverage pursuant to NJSGC may end earlier than the prescribed continuation period if:

- the employer ceases to offer any health benefits plan;
- the covered person fails to make appropriate payment (subject to a 31-day grace period);
- the covered person becomes covered under another health benefits plan that applies no pre-existing condition limitation to the covered person and anyone else under the continued health benefits plan; or
- the covered person becomes entitled to [Medicare](#).

Employer's obligation

Employers have a legal obligation to notify their employees of the right to continue coverage at the time of termination or at the time the employee assumes part-time status. An employer has an obligation to remit the premium paid to the employer by the employee/former employee or dependent on continuation as part of the employer's regular premium payment. In other words, the employer is obligated to serve as a conduit for the premium payment to the carrier. However, employers are not required to contribute to the premium or otherwise "front" the money for the continuee.

Continuation in the event of total disability

New Jersey law (N.J.S.A. 17B:27-51.12 and N.J.S.A. 17:48E-32) requires that when a covered employee terminates employment due to total disability, the employee may continue coverage (including coverage for his or her dependents) under the group's health benefits plan. The employee must have been covered under the health benefits plan at least three months prior to termination of employment. The employee may be required to pay the group rate for the continued coverage. An election must be made within 31 days after the date the coverage would otherwise terminate. *An employee's eligibility for Medicare or entitlement to Medicare does not limit the right to continue coverage under the group health benefits plan.*

Under this election, continued coverage will end:

- for the employee and any covered dependents if the employee fails to pay the required premium
- for the employee and any covered dependents when the employee is again employed and eligible for another group health plan
- for a dependent when that dependent stops being an eligible dependent or becomes eligible for another group health plan
- for the employee and any covered dependents if the employer ceases to offer a group health benefits plan to all employees.

In the event the employer replaces the group health benefits plan with another such plan, the disabled employee has the right to become covered under the replacement group health benefits plan, provided the replacement plan is subject to the requirements of the law.

Please note: **all** small employer health benefits plans have terms and conditions that address this New Jersey continuation requirement, including those offered by HMOs. However, in the larger group market, New Jersey law does not require HMO's to provide continuation coverage specifically for termination due to total disability.

Other Important Features

Domestic Partners and Civil Union Partners

New Jersey law recognizes domestic partnerships and civil unions in addition to marriages. Civil unions may be created only among individuals of the same gender. Domestic partnerships include individuals of the same gender or of opposite genders, but for purposes of health coverage, only same-gender domestic partnerships are considered. Note that same-gender domestic partnerships are no longer formed as a matter of law in New Jersey as of February 19, 2007.

In general, the rights of spouses and partners of civil unions are the same for purposes of health coverage under New Jersey law. If an employer offers dependent coverage to employees, the employer must permit an employee to cover a civil union partner. Employers do not have to offer coverage to domestic partners when offering coverage to spouses or partners of civil unions. However, when an employer opts to offer coverage to domestic partners, the employer must treat all domestic partners consistently.

Neither an employer nor a carrier may discriminate in the coverage of a child the employee claims as a dependent based on whether the child becomes a dependent of the employee pursuant to birth, adoption, marriage, civil union or domestic partnership.

“Dependent Under 31” Continuation Election

New Jersey law permits an employee’s child who no longer qualifies as a child dependent under the terms of an employer’s health benefits plan to elect to remain covered as an “over-age” dependent until the child’s 31st birthday, so long as he or she meets the other eligibility requirements associated with the “Dependent Under 31” continuation election. In the case of a child who is aging-out of a parent’s coverage at age 26, the Dependent Under 31 continuation election right is *in addition to* the aging-out child’s right to make either a COBRA or NJSGC election. Thus, upon aging-out on his or her 26th birthday (or such later date as may be stated in the health benefits plan), a child covered under a small employer health benefits plan may make a continuation election pursuant to COBRA or NJSGC with the expectation of continuing coverage for up to 36 months, or may make a Dependent Under 31 (DU31) election with the expectation of continuing coverage until age 31, so long as he continues to be DU31-eligible.

An over-age child may make a DU31 election upon loss of the group coverage as a result of turning age 26 as well as during the employee enrollment period or any special enrollment period that may occur prior to the attainment of age 31.

The cost of continuing coverage pursuant to a DU31 election will be determined by the age of the dependent.

Appealing Unfavorable Medical Necessity Decisions

The SEH Program health benefits plans permit carriers to consider whether many of the services covered under the contract or policy are medically necessary and appropriate for purposes of treatment of the covered person's condition. If a carrier determines that a service is not medically necessary and appropriate (including determinations that the service is experimental or investigational, cosmetic, or dental instead of medical), the covered employee or dependent has the right to appeal the unfavorable determination.

In New Jersey, carriers are required to have a two-stage internal appeal process. In addition, if the outcome continues to be unfavorable and the employee or dependent continues to disagree, the appeal may be taken to an external independent utilization review organization through the [Independent Health Care Appeals Program](#), which is under the auspices of the New Jersey Department of Banking and Insurance.

The covered employee or dependent may authorize a health care provider to make the appeals on behalf of the covered employee or dependent by providing written consent. The small employer does not have to become involved with either the internal or external appeal process.

The New Jersey Department of Banking and Insurance has a more detailed discussion of the right to [appeal medical necessity determinations](#) both internally and through the Independent Health Care Appeals Program on the Department's website.

The Appeal and Complaint Guide available at www.state.nj.us/dobi/division_consumers/insurance/appealcomplaintguide.pdf provides an easy-to-read explanation of the process.

The Standard Small Employer Health Benefits Plans

The SEH Program Board of Directors has adopted four standard small employer health benefits plans, generically known as Plans B through E, plus standard HMO and HMO-POS plans.

Plans B, C, D and E

Plans B through E all provide comprehensive inpatient and outpatient hospital and medical coverage, including the following health care services:

- office visits
- hospital care
- prenatal and maternity care
- immunizations and well-child care
- screenings, including mammograms, pap smears and prostate examinations

- x-ray and laboratory services
- mental health coverage services
- substance abuse services
- therapy services
- prescription drugs

- pediatric vision services

pediatric dental services must be embedded in the medical plan or bought as a stand-alone plan.

Plans B through E **differ** from one another because of the **cost sharing** they offer – that is, because of the amount of allowed charges for which the carrier agrees to be responsible. Carriers may offer Plans B through E with a variety of **deductible** options among which employers may choose. The plans have specified **coinsurance** levels, with the carrier agreeing to pay 50% or 60% of the allowable charges for Plan B, 70% for Plan C, 80% for Plan D and 90% for Plan E. In 2020 the **MOOP** amount cannot exceed \$8,150 per person for network services and supplies. This amount may be adjusted annually.

Delivery Systems: Network-based Health Benefits Plans

Plans B through E can offered as several types of network-based products. The products are known as PPO which is the acronym for preferred provider organization, POS which is the acronym for Point of Service and EPO which is the acronym for Exclusive Provider Organization. A PPO or POS product gives a consumer the option to access services in the carrier’s network, or go to out-of-network health care providers. The individual receives greater benefits when he or she uses in-network health care providers, and when using in-network providers will not be responsible for any charges in excess of what has been negotiated between the carrier and health care provider. POS products may require members to obtain referrals for various services, but PPO products do not. EPO products are network-only plans, meaning services and supplies are covered only if the person uses a network provider. EPO plans do not cover services of a non-network provider, except in case of medical emergency or urgent care. With an EPO the carrier may require the person to select a primary care physician (PCP) who generally coordinates the health care services the covered person needs, and provides referrals, as may be required under the EPO plan. Although PPO and POS plans are the only plans that feature out-of-network benefits, all plans cover out-of-network providers under certain circumstances. The phrase “out-of-network” is used to refer to different circumstances. See the out-of-network discussion below.

The HMO plan is a network-based product, with services provided through a network of health care providers under contract with the carrier. The HMO Plan is a closed network product, meaning services and supplies are covered only if rendered by in-network providers, except in case of medical emergency or urgent care. The covered person selects a primary care physician (PCP) who generally coordinates the health care services the covered person needs, or refers the covered person to an in-network specialist when necessary.

HMO Carriers may also offer the HMO Plan as a POS product which is called an HMO-POS plan, which allows an individual to use in-network services, but also allows the option of obtaining services outside of the HMO's network. The individual will have to pay more in out-of-pocket costs, and may incur charges in excess of allowed charges when he or she goes out-of-network.

Some of the network –based plans feature network “tiers.” When a member selects the services of a provider in the preferred tier the cost sharing is generally lower than if services are provided by another network provider. Whether the provider is in the preferred tier or not an individual using a network provider will not be responsible for any charges in excess of what has been negotiated between the carrier and the health care provider. When considering a plan that uses tiers it is important to understand the interaction of cost sharing for the tiers. For example, a plan might provide that if a person uses providers in the preferred tier, that preferred tier deductible is satisfied separately from the overall network deductible. And, that preferred tier deductible amount is also applied toward the satisfaction of the overall network level deductible. Carefully read the plan text to be sure you understand how the deductible accumulates.

Out-of-Network

The term “out-of-network” is commonly used to define types of plans and is also used to address two very different situations.

Types of Plans

As discussed above, small employers have the opportunity to select from a number of different types of plans. Some plans feature out-of-network benefits while others do not.

Plans with **no** out-of-network benefits

- HMO – Except for emergency and urgent care, HMO plans require a covered person to use the services of network providers. If a person covered under an HMO plan *voluntarily* decides to use the services of an out-of-network provider, the HMO will not cover the services.
- EPO - Except for emergency and urgent care, EPO plans require a covered person to use the services of network providers. If a person covered under an EPO plan *voluntarily* decides to use the services of an out-of-network provider, the EPO will not cover the services.

Plans that **include** out-of-network benefits

- PPO – A PPO plan provides coverage for the services of network providers as well as the services of out-of-network providers. Generally, the out-of-pocket cost to a person covered under a PPO plan will be less if the person uses the services of a network provider rather than the services of an out-of-network provider. See the discussion below.
- POS - A POS plan provides coverage for the services of network providers as well as the services of out-of-network providers. Generally, the out-of-pocket cost to a person covered under a POS plan will be less if the person uses the services of a network provider rather than the services of an out-of-network provider. See the discussion below.

Beyond the Covered Person’s Control

Regardless of whether a person is covered under an HMO, EPO, PPO or POS plan, there are situations in which the person has no opportunity to select a provider. The following requirements apply to **all fully-insured plans issued in New Jersey**, including the small employer plans governed by the SEH Board.

- Emergency – As required by New Jersey law, medically necessary services a covered person receives to treat an emergency are covered with the person’s liability limited to the network level cost sharing. See N.J.A.C. 11:4-37.3, 11:24-5.3 and 9.1(d), and 11:24A-2.5 and 2.6. Thus, when a person receives emergency services from an out-of-network provider the services are not covered as out-of-network services. Rather, the cost sharing (deductible, copayment, and coinsurance) the person pays is the network cost sharing for the services.
- Services during hospitalization – As required by New Jersey law, when a person is an inpatient in a hospital, services provided during the hospitalization, such as anesthesia, radiology and laboratory are covered with the person’s liability limited to the network level cost sharing. See N.J.A.C. 11:22-5.8(b). Thus, when a person is hospitalized and receives services from an out-of-network provider the services are not covered as out-of-network services. Rather, the cost sharing the person pays is the network cost sharing for the services.
- The Out-Of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act, P.L. 2018, c. 32 (N.J.S.A. 26:2SS-1 to -20), was effective on August 30, 2018. This law further enhanced consumer protections from surprise bills for out-of-network health services and changed several elements of New Jersey’s health care delivery system. The law requires transparency requirements and various consumer disclosures, the creation of an arbitration system, and cost containment for inadvertent and emergency or urgent out-of-network services.

In-Plan Exception

Whether covered under an HMO, EPO, PPO or POS plan, a person may require the services that are not available from a network provider.

QUESTIONS: What if a person is currently covered under a group plan allows use out-of-state doctors and facilities? Or what if the current plan has out of network benefits? What if a person is in the midst of treatment with a doctor that is located out-of-state? What is a person supposed to do?

The answer depends on the person's medical condition(s), the person's course of treatment, the person's medical history and the availability of providers in the new plan's network

- If none of the plans the small employer offers includes the person's doctor or facility in the network, it may be appropriate to request that the new company the employer selects provide coverage for the ongoing treatment using the person's current doctor and facility.
- Generally, it is appropriate to request an in-plan exception if the medical condition cannot be appropriately treated using providers that participate in the plan. Maybe the network just does not have the type of provider the person needs. Or, the network has the type of provider but the distance is unmanageable or the provider has no available appointments for months.
- Personal preference, regardless of the reasons for the preference, is not a good reason to expect that an in-plan exception will be allowed.

Some examples might help. The first three address situations that could warrant an in-plan exception. The last two address situations where a request for an in-plan exception would probably fail.

Example 1: Suppose a person has a medical condition for which there are a limited number of doctors with training and experience to treat the condition. If none of these doctors participate in the new plan's network, a person would want to request an in-plan exception.

Example 2: Suppose a person has complicated medical conditions, has used local doctors in the past but they referred the person to out of state doctors really specialize in treating specific types of conditions but they do not participate in the new plan's network. The person would want to request an in-plan exception.

Example 3: Suppose the person has breast cancer and will be undergoing a mastectomy and reconstructive surgery. The surgeon for the mastectomy is in the network but the

reconstructive surgeon the surgeon generally works with is not in the network. The person would want to request an in-plan exception.

Example 4: Suppose the person has a medical condition that can be treated in New Jersey but the person has chosen to use an out of state doctor and facility because of an excellent reputation. Or maybe someone the person knows used a certain doctor and had good outcomes. The person can certainly request the in-plan exception. However, if the plan has network doctors who have the qualifications to provide medically necessary services and who are accepting new patients it will be difficult to build a case that it is clinically necessary to use an out of network provider.

Example 5: Suppose the person was diagnosed with a chronic condition such as diabetes several years ago and has to go to an endocrinologist every six months for checkups. Even though the person has a several year history with the same endocrinologist, the person would probably not be successful in obtaining an in-plan exception to continue with the same endocrinologist since all of the plans have endocrinologists in the network who could perform the same semi-annual exams and tests for the condition.

A request for an “in-plan exception” would be made to the company issuing the plan in which the person enrolls. The request must explain why it is medically necessary to continue treating with the doctor and why transitioning care to a doctor in the new plan’s network would not allow the person to continue clinically necessary care. Be sure to address anticipated care and treatment. It would be helpful to ask treating doctors to provide a clinical justification for continued treatment by them. When asking doctors to provide information ask them to prepare the same type of justification they generally provide for a utilization review request and to specifically explain why a change in providers would result in a deterioration of the person’s health. The request will be reviewed by the medical director at the company.

If the in-plan exception is approved the person will be allowed to continue to treat with the doctor and cost sharing will be at the network level. In other words, it will be as if the person is using a provider that is in the network. Please note that the approval of the in-plan exception may be limited to a certain time period.

If the request is denied the person has a right to appeal the denial. The Appeal and Complaint Guide explains the process and is available at www.state.nj.us/dobi/division_consumers/insurance/appealcomplaintguide.pdf.

Remember: With the in-plan exception the covered person receives care from an out-of-network provider, but is responsible only for the network level cost sharing.

Voluntary Out-of- Network

Coverage of Out-of-Network Services under Plans with Out-of-Network Benefits

PPO and POS plans are the only types of plans that cover services and supplies provided by out-of-network providers when the covered person *voluntarily* decides to use the services of the out-of-network provider. This circumstance is distinguished from the above circumstances, like emergencies, by the choice the covered person enjoys. Network providers are available, and the covered person may elect to use them. For any number of reasons, the covered person may prefer to use the out-of-network provider instead. In the case of the *voluntary* use of an out-of-network provider the person is responsible for the out-of-network level cost sharing specified in the PPO or POS plan. Additionally, the covered person is responsible for any difference between the amount the out-of-network provider bills for the service and the allowed charge for the service or supply. This difference is referred to as balance billing.

A covered person deciding whether to utilize an in-network or out-of-network provider will have access to information regarding the allowed charge to enable the person to calculate the cost sharing and balance billing associated with the voluntary use of an out-of-network provider.

Health Savings Accounts and Other Tax-favored Options

The standard plans can be designed as “high deductible health plans” (HDHP) that may qualify for use with a Health Savings Account (HSA). An HSA permits money to be set aside in a federally tax-favored savings vehicle for subsequent distribution without a federal tax liability if used to pay for qualifying medical expenses, [set forth in IRS Publication 502](#). There are differing minimum and maximum deductible and MOOP amounts that an HDHP must meet to qualify for use with an HSA. Not all plans with high deductibles necessarily qualify as HDHPs. Carriers may market both the HDHP and the savings account, or an employer may purchase an HDHP from a carrier and obtain the savings account through another financial institution. For more information, consult [IRS Publication 969](#). In addition, [IRS Publication 969](#) provides information about other employer-sponsored, federally-tax-favored health accounts, such as Flexible Spending Accounts (FSAs) and Health Reimbursement Arrangements (HRAs), which permit employees to pay for [qualified medical expenses](#) using pre-tax dollars.

More about Cost-Sharing Requirements for the Standard Plans

Deductibles

The deductible is the amount of the allowed covered charges that the covered person must satisfy before the carrier agrees to pay anything towards covered charges. Deductibles are a specified dollar amount and are usually determined per person and per family when more than

one person in a family is covered. The employer may choose among the options available for the per person deductible.

Embedded or Non-Embedded – It makes a difference!

With an embedded deductible, there are two deductible amounts - the individual deductible and the family deductible. The family deductible is twice the individual deductible. Amounts applied to the individual deductible are also applied toward the family deductible.

With a non-embedded deductible and coverage for more than one person, there is no individual deductible. This means the family deductible must be reached, either by one person in the family or by a combination of members of the family. Note: High deductible health plans that could be used with a Health Savings Account must have a non-embedded deductible. Other plans *may* use a non-embedded deductible.

Coinsurance

The coinsurance is the percentage of the allowed charges that are shared by the carrier and the covered person after the deductible is satisfied. The carrier and covered person both contribute a specified percentage to the allowed charges until the MOOP amount is satisfied. The MOOP is explained below. Depending upon what plan is chosen, the carrier will pay 50% to 90% of the allowed charges, and the covered person will pay 10% to 50% of the allowed charges until the MOOP amount is reached.

Copayments

A copayment is a specified dollar amount that a covered person pays per visit, per day or per service. In many plan designs copayments are applied to office visits. A copayment may be applied for each day in the hospital (for a limited number of days). A copayment applies for use of a hospital's emergency department (but the copayment – which is more akin to a penalty – is waived if the person is admitted to the hospital). Copayments accumulate towards the MOOP amount. Services subject to a copayment may not also be subject to coinsurance.

Maximum Out-of-Pocket (MOOP)

MOOP is the term used to refer to the maximum total amount of covered charges that a covered person is required to pay in a calendar year for health care services before the carrier pays 100% of the covered charges for the remainder of the calendar year. The MOOP is satisfied by the covered charges incurred by the covered person as part of the deductible, coinsurance and copayments required under the health benefits plan. The following do not count towards satisfying the MOOP:

- Charges incurred by the covered person for services that are not covered under the terms of the health benefits plan.
- Charges that exceed the amount that the carrier considers reasonable and customary (or allowed charges) for the non-network covered services.

Just as the deductible can be embedded or non-embedded, the MOOP can be embedded or non-embedded.

Allowed Charges

Carriers will not cover or pay for charges associated with services or supplies that:

- are excluded under the terms of the health benefits plan;
- exceed limits set forth for the services or supplies in the health benefits plan; or
- are not considered medically necessary and appropriate by the carrier. *(Remember, the covered person may appeal the determination.)*

If a health care service or supply is excluded or exceeds the limitations under the health benefits plan, the covered person is responsible for the charges related to the health care service.

The carrier will issue the covered person an explanation of benefits (EOB) indicating whether costs for services and supplies are the responsibility of the covered person when the carrier determines the health care services or supplies are not medically necessary and appropriate. An individual may appeal the carrier's medical necessity determination.

In addition, **a carrier will only pay for what the carrier determines are allowed charges** for the covered services. Carriers and in-network health care providers come to an agreement on fees for health care services as part of the contract between them. Health care providers that are not in a carrier's network may charge fees they determine for the services they provide. However, carriers may only pay what they consider to be a "the allowed charge for the services. Carriers define the term allowed charge in the group plan and certificates issued to employees. The definition specifies the basis to determine the allowed charge for any given service.

In New Jersey, **in-network** health care providers may **not** bill a covered person for amounts that exceed the fees agreed to between the carrier and the health care provider. However, a **non-network** health care provider may bill charges in excess of what a carrier defines as allowed charges and the covered person is responsible for any amounts that exceed the allowed charges. This is sometimes known as balance billing.

Although written to explain the purchase of an individual plan, the Which Individual Insurance Plan is Best for You? resource available at

www.state.nj.us/dobi/division_insurance/ihcseh/whichindividualplanbest/whichplan.html provides tips that are applicable to small employer plans as well.

Obtaining and Renewing Coverage

After reviewing this Buyers' Guide, review the list of participating carriers and the premium information. Contact the carriers offering coverage in the small group market for specific plan information, or a licensed insurance producer (agent or broker), who can help you evaluate choices for your group's needs. Note: not all carriers use agents or brokers, and no agent or broker offers information about *all* carriers. Review the materials you receive from the carrier(s) or agent(s) and select the carrier and health benefits plan that best meets your group's needs. Obtain a price quote from the carrier or its agent before making any decisions. A carrier should provide a price quote within 10 business days after you give the carrier all necessary information.

Complete the selected carrier's application form. Carriers' forms may look differently, but the information requested is standardized. Submit completed employee enrollment forms (sometimes called the HINT form) and any waiver forms with the initial application, if required. Employee enrollment forms are also standard from one carrier to another. Send your completed application, completed employee enrollment forms and/or waivers, and the required premium (typically, one month of premium) to the carrier. Carriers should approve or deny an employer's application within 15 business days after receiving it. If approved, the group's effective date of coverage will be no later than the first of the month following the date of notice of approval, unless **you** request a later effective date.

The carrier will issue ID cards to covered employees (and dependents, if appropriate) as proof of the group coverage. Remember to inform the carrier or its agent as employees' circumstances change. Note: you may request an orientation period of one month and/or a waiting period of up to 90 days for employees to be considered eligible for enrollment.

Every year thereafter, in order to renew your coverage, the carrier will ask you to verify:

- Whether you still meet the definition of a small employer;
- Whether your group continues to meet employee participation requirements; and
- Whether your group continues to meet employer contribution requirements.

At the time of initial application and upon annual renewal, the carrier may require documentation verifying an employee's employment status. If you fail to meet the requirements to keep your coverage in effect, or if you fail to return the employer certification, then the policy will not be renewed. However, if a small employer fails to meet the participation or contribution

requirements, the small employer may apply during the Employer Open Enrollment Period as discussed earlier.

Questions on Eligibility

1. How can I figure out if I can provide a small employer plan?

First, you have to determine if you qualify as a small employer. If yes, you then have to determine whether your employees are eligible under New Jersey law. Some examples might help.

Example A “Mike’s Bike Shop” Mike is the owner and has one employee who works 37 hours per week, another employee who works 31 hours per week and a third who works 10 hours per week. These employees worked for Mike’s Bike Shop on business days in the preceding calendar year and all earn at least the minimum wage.

First, put Mike aside. As the owner, Mike is **not** an employee

- i. Next look at the employees. How many work 30 or more hours? Two
- ii. Now look at the employees working fewer than 30 hours. How many hours? 10 Multiply by 4 and we get 40. Now we divide by 120. $40/120 = 1/3$. Rounding down to the nearest whole number we get 0.

Add the results from i and ii. The sum is 2.

Mike’s Bike Shop is a Small Employer

Now, that we know Mike’s Bike Shop is a Small Employer we need to check if Mike has employees who are eligible for coverage. To be eligible, an employee must work at least 25 hours per week. Mike has 2 employees working 25 or more hours per week.

Mike can apply for a Small Employer plan to cover those two employees, their dependents, and even though he is not an employee, if Mike works at least 25 hours per week, Mike and his family can also be covered.

Example B “Sara’s Sandwich Shop” Sara and her husband Paul are the owners and they have 7 employees who work 20 hours per week. These employees worked for Sara’s Sandwich Shop on business days in the preceding calendar year and all earn at least the minimum wage.

First, as owners, Sara and Paul are not employees. Put them aside.

- i. There are no employees working 30 or more hours per week so we have 0.
- ii. There are 7 employees working 20 hours per week (they are part-time employees) which means a total of 140 hours per week ($20+20+20+20+20+20+20$). Next we multiply 140 by 4 and the product is 560. Next divide 560 by 120. The result is 4.66666 which we round down to the nearest whole number 4.

Add the results from i and ii. The sum is 4.

Sara’s Sandwich Shop is a Small Employer.

Now, that we know Sara's Sandwich Shop is a Small Employer we need to check if Sara has employees who are eligible for coverage. To be eligible, an employee must work at least 25 hours per week. There are no employees working 25 or more hours per week.

Sara is not eligible to apply for a Small Employer plan because she has no employees eligible to be covered.

Example C "Holly's Home Care" Holly is the owner owners and has 7 employees. Their hours vary based on the needs of the clients. These employees worked for Holly's Home Care on business days in the preceding calendar year and all earn at least the minimum wage.

First, as the owner, Holly is not an employee. Put her aside.

- i. There are no employees working 30 or more hours per week so we have 0.
- ii. There are 7 employees working variable hours *averaging* 350 hours *per month*. (Because the average hours is a monthly average, do not multiply by 4!) Next divide 350 by 120. The result is 2.92 which we round down to the nearest whole number 2.

Add the results from i and ii. The sum is 2.

Holly's Home Care is a Small Employer.

Now, that we know Holly's Home Care is a Small Employer we need to check if Holly has employees who are eligible for coverage. To be eligible, an employee must work *at least 25 hours per week*. The employees work variable hours and none regularly work 25 or more hours per week.

Holly is not eligible to apply for a Small Employer plan because she has no employees eligible to be covered.

2. How can I tell who is eligible to be covered?

When counting employees *for eligibility*, first identify all employees who work a normal work week of 25 hours or more. They must be paid at least the minimum wage. Each such employee counts as one.

An Example might help.

"Plumbing Plus" is owned by Paul, Ralph and Mark who have six full-time plumbers and two permanent office staff and one temporary office staff. The nine employees working for Plumbing Plus are paid at least minimum wage and work 30 hours per week.

There are nine employees working 25 or more hours per week. BUT

One member of the office staff is a temporary employee brought in to do year end accounting for two months. Temporary employees are not eligible to be covered.

The six plumbers belong to the Plumber's Union and get health benefits from the labor union. Are they employees? YES. They count even though they do not need or want the Plumbing Plus coverage.

9 employees – 1 temporary employee = 8 employees eligible for coverage

3. If some of my employees work outside of New Jersey does that change the way employee is determined and whether I am a small employer that can buy coverage under the SEH Program?

Where your employees live and work would not affect whether or not the business is a small employer. There is no difference in determining who is and is not an employee based on an employees' work location(s). However, where they live or work may mean they are outside the service area meaning they could not be covered under your small employer plan. Remember that employees and dependents can only be covered if they live, work or reside in the service area of the plan.

An example might help.

Craig's Computers is located in New Jersey. Craig, the owner, works at the New Jersey store. Craig has five employees who work from their homes in Pennsylvania and Delaware. They each work 40 hours per week and each are paid well above the minimum wage.

Is Craig's Computers a small employer? Yes since Craig employs 5 employees who work 25 or more hours per week. If Craig applies for a small employer plan can those employees be covered under the small employer plan? It depends. If Craig shops carefully to find a plan that includes Pennsylvania and Delaware in the service area then the employees working in Pennsylvania and Delaware would be eligible to be covered under the plan Craig buys. If Craig buys a small employer plan with a service area of New Jersey, the employees would not be eligible to be covered.

4. Does the Service Area have to be the whole state of New Jersey?

Although it is common for carriers to offer plans where the service area is the entire state of New Jersey, carriers may offer plans where the service area is limited to specified counties within New Jersey. It is also possible that carriers may offer plans where the service area is broader than the state of New Jersey. Ask the carrier to define the service area for the plan you are considering.

5. How is "temporary" or seasonal employee defined?

The SEH Program Act does not define what constitutes "temporary" or seasonal, and the SEH Board has not defined the terms by regulation. Carriers establish criteria for who is considered a temporary or seasonal employee, and so the standards may differ slightly

from one carrier to another. An employer or a broker should consult with a carrier on this issue.

6. If I own multiple businesses, do I count my employees for all businesses together, or separately?

Whenever there are affiliated businesses, the first determination that must be made is whether the businesses are treated as a single employer under subsections (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 ([26 U.S.C. §414](#)). The employer will need to obtain a statement from a tax accountant or a tax attorney specifying whether or not the affiliated companies are a single employer for tax purposes. If the affiliated companies are considered a single employer under the federal tax code, then the combined employment base is considered in the analysis of whether the affiliated companies are a small employer. If the affiliated companies are considered to be separate employers under the federal tax code, then the analysis of whether a small employer exists is performed separately for each company.

7. Does New Jersey small employer law require that I provide health benefits for my employees?

No, New Jersey law does not require any employer to provide coverage to employees. However, if you provide small group health coverage, you must comply with the requirements of the law.

8. May a self-employed husband and wife with no other people working in the business obtain group coverage under the small employer health benefits program?

No, a business with only husband and wife does not qualify as a small employer. Neither are employees and thus there are no employees working in the business.

9. May a self-employed husband and wife with a full-time employee working in the business obtain group coverage under the small employer health benefits program? If yes, who can be covered?

With at least one full-time employee (must work at least 30 or more hours per week) the business would qualify as a small employer and could buy small employer coverage assuming the employer satisfies the participation and contribution requirements. In that case, the husband, the wife and the employee can be covered.

But note: In order to have a group plan there must be at least one employee covered under the plan. This means if the employee waives or refuses coverage the business cannot buy a small employer plan.

10. What if my business didn't have employees in the previous calendar year?

If the business is in its first year of operation, and so had no employees in the prior calendar year, the employer does not have to wait a whole year to purchase coverage. Instead, the number of employees will be based on the average number of employees the business is *reasonably* expected to employ on business days in the current calendar

year **and** the employer must have at least one employee on the effective date of coverage.

If the business is not in its first year of operation, but is just now hiring one or more additional employees, then the carrier will consider the prior calendar year employment average. Such a business will not meet the definition of a small employer unless there was at least one employee on business days in the **preceding** calendar year.

11. If I decide to offer coverage, must I offer it to all employees?

No. You may elect to offer coverage to one *class* of employee and not another *class*. However, distinctions in classes of employees must be based on *bona fide* conditions pertaining to employment, such as job title, length of service, hours worked, salary, etc. Even if you decide to offer coverage to a class of employees, you still must meet the small group participation requirements based on the *total number of employees who work 25 or more hours per week*, not just the class of employees to which you offer coverage.

12. May a small employer provide coverage to independent contractors?

No, they are not employees. They may choose to pursue individual coverage.

13. May a small employer voluntarily elect to provide coverage to employees who work fewer than 25 hours per week?

No, they are not eligible to be covered. They may choose to pursue individual coverage.

14. If I offer my employees a health benefits plan, must coverage become effective immediately?

It can, if that is what you elected for your employees. For example, if an employee begins work on June 1, the employer plan may provide that the coverage is effective as of June 1.

If you elected to apply an orientation period, or a waiting period, or both, the coverage would not begin immediately.

Some examples may help. The examples assume the new employee begins work on June 1.

If the employer plan applies an **orientation period**, the orientation period would run from June 1 – June 30. (to count one month, add one calendar month and subtract one calendar day – so June 1 plus one month is July 1, then subtract one calendar day to get June 30) If the employer plan applies an orientation period but not a waiting period and the new employee satisfactorily completes the orientation period, the coverage would be effective July 1.

If the employer plan applies an **orientation period** and a **waiting period**, the orientation period would run from June 1 – June 30 and the waiting period would begin the day after the orientation period ends, or July 1. Assume the employer plan has a waiting period of 60 days, with coverage effective on the 1st of the month following the 60-day waiting period. The 60-day waiting period would begin July 1 and run for 60 days and thus end

on August 29. Coverage would take effect September 1 which is the 1st of the month following the 60-day waiting period.

If an employer applies a **waiting period** but not an orientation period the waiting period would run from June 1. Assume the employer plan has a waiting period of 60 days, with coverage effective on the 1st of the month following the 60-day waiting period. The waiting period runs from June 1 – July 30. Coverage would take effect August 1 which is the 1st of the month following the 60-day waiting period.

15. May I impose an orientation period and/or a waiting period that is different for some employees?

If the employer elects an orientation period it must be one month. The employer could apply the orientation period to some classes of employees but not others provided the differing treatment of employees is based on class distinctions established on *bona fide* conditions of employment, such as hours worked, salary, title, etc.

The employer may elect a waiting period provided the duration does not exceed 90 days. The employer could provide for different waiting periods provided the differing treatment of employees is based on class distinctions established on *bona fide* conditions of employment, such as hours worked, salary, title, etc.

16. May a carrier require that a certain number of my employees “participate” if I offer a health benefits plan?

Carriers are permitted to impose a participation requirement. However, the SEH Program Act does not permit carriers to require more than a 75% participation requirement. In addition, carriers are required by law to credit towards the 75% participation requirement all employees that have certain other health coverage: Medicare, Medicaid or NJ FamilyCare, coverage as an employee through another employer’s group health plan, or coverage under any group health plan as a dependent and Tricare. Carriers are not required to count the employer’s employees covered under another carrier’s policy offered by the employer. Note that even if an employer pays 100% of the cost of coverage, a carrier cannot require greater than 75% participation.

Remember that the 75% participation requirement is waived during the Employer Open Enrollment Period.

17. If I offer my employees coverage, do I have to contribute to the premium?

You must contribute at least 10% of the **total** group’s premium; of course, you can choose to contribute up to 100%. You are not required to contribute a specific percentage of each employee’s premium, but can choose to vary contributions by *class* of employee, so long as your total contribution is 10% of the group’s premium. Distinctions in classes of employees must be based on conditions pertaining to employment, such as job title, length of service, or salary.

Note that the 10% contribution requirement is waived during the Employer Open Enrollment Period.

18. If I offer coverage to my employees, do I have to permit coverage of dependents?

No. But if you permit one employee within a class to cover dependents, then you must permit all employees within that class to cover dependents. Distinctions in classes of employees must be based on *bona fide* conditions pertaining to employment, such as job title, length of service, salary, etc.

19. If I permit my employees to cover dependents, do I have to contribute to the premium for dependents?

No. While you are required to contribute 10% of the total premium for your covered employees, you do not necessarily have to contribute to the premium related to dependent coverage. Because the dependent premium is part of the total premium, if you contribute nothing towards dependent coverage, you'll need to contribute more than 10% of the employee cost in order to satisfy the requirement to contribute at least 10% of the total premium. Of course, if you elect to contribute to the dependent premium, you may choose to contribute any amount you wish, by class of employee.

20. If I contribute to a health savings account for my employees, does that amount count towards the required contribution for the health benefits plan?

No.

21. May I change my contribution levels?

Yes. However, you may not contribute less than 10% of the group premium. Further, the change can only be made if the current plan has been in force at least 12 months. Pursuant to federal law, if you elect to change your contribution levels, the change creates a special enrollment period for your employees. This allows employees who may have previously declined coverage to enroll, and allows enrolled employees to terminate their enrollment or to change to an alternate coverage option if your group has more than one option available.

22. Does my group have to continue to meet eligibility requirements?

Yes, on an annual basis. Once a year – several months prior to the anniversary date of your policy – you will have to complete an employer certification regarding your group's census, and verify that contribution and participation requirements continue to be met.

23. What happens to my group's coverage if the number of my employees eventually exceeds 50?

If your business grows to more than 50 employees, you may become ineligible to purchase or amend small employer coverage, but not right away, because eligibility is based on average employment activity in the prior calendar year. So, even if you have 55 employees today, the carrier will look at the number of employees you had during the prior calendar year.

Once the number of employees *during the prior calendar year* exceeds 50, an employer is no longer a small employer. If such an employer wishes to remain covered under the plan(s) purchased while the employer was a small employer, the employer may renew

the previously purchased small employer plan(s) without any changes. However, the rates charged *may* no longer be the carrier's SEH market rates. The carrier will refuse any application to make a change to the plan(s) in any way, no matter how minor, because the employer completing the application is no longer a small employer. Instead, the employer may apply for plans the carrier makes available to large employers.

24. What happens to my group's coverage if the number of my employees eventually falls below one?

Annually upon renewal, you must show that you have at least one employee or your SEH policy will be non-renewed. If less than one employee remains (for example, only the owner remains), coverage may be obtained in the individual market.

25. Suppose I have employees but they all have coverage elsewhere and do not want to enroll under a group plan I may offer. May I still have a group plan if I enroll? I own the business and work about 50 hours per week.

Unless there will be at least one employee covered under the plan there is no group plan. The owner of the business is not an employee and does not satisfy the requirement to have at least one employee covered.

26. We have a husband/wife business with 2 full-time employees who are currently covered under our group plan. One gave notice that she will be leaving at the end of the month. We do not intend to replace her. The other just got married and told us he will be covered under his spouse's group plan as of the first of the month. What will happen to our group plan when it comes up for renewal in three months?

Since one employee will be terminating employment and one employee will be waiving coverage, there will be no employees to be covered under the plan. Since there will be no employees covered the carrier will not renew your group plan.

27. Follow-up to the above – our renewal date is December 1 and I understand there is an open enrollment period from November 15 through December 15. Since we would be up for renewal during the open enrollment period can't we renew our group plan?

During the open enrollment period employer need not satisfy the participation requirement and/or the contribution requirement. The employer must, however, be otherwise eligible to buy a group plan. With no employees to be covered you do not qualify to buy a small employer group plan. Remember, neither you nor your spouse count as employees.

Questions on Enrollment

- 1. Do I have to wait until the Employer Open Enrollment period to buy a new policy for my employees?**

No, there are no restrictions on when a small employer may buy group coverage provided you satisfy the participation and contribution requirements.

- 2. What are late enrollees?**

Generally, a late enrollee is someone who declined coverage when he or she was first eligible to enroll, and then seeks to enroll at a later date.

- 3. How long does a late enrollee have to wait to enroll?**

It depends. A late enrollee can enroll during the employee annual enrollment period which is defined by the employer and is generally a month or two before the employer's anniversary date. So, how long a late enrollee may have to wait depends on the timing of the employee open enrollment period relative to when the late enrollee decides he or she wants to enroll. A late enrollee can also enroll if he or she experiences a triggering event. The timing for enrollment depends on what the triggering event is.

- 4. Who is considered an eligible dependent?**

An eligible dependent includes a spouse, a civil union partner, and an employee's child through birth, marriage, civil union, adoption or placement for adoption. A domestic partner and his or her children may be considered dependents for purposes of coverage under a health benefits plan, at the option of the employer. When children are covered, they are covered up to a specified **limiting age**, which is at least to age 26 years old. "Over-age" children – those who have attained the limiting age, but who are not yet 31 years old – are also eligible to be covered through a continuation law referred to as "[Dependent Under 31](#)."

- 5. Do I have to offer a continuation option?**

Yes, you must offer a continuation option to employees and their qualified beneficiaries upon the occurrence of qualifying events. If you have 20 or more employees, you are required to offer a continuation election option in accordance with the federal law referred to as [COBRA](#) as well as the New Jersey State Group Continuation (NJSGC) law. If you have fewer than 20 employees, you are required to offer a continuation election option in accordance with the NJSGC law only, because [COBRA](#) does not apply to employers with fewer than 20 employees.

6. Do I have to contribute to an employee's premium in the event he or she elects continuation if I was contributing to premium when he was covered as a regular group member?

Not generally. However, an employer subject to the requirements of the Family Medical Leave Act has to contribute to the premium related to an individual with continuing coverage when the employee is not working because of use of leave under the [Family Medical Leave Act](#).

7. What is the duration of the election period for an employee or dependent to make a continuation election?

[COBRA](#) permits an employee or dependent, as appropriate, to make an election within 60 days following notice of the opportunity to continue coverage. NJSGC permits an employee or dependent to make an election within 30 days following the occurrence of a qualifying event (loss of coverage).

8. Can dental coverage be continued?

[COBRA](#) permits continuation of dental benefits. Pediatric dental benefits can be continued under the NJSGC law if the pediatric dental benefits are embedded within the medical plan. If the pediatric dental benefits are purchased and issued separately such benefits are not subject to NJSGC.

9. Is the coverage under COBRA and NJSGC really the same coverage the person had when the person was covered as an active employee?

The list of services and supplies that are covered will be the same unless the employer makes a change to the plan. Coverage under COBRA and NJSGC is treated differently than active coverage whenever coordination of benefits is involved. This is particularly true with respect to coordination with Medicare.

An example may help.

Larry's Lighting has 25 employees and is subject to COBRA. Laura and her husband Len have been covered under the plan. Len is 66 years old and has Medicare Part A but not Part B because he has been getting benefits through his wife's group plan and that plan is primary. Laura retires and elects COBRA for herself and her husband. Laura notices no difference – but Len will unless he enrolls for Medicare Part B. When the coverage changes to COBRA the employer plan will no longer be primary. Medicare becomes primary. Len needs to enroll for Part B.

Questions on Rates and Plans

1. How does a carrier determine the premium for my group?

Carriers determine a group's rates based on the plan of benefits selected and the characteristics of the group. Carriers can only consider the ages of the people to be covered and the location of the business in New Jersey in determining the premium. Carriers may not consider the health status, nature of business, or past claims experience of a group in determining premium.

2. Are rates guaranteed for a specific period of time?

The SEH Program Act does not require that carriers guarantee their rates for any period of time. However, most carriers do. Ask the carrier or your broker or agent if rates are guaranteed and for how long.

3. How long should I expect to wait for a price quote?

In practice, price quotes are run immediately, so you should not have to wait. (Technically, a carrier has up to 10 business days to provide you with a price quote after you have given the carrier all the information the carrier needs to develop the quote.)

4. If one or more of my employees incurs significant claims, can a carrier cancel the coverage or refuse to renew it?

No, a carrier may not terminate a small group's coverage based upon the claims experience of the group or specific members of the group. Small employer coverage is guaranteed renewable at the option of the employer, except when: the employer fails to pay the premium, the employer fails to provide the completed Employer Certification; the employer has acted fraudulently with respect to the coverage; the carrier has elected to withdraw from the small employer market entirely; the employer no longer meets the definition of a small employer; or, the group no longer meets participation or contribution requirements.

5. If one of my employees incurs significant claims, can a carrier refuse to continue covering that employee?

No. Carriers cannot refuse to renew coverage for any member of a small employer group because of claims experience or health status-related factors.

6. If one or more of my employees incurs significant claims, should I expect to see a significant increase in rates because of it?

Not necessarily. Because of how rates are developed, your group's specific premium is not directly related to your group's specific claims. The law requires carriers to community rate health benefits plans, which means that the carriers blend the experience of all groups that purchase a health benefits plan to develop a community rate. The rate is then modified by group to take into consideration specific group characteristics as permitted by the law. Although the experience of your group will have an impact on the

rate for the health benefits plan for your carrier, it will be blended with the experience of all other groups purchasing the same health benefits plan, and will not be tied directly to your premium.

7. What can I do if I am unhappy with the rates being charged by my current carrier?

You have several options. You are not required to stay with a specific health benefits plan indefinitely. You may have an option to change some of the cost-sharing requirements of your current health benefits plan, or add or remove coverage riders. You also may be able to switch to a lower cost plan offered by your current carrier. In addition, you may be able to switch to another carrier offering the same health benefits plan at lower rates. But note: changes in health benefits plans are not entirely unrestricted. Carriers are not required to honor *any* requests for plan changes unless the existing plan has been in effect for at least 12 months.

8. How do deductibles work?

Deductibles are the amount of allowed charges for which the covered person is responsible before the carrier agrees to pay anything towards covered charges. Preventive care services are an exception. No deductible applies to preventive care services. So, for instance, if a person has a policy with a \$2000 deductible, until the covered person pays \$2000 in allowed charges for covered services, other than preventive care, the covered person is not entitled to have any of the charges reimbursed by the carrier.

9. How does coinsurance work, and what are the coinsurance requirements for the standard health benefits plans?

“Coinsurance” is a term used to express the promise by the carrier to share, on a percentage basis, payment for allowed charges for covered health care services with the covered person. The standard small employer Plans B through E have specified coinsurance requirements, but the actual coinsurance amount may vary depending on whether the plan is offered with or without a network feature. When the standard plans are offered with a network feature then the coinsurance percentages in-network and out-of-network may differ for in-network and out-of-network benefits, each ranging from 50% to 100%. For the HMO Plan, when coinsurance applies (and it only applies when copayments do not apply to a covered service), the carrier may offer the plan with a coinsurance specified within a range of 50% to 100%.

10. What is the Maximum Out-Of-Pocket (MOOP) amount and how does it work?

The MOOP is the maximum amount of allowed charges for covered services that a covered person/family is obligated to pay before the carrier agrees to pay for **all** of the allowed charges for covered health care services for the rest of the calendar year. For the standard health benefits plans, allowed charges the covered person pays towards the deductible, coinsurance and copayments accumulate to satisfy the MOOP.

11. Are there any charges that do not count towards satisfaction of the MOOP amount?

Yes, some charges may not count towards satisfaction of the MOOP.

Charges for health care services that are not covered under the health benefits plan do not count towards the MOOP amount. In addition, charges for covered health care services that *exceed* the allowed amount – as determined by the carrier – are not counted toward the MOOP amount.

12. What does “allowed charges” refer to?

“Allowed charges” refers to either the charges billed by the health care provider or the amount of billed charges that a carrier considers eligible and covered under the health benefits plan, whichever amount is less. “Allowed charges” may also refer to the negotiated rate of payment. The amount of charges that a health care provider bills for his or her services, and the carrier’s allowed charges may not be the same – sometimes the provider bills more than allowed charge, and sometimes the provider bills less. When determining amounts due to the provider subject to a coinsurance percentage, the carrier bases what it pays on either the allowed charges or the provider’s billed charges, whichever amount is less. When there is a negotiated rate of payment, the provider’s bill may reflect the negotiated rate, or it may be in excess of the negotiated rate, but the carrier will only pay the negotiated rate.

Example: A physician bills a covered health care service at \$1,000. The carrier determines the allowed charges to be \$800. If the carrier is paying 80% of the allowed charges, then the carrier will pay \$640 ($\$800 \times .80 = \640). The covered person would pay 20% of the allowed charge, or \$160. If the health care provider is an out-of-network physician, the covered person is also responsible for the remaining \$200 “excess” charge between what the provider billed and the allowed charges.

13. What’s an in-network benefit versus an out-of-network benefit?

The in-network benefits are the benefits (reimbursement or monetary value) a covered person is entitled to when he or she receives covered services through an in-network health care provider. The out-of-network benefits are the benefits a covered person is entitled to when he or she receives covered services through an out-of-network health care provider. Because health care providers in a carrier’s network have agreed with the carrier to a negotiated rate of payment, and have agreed not to collect charges in excess of the negotiated rate of payment from the carrier’s covered persons, in-network benefits are almost always greater than out-of-network benefits for the covered person. When a covered person chooses to receive covered services outside of the carrier’s network, the covered person is responsible for any charges that the health care provider may bill that exceed what the carrier considers to be reasonable and customary, and these excess charges do not count toward satisfying any deductible or maximum out-of-pocket (MOOP) requirements in the standard health benefits plan.

14. Is there a grace period for paying premiums?

Yes. If premiums are paid within 31 days following the premium due date, the policy will remain in effect. If an employer does not pay premiums by the end of the grace period, the coverage will lapse. To avoid potential problems and misunderstandings, it is always advisable to submit premiums by the due date.

Premiums continue to be owed while coverage is in effect. If a policy lapses at the end of a grace period, the employer remains liable for the premium for the period coverage was in effect.

15. After I have purchased a small employer health benefits plan, may a carrier continue to require me to complete forms?

Yes. The carrier will require you to fill out an Employer Certification form once per year in order to determine the number of employees and your participation rate. Failure to provide this information will result in non-renewal of coverage.

16. What is "self-insurance" and "stop loss" or "excess risk" insurance?

Some employers, especially large employers, opt to provide health coverage to their employees through a self-funded arrangement. Under such an arrangement, the employer is liable for expenses for the health coverage offered to the employees. Most employers that self-fund elect to purchase "stop-loss" or "excess risk" insurance for some portion of their potential liability from claims under the contract for health coverage. Stop loss and excess risk insurance is designed to reimburse the self-funded arrangement for catastrophic, excess or unexpected claims expenses. Carriers may not legally offer stop loss or excess risk policies to small employers with "attachment points" of less than \$20,000 per person per plan year and 125% of expected claims per plan year. The attachment point is the line of demarcation between the employer's liability and the carrier's liability. That is, a stop loss policy with an attachment point of \$20,000 per person and 125% of expected claims per plan year means that the employer is responsible for at least \$20,000 per person and 125% of expected claims for the group per plan year before the carrier pays any of the health care expenses incurred by group members. Please note that employees covered under an employer's self-funded plan do not count when determining whether an employer has met participation requirements for SEH plans.

17. What is the impact on a small employer group when a full-time employee turns age 65 and becomes eligible for Medicare?

Eligibility for [Medicare](#) does not preclude eligibility for coverage under the employer plan. Thus, the employee may be covered under both Medicare and the group plan. However, it may be essential for the employee to sign up for Medicare even though the employee continues working. It depends on the size of the group.

Employer has fewer than 20 employees

Under Federal law, Medicare will be primary to the small employer plan when benefits are coordinated. The small employer plan will pay *after* Medicare pays. The employee needs to enroll for Medicare Parts A and B. If the employee does not enroll for Medicare the small employer plan will coordinate against what Medicare part B would have paid even though the person does not have Medicare part B.

Employer has 20 or more employees

Under Federal law, the small employer plan will be primary to Medicare when benefits are coordinated. The small employer plan will pay *first*. As long as the employee is still working and eligible for the group plan the employee does not need to enroll for Medicare Parts A and B. The employee can delay enrolling in Medicare until the employee is going to stop working.