

The New Jersey  
Individual Health Coverage Program

# **BUYER'S GUIDE**

How to Select a Health Plan

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## Introduction

In 1992, the New Jersey Legislature created the Individual Health Coverage (IHC) Program to ensure that people without access to employer or government sponsored health care programs could purchase health coverage for themselves and their families from a variety of private carriers. Prior to that time, few insurance companies offered policies to individuals and coverage was often inadequate, especially for people with chronic illnesses or injuries.

Today, individuals -- regardless of their age or health status -- are guaranteed renewable health coverage under standard individual plans designed by the Individual Health Coverage Program Board as well as under the Basic and Essential Plans sold by carriers.

This Buyer's Guide\* provides general information on individual health benefits plans (referred to in this Buyer's Guide as individual plans) and is designed to help you shop for the plan that best meets your needs. Individual plans are available for a Single person, Two Adult, Family or Adult and Child(ren). To assist you with your plan selection, enclosed with this Buyer's Guide is a list of participating carriers, their current rates and their telephone numbers. The rate comparison sheets are updated monthly, providing rates for the current month, so please note the date that appears at the bottom of the rate sheet.

Individual plans may be purchased from a variety of carriers as either an indemnity plan (commonly known as a "traditional" or "fee-for-service" plan) or a managed care plan (a Health Maintenance Organization (HMO), Preferred Provider Organization (PPO) or Point-of-Service (POS)). The Basic and Essential Health Plan (B&E Plan) is also available as an Exclusive Provider Organization (EPO) plan. These plan options are explained in detail in this Buyer's Guide.

The law governing the Individual Health Coverage Program was significantly amended in 2009, and was generally effective January 5, 2009. The amendments affecting consumers are described in this 2009 edition of the Buyer's Guide.

You can learn more about the New Jersey IHC Program by browsing our Internet Web Address: [http://www.state.nj.us/dobi/division\\_insurance/ihcseh/ihcmain.htm](http://www.state.nj.us/dobi/division_insurance/ihcseh/ihcmain.htm)

\* This Buyer's Guide provides only a summary of the New Jersey Individual Health Coverage Program requirements and is intended to help consumers make informed decisions concerning health coverage; contract provisions govern the terms and conditions of coverage.

## Obtaining Coverage

To obtain coverage, we suggest you follow these steps:

Review this Buyer's Guide to learn more about individual health coverage in New Jersey, the standard plans available, and the benefits they provide. The Basic and Essential Health Plan (B&E Plan) is not a standard plan, but this Guide will provide some general information concerning that plan and direct you to the carriers for more specific information on the B&E Plans they offer.

Review the list of participating carriers and the rate comparison sheets. For additional information, you may contact the carriers directly. You may also decide to contact a licensed insurance producer, sometimes known as an agent or broker, who can help you make an informed decision, at no additional cost to you. However, some carriers do not offer coverage through insurance producers, so you will have to contact those carriers directly.

Review the carrier's materials and select the carrier that best meets your needs.

Apply directly to the carrier you have selected by completing the application provided by that carrier. All carriers are required to use a standard application form (you may hear some carriers refer to it as the HINT form) so the application from one carrier should look very much like the application from another carrier.

Mail your completed application to the carrier. If your coverage will take effect within the next month, you must include the first premium payment with your application. Some carriers may allow you to authorize the carrier to deduct the premium payments from your checking account before the effective date. Check with the carrier you are selecting to find out if this is an available option.

Since coverage applied for during November as part of an Open Enrollment Period application does not take effect until the following January 1, the payment of the first premium either by check, or pre-authorized checking account deduction, may be delayed until December, even though you are applying in November.

Upon receiving your application and premium payment, your carrier will send you an identification card and a policy or contract which will indicate the effective date of your coverage. (Check the enrollment materials regarding the effective date of coverage. The effective date of coverage generally depends on the date of receipt of the completed application materials and premium payment.) If the ID card is not provided prior to the effective date of coverage, the carrier may suggest that you use a copy of your application as evidence of coverage.

You cannot be covered under two individual plans at the same time. If you currently have individual coverage, you must notify the current carrier, within 30 days after the new coverage takes effect that you want to terminate the current coverage. The current coverage will be retroactively terminated as of the day before the new coverage takes effect.

Generally, you cannot be covered under both an individual plan and a group plan. If you are currently covered under a group plan and are applying for an individual plan during the November Open Enrollment Period, that individual coverage takes effect on January 1. You must terminate the current group coverage no later than December 31. See the Group coverage section on the following page for information regarding eligible for group coverage after you already have an individual plan.

## Eligibility

As explained below, you are eligible to purchase an individual plan if you are:

- a resident of New Jersey;
- not eligible for coverage under a group health plan, governmental plan or church plan; and
- not eligible for coverage under Medicare.

1. Residency -- A New Jersey resident is defined as someone whose primary residence is in New Jersey and who is present in New Jersey for at least six months of the calendar year. However, if a person qualifies as a "federally defined eligible individual" as defined below, the person does not need to be present in New Jersey for at least six months. For non-Health Maintenance Organization (HMO) coverage, residency requirements apply only to the individual who applies for coverage -- the policyholder. The policyholder's spouse, children or other dependent(s) do not have to reside in New Jersey. However, they must reside in the United States and there are some benefit restrictions if care and treatment are received outside the United States. If you choose to purchase coverage from a Health Maintenance Organization (HMO), all covered persons must reside in that HMO's service area.

A "federally defined eligible individual" is defined as "a person who has been covered for at least 18 months without a break in coverage of 63 or more days and whose most recent coverage was under a group health plan, governmental plan, church plan, or health insurance coverage offered in connection with any such plan; who is not eligible for coverage under Medicare or Medicaid; and who does not have another health benefits plan, or hospital or medical service plan."

2. Group Coverage -- Generally, you are considered eligible for group coverage if your employer or union -- or your spouse's employer or union -- makes a group plan available and you satisfy all the conditions for participation imposed by that group plan. Even if you choose not to participate in that group plan, you are still eligible for group coverage -- and, therefore, ineligible for individual health coverage. (However, you may have an opportunity to purchase an individual plan during the Open Enrollment Period in November of each year even if you are eligible for group coverage. There are specific rules that apply to the Open Enrollment Period, so it is best to consult with an insurance producer or carrier before doing so.)

If you are already covered under an individual plan when you first become eligible for group coverage, you may elect to retain your coverage under the individual plan. The individual plan would apply a "coordination of benefits" provision, which means that the group plan would pay benefits first, and then the individual plan would pay benefits as the secondary payor. If you elect to retain your individual coverage even while you are eligible for or covered under a group plan, you will be required to pay the full premium for individual coverage.

3. Medicare -- You are not eligible to purchase an individual plan if you are already eligible for Medicare, regardless of whether or not you apply for all available benefits under Medicare. Thus, if you are age 65 and eligible for Medicare, but do not sign up for Medicare, you are still eligible for Medicare and, therefore, you are ineligible to purchase an individual plan. Most people become eligible for Medicare because of their age (65 or older), but a person may become eligible for Medicare prior to age 65 because of a disability, including end-stage renal disease. If you are age 65 or older and not eligible for Medicare you will be asked to provide evidence that you are ineligible for Medicare.

While you may not purchase an individual plan if you are already eligible for Medicare, if you are already covered under an individual plan when you first become eligible for Medicare, you may elect to retain your coverage under the individual plan, or you may elect to terminate coverage under the individual plan. If you retain the individual plan, the individual plan would apply a "coordination of benefits"

provision, which means that Medicare would pay benefits first, and then the individual plan would pay benefits as the secondary payor. If you elect to retain your individual coverage even while you are eligible for or covered under Medicare, you will be required to pay the full premium for individual coverage.

Even when a Medicare-eligible person does not enroll in Medicare, the individual plan will still act as the secondary payor, applying the "coordination of benefits" rules against the benefits Medicare would have paid, if the person had enrolled. Although a Medicare eligible person may elect to continue existing coverage under an individual plan, the individual plan is not a Medicare Supplement Plan and may not be used as a substitute for Medicare.

People who are already covered under an individual plan and then become eligible for Medicare should contact the New Jersey Department of Health and Senior Services, NJ Division of Aging and Community Services at 1-800-792-8820 for information concerning Medicare Supplement Plan options. Information is also available on their website which is [www.state.nj.us/health/senior/ship.shtml](http://www.state.nj.us/health/senior/ship.shtml).

Note: If you are an employer with two or more employees, you may be eligible for group coverage. If you would like information on Small Employer Health Benefits Plans, please call 1-800-263-5912, or visit the website at [http://www.state.nj.us/dobi/division\\_insurance/ihcseh/sehmain.htm](http://www.state.nj.us/dobi/division_insurance/ihcseh/sehmain.htm)

## **Dependent Eligibility**

Individual health coverage may also cover your eligible family members, as discussed below.

Dependent is defined to mean your:

- Spouse;
- unmarried Dependent child who is under age 19; and
- unmarried Dependent child from age 19 until his or her 23rd birthday, who is enrolled as a full-time student at an Accredited School. Full-time student status will be as defined by the Accredited School. We can require periodic proof of a Dependent child's status as a full-time student.

In the individual plans, the term "spouse" includes an individual legally married to you under the laws of the State of New Jersey and also includes your Domestic Partner pursuant to P.L. 2003, c. 246 as well as your Civil Union Partner pursuant to P.L. 2006, c. 103 as well as a person legally joined to you in a same sex relationship in another jurisdiction if such relationship provides substantially all of the rights and benefits of marriage..

Under certain circumstances, an incapacitated child is also a Dependent.

Your "unmarried Dependent child" includes:

- Your biological child,
- Your legally adopted child,
- Your step-child
- the child of Your Domestic Partner or Civil Union Partner if the child depends on You for most of his or her support and maintenance,
- children under a court appointed guardianship; and
- any other child over whom You have legal custody or legal guardianship or with whom You have a legal relationship or a blood relationship, provided the child depends on You for most of the Child's support and maintenance and resides in Your household.

Please note that the law allowing certain children to remain covered under the same group plan as a parent up to age 31 does **not** apply to individual plans. If you have a child who is not eligible under your policy as a dependent, he or she may be eligible to purchase his or her own individual plan.

## **Frequently Asked Questions About Eligibility and Dependent Eligibility**

### ***Question 1: May I purchase an individual plan if I live in another state during part of the year?***

Yes, provided New Jersey is your primary residence and you are present in New Jersey for at least six months of the year. The policyholder is required to be a New Jersey resident. These residency requirements do not apply to dependents. Although, for coverage under an HMO, everyone intended to be covered must live in the HMO's service area. Also, as explained in the section on residency, the requirement to be present in New Jersey for at least six months of the year does not apply to a federally defined eligible individual

### ***Question 2: My parents are coming to visit me from abroad. They will be staying with me for about 4 months. May I buy a plan to cover them while they are in New Jersey?***

No, visitors do not generally satisfy the residency requirement and should investigate coverages available where they reside.

### ***Question 3: I just moved to New Jersey, may I purchase an individual plan?***

Yes, if you relocate to New Jersey with the intention of being present in New Jersey for at least 6 months of the year, and meet all other eligibility requirements, you may purchase individual coverage.

### ***Question 4: May I keep my New Jersey individual plan if I move out of state?***

No. However, your carrier may offer a plan with similar benefits in other states. You should check with your insurance company or HMO regarding a plan termination date before you move.

### ***Question 5: May I keep my New Jersey individual plan if I become eligible for Medicare?***

Yes. However, the individual plan will not act like a Medicare Supplement Plan and it will not replace Medicare coverage. The benefits for which you are eligible under Medicare will be coordinated with the benefits of the individual plan whether or not you actually enroll in Medicare. Medicare would pay benefits first, and then the individual plan would pay benefits as the secondary payor. In addition, the only individual plan you may be covered under once you become eligible for Medicare is the plan you are covered under at the time you become eligible for Medicare. You may not elect another individual plan or plan option or switch to another carrier.

***Question 6: I need family coverage, not just individual coverage. How do I get coverage for my family?***

It is called individual coverage because you are buying it on your own rather than getting the coverage through an employer group plan. If the members of your family qualify as dependents, they can also be covered under your individual plan.

***Question 7: My son will be graduating from college in May. He is covered under the group plan I have from my employer until he graduates. May I purchase a short-term policy to cover him until he finds a job that offers group health coverage?***

No. There are no "short-term" plans available in New Jersey. However, you may purchase an individual plan for him and decide to keep it only until he becomes covered under a group plan. Another option to cover him would be COBRA or New Jersey group continuation. You should check with your employer to find out whether the employer is subject to the requirements of COBRA or New Jersey group continuation. Under both of these continuation laws, your son could elect to continue coverage under your group plan for up to 36 months. Another option is coverage for certain dependents who are under 31 years old under P.L. 2005, c. 375. You can find lots of information about coverage under this law on the Department of Banking and Insurance website which is [www.state.nj.us/dobi/division\\_consumers/du31.html](http://www.state.nj.us/dobi/division_consumers/du31.html)

***Question 8: If I cover my children under my individual plan, up to what age will they be covered?***

A policyholder's children -- including those for whom you have legal custody or guardianship, as well as those with whom you have a blood or legal relationship, and who depend on you for most of their support and maintenance and live in your household -- are eligible for coverage under your plan until their 19th birthday. Children who are and remain full-time students may be covered until their 23rd birthday. Coverage will end earlier, if the child graduates or is otherwise no longer a full-time student. Dependents who are incapacitated may be covered indefinitely, provided documentation is supplied to the carrier as requested, and your plan remains in effect. Please note that the option to continue coverage for dependents to age 31 under P.L. 2005, c. 375 does not apply to individual coverage.

***Question 9: Can I purchase coverage for a child or children only?***

Yes. If you wish to purchase coverage for one child, you will be charged the single rate. If you wish to purchase coverage for more than one child, you will be charged the adult and child(ren) rate. Since all plans may be age-rated, resulting in more favorable rates for younger people, you may want to explore coverage options under age-rated plans as described later in this Guide and identified on the rate comparison chart.

***Question 10: My grandchildren live with me and I am responsible for their care and support, but I am not their legal guardian. I am covered under an individual plan. May I add them for coverage under my individual plan?***

Yes. A dependent child, for the purpose of an individual plan, includes a child related to you by blood, if the child depends on you for most of the child's support and maintenance and resides in your household.

***Question 11: If I waive coverage under Medicare, may I purchase an individual plan?***

No. Even if you waive or postpone coverage under Medicare, you are considered eligible for Medicare and thus not eligible for IHC coverage. If you are concerned that Medicare may not provide adequate coverage, you may purchase another type of health plan specifically designed to supplement Medicare coverage. You may obtain free information on plans that supplement Medicare by contacting the New Jersey Department of Health and Senior Services, NJ Division of Aging and Community Services at 1-800-792-8820 or visit their website at [www.state.nj.us/health/senior/ship.shtml](http://www.state.nj.us/health/senior/ship.shtml).

***Question 12: May I purchase an individual plan if I am eligible for coverage under COBRA or New Jersey State continuation?***

Yes. Although COBRA and New Jersey State continuation are a continuation of a group plan, eligibility for coverage under COBRA or New Jersey State continuation does not preclude the purchase of an individual plan. You may choose to continue your coverage under COBRA or New Jersey State continuation for some, all, or none of the permissible continuation period. Once you purchase an individual plan, you may not maintain health coverage under COBRA or New Jersey State continuation, and therefore, you will have to cancel your health coverage under COBRA or New Jersey State continuation. If you are eligible for COBRA you may elect to maintain your dental or vision coverage, if available, since dental and vision coverage is not available with individual plans.

***Question 13: May I purchase an individual plan if I am eligible for coverage as a dependent under age 31 under P.L. 2005, c. 375?***

Yes. Although over-age dependent coverage is coverage under a group plan, eligibility for such coverage does not preclude you from purchasing an individual plan. For some over-age dependents, a plan using rates that vary by age may be an option worth exploring. You can read about age-rated plans later in this Guide.

***Question 14: May I purchase an individual plan if I actually have group coverage?***

The law generally prohibits you from purchasing an individual plan if you are covered by or eligible for a group health plan. However, you may be eligible to purchase an individual plan during the Open Enrollment period in November of each year, subject to certain restrictions. You would be required to terminate your coverage under the group plan no later than December 31 since the individual coverage would take effect on January 1.

Please note that, even if you are eligible for an individual plan, you may not purchase an individual plan that provides the same or similar level of coverage as the group plan for which you are eligible.

An insurance producer or carrier representative can help you evaluate your particular circumstances and the options that may be available to you during the Open Enrollment Period which occurs each year during the month of November. The individual plan would not take effect until January 1 following the Open Enrollment Period.

***Exception:*** If you are covered under your parent's group plan as an over-age dependent you may elect to drop that over-age dependent coverage at any time and purchase your own individual plan.

## **Key Features of the Individual Health Coverage Program**

The Individual Health Coverage Program requires each carrier to:

- guarantee coverage and renewability for all eligible people regardless of health, subject to the pre-existing conditions provision, as applicable;
- establish modified community rates -- which are rates that apply to all people who purchase the same standard IHC plan and do not vary based on an individual person's gender, occupation, geographic location or health status, but may vary based on age. Carriers may use modified community rates for the Basic and Essential Plan (B&E Plan) where rates may vary based on age, gender and geographic location. Health status is not a permissible rating factor for any plan. Please note that while carriers *may* vary standard plan rates based on age, not all carriers were doing so as of the date such rating was first permitted. Refer to the rate comparison pages for information as to which carriers are using age as a factor for rating standard plans.
- offer at least three of the standardized individual plans (referred to as Plans A/50,B,C D and/or an HMO Plan) to make it easier for you to compare benefits and costs among the many participating carriers offering coverage. Plans A/50, B, C and D can be offered as indemnity or traditional plans, or as PPO or as POS plans. Carriers may file riders to increase the benefits under one or more of the standard plans.
- offer a Basic and Essential Plan (B&E Plan). The B&E plan is not a standard plan and provides only limited coverage. Carriers may file riders to enhance the limited coverage. As mentioned above, carriers may vary the rates for the B&E plan based on age, gender and geographic location. The rate comparison pages identify which factors each carrier uses for B&E rates.

### ***Guaranteed Coverage and Guaranteed Renewability***

Provided you satisfy the eligibility requirements described in the Eligibility Section, you cannot be denied coverage for any reason including your past or current health condition. However, the "pre-existing conditions" provision may limit coverage during the first 12 months. You are guaranteed that your policy will be renewed provided you remain a resident of New Jersey and your premium is paid in a timely fashion and you do not commit fraud.

### ***Pre-existing Conditions and Portability***

Except as stated below for federally defined eligible individuals, if you have been uninsured for more than 31 days prior to the enrollment date (which means the effective date of coverage under the individual plan), you are subject to a 12-month waiting period for coverage of "pre-existing conditions."

A "pre-existing condition" is an illness or injury which manifests itself in the six months before the enrollment date and for which:

- a person sees a doctor, takes prescribed drugs, receives other medical care or treatment or had medical treatment recommended by a doctor, or
- an ordinarily prudent, or careful, person would have sought medical advice, care or treatment.

A pregnancy which exists on the date coverage begins is a pre-existing condition and will be subject to the limitations described above. However, certain complications of pregnancy will not be excluded for coverage as pre-existing conditions.

During the 12-month "pre-existing condition" waiting period, you will be covered for all conditions other than the pre-existing condition, subject to the terms of your contract or policy. After the "pre-existing condition" waiting period has ended, all illnesses and injuries -- including those related to the "pre-existing condition" -- will be covered subject to the terms of your contract or policy.

"Creditable coverage" is the term used under the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to define the types of prior coverage a person may have had. It is a very broad definition and includes, but is not limited to: individual and group plans, whether insured or self-funded, Medicare, Medicaid, and CHAMPUS. The individual plans contain a complete definition of "creditable coverage".

The "pre-existing condition" waiting period is waived for treatment of conditions which were treated or diagnosed and were covered under "creditable coverage" that terminated no more than 31 days prior to the effective date of your new individual plan.

The "pre-existing condition" limitation period is credited for time satisfied under for any "creditable coverage" provided there is no more than a 31-day lapse between your prior and your new coverage.

You will be required to provide your new carrier with proof of the prior "creditable coverage," so that the waiver or credit may be applied. Your prior plan should provide you with a certificate of creditable coverage to be used for such proof. If you do not have more than a 31-day lapse in coverage, you may change health plans without having to satisfy any new "pre-existing condition" waiting period. If you have only partially satisfied the "pre-existing condition" waiting period under prior coverage, you will have to satisfy only the balance of a "pre-existing condition" waiting period under your new coverage.

**Exception:** If an eligible person is a "federally defined eligible individual" the "pre-existing condition" waiting period requirement will only apply if there has been more than a 63-day lapse in coverage between the date the prior "creditable coverage" ends and the enrollment date. (For a federally defined eligible individual, the enrollment date is the date the person submits a substantially complete application for coverage.)

A "federally defined eligible individual" is defined as "a person who has been covered for at least 18 months without a break in coverage of 63 or more days under a group health plan, governmental plan, church plan, or health insurance coverage offered in connection with any such plan; who is not eligible for coverage under Medicare or Medicaid; and who does not have another health benefits plan, or hospital or medical service plan." The prior creditable coverage must not have been terminated, based on a factor relating to nonpayment of premiums or fraud. In addition, if the person was offered the option of continuation of coverage under a COBRA continuation provision or similar State continuation option, the person must have elected and exhausted that continuation coverage.

## ***Rating***

***Modified Community Rating for Standard Plans:*** Carriers have the option to use modified community rating for the standard plans. The rates may vary based solely on age. Rates vary from carrier to carrier and from one individual plan to another. That is, one carrier's price for Plan D is not likely to be the same as another carrier's price for Plan D. And, because Plan D has a higher carrier coinsurance than Plan B, Plan D will generally be priced higher than Plan B. The list of carriers and their rates for various plans can assist those interested in purchasing individual health coverage with a comparison of rates.

**Modified Community Rating for B&E Plans:** Carriers have the option to use modified community rating for the B&E plan. For the B&E plan, the rates may vary based on age, gender and/or geographic location. Carriers may use one or more of those permissible rating factors. As with the standard individual plans, the rates for one carrier offering B&E may be very different from the rates for another carrier. In addition, while the B&E coverage basically covers the same services and supplies, the addition of a carrier-designed rider to enhance the benefits under the B&E plan can result in some significant differences between the B&E plan with rider offered by one carrier as compared to that of another. Those benefit differences result in further rate differences among carriers.

**Caps on Rate Increases:** As of January 5, 2009, and for the next four years, the law imposes a renewal rate cap. The renewal increase for consumers who bought a plan prior to January 5, 2009 is limited to a 15% increase. The renewal increase for consumers age 55 or older who buy a plan on January 5, 2009 or later is limited to a 15% increase. As mentioned, the cap applies only for 4 years and thus will expire in 2013.

## **Frequently Asked Questions About IHC Plan Features And Rates**

***Question 1: If I have a pre-existing condition and apply for coverage on February 12<sup>th</sup> requesting that the individual plan be effective March 1, and I enter the hospital on March 2 because of that condition, would I be covered for the hospitalization?***

It depends on whether you were covered under prior coverage. If you are **not** a “federally defined eligible individual,” as defined earlier in this Guide, but you were covered for the condition under prior coverage and that coverage ended no more than 31 days before your enrollment date (which is the effective date of the individual plan, March 1 in this example), your new coverage will cover the condition, subject to the terms of the new plan.

If you are a "federally defined eligible individual," and your prior group coverage ended no more than 63 days before your enrollment date (which is the date you submitted a substantially complete application for the individual plan, February 12<sup>th</sup> in this example), your new coverage will cover the condition, subject to the terms of the new plan.

If you had no prior coverage, or if any prior individual coverage ended more than 31 days prior to the enrollment date (March 1, in this example) or your group coverage ended more than 63 days before the enrollment date (February 12<sup>th</sup> in this example) if you are a federally defined eligible individual, the new coverage will not cover a pre-existing condition until the end of the required 12-month "pre-existing condition" waiting period.

***Question 2: If I purchase an individual plan with an effective date of March 1 and I am injured on March 3, would I be covered for treatment of the injury?***

Yes. Conditions which first manifest themselves after your new coverage begins (i.e., March 1, in this example) are covered, subject to the terms of the new plan.

***Question 3: Do I have to satisfy another waiting period for a "pre-existing condition" if I change from one individual plan to another or from one carrier to another?***

If there is no more than a 31-day lapse in coverage between the date your prior plan ends and the date your new plan begins, there will be no new "pre-existing condition" waiting period, provided your previous plan also covered you for the condition or you had coverage under the previous plan for at least 12 months, and, therefore, satisfied the 12-month "pre-existing condition" waiting period. However, if you did not entirely satisfy the 12-month "pre-existing condition" waiting period under the prior plan, you will be required to satisfy the balance of the waiting period under the new plan. You will have to provide proof of prior coverage to the new plan.

For example, if you bought a plan from one carrier on March 1 and were required to satisfy a 12-month "pre-existing condition" waiting period, and canceled that coverage on October 1 to buy coverage with another carrier, you would have already satisfied 7 months of the 12-month waiting period. The new carrier would then apply those 7 months to the "pre-existing condition" waiting period, so you would have to satisfy just the remainder of 5 months of the waiting period while covered with the new carrier.

***Question 4: I have Plan C and my premium is due on May 1. How long do I have to pay that premium? If I do not pay the premium, when will my coverage end?***

There is a 31-day grace period, so you have until May 31 to pay the premium. Coverage stays in force during the grace period. If you do not pay the premium by the end of the grace period, coverage ends as of the end of the grace period. If you incur charges during the grace period and submit a claim to your carrier, your benefit will be reduced by the amount of unpaid premium. For the purpose of the portability provision of the plans, however, the permissible 31-day lapse period is measured from the last date coverage is in force on a premium-paying basis, not the end of the grace period. In this example, premiums are paid through April 30, so May 1 would be the beginning of the lapse period.

***Question 5: Why do rates for identical standard plans vary from carrier to carrier?***

Each carrier evaluates the benefits required to be provided under each of the standard individual plans and determines how much the carrier expects it will cost to provide those benefits to their customers. Carriers must also price plans to comply with a provision of the law which requires them to pay out at least 80 cents in benefits, services or supplies to their covered individuals for every dollar collected in premiums.

***Question 6: If I do not submit any claims to my carrier, will my rates remain the same?***

No, not necessarily. The rates for any given individual plan are not adjusted only based on your or your family's utilization of health benefits or lack of utilization. Rather, each carrier reviews its utilization by all persons covered by the same type of individual plan. Any adjustment will apply to everyone covered under the specific plan, not just persons who may have submitted claims.

***Question 7: Are rates locked-in for any length of time?***

Carriers are not required to "lock-in" or guarantee their rates for any specific amount of time, however, many carriers elect to do so. The rate comparison sheets show the duration of the rate guarantees for each

carrier. For more specific information on rates -- or any available rate guarantee -- contact the carriers directly.

***Question 8: I am thinking about buying a plan now. I am 56 years old. What does the 15% cap mean for me?***

As a new purchaser, the rate you'll be charged for your new plan will be the rate applicable to a 56 year old purchaser. The 15% rate cap will first affect you next year when your new plan renews. The renewal rate increase will be limited to 15% as compared to the rate you'll pay as a new purchaser this year.

## **Delivery Systems**

Individual plans may be purchased from a variety of carriers as either an indemnity plan (commonly known as a "traditional" or "fee-for-service" plan) or as a managed care plan (HMO, PPO or POS). The B&E Plan may also be offered as an Exclusive Provider Organization (EPO) plan. These options are outlined in more detail below.

### ***Indemnity Plans***

Generally, indemnity plans allow you to choose any physician or hospital and require you to file a claim after treatment and expenses are incurred. Thus, your choice of a licensed health care provider is made by you. The indemnity plans do, however, incorporate some elements of cost-containment, such as requiring pre-authorization of non-emergency hospitalizations and prior review and approval for certain services (for example, non-emergency surgery and certain tests and procedures).

The policy issued by your carrier carefully outlines the procedures you must follow. If you have questions about those procedures, you should contact your carrier or producer for further assistance.

Indemnity plans typically require you to satisfy a deductible before the carrier will pay benefits based on the covered charge. You are responsible for your coinsurance share. The standard individual plans have various deductibles and coinsurance options to choose from. Some carriers offer the B&E plan as an indemnity plan. Those carriers are identified on the rate comparison sheet.

"Covered charges" are charges for services and supplies which are covered by the policy or contract and which are less than or equal to the allowed charge for the service or supply.

For example, assume you have chosen Plan C with a \$1,000 deductible. You receive a bill for \$4,000 and the entire amount is considered a "covered charge." You will be responsible for the first \$1,000, as your deductible. Of the remaining \$3,000, your carrier pays 70 percent -- or \$2,100. You would be responsible for the 30 percent balance -- or \$900. Subsequent covered charges during that same year would be paid at 70 percent by the carrier, with you responsible for paying 30 percent. Once the sum of your deductible plus your 30 percent coinsurance share reaches the Maximum Out of Pocket (MOOP) of \$3,500, the carrier pays for most further "covered charges" at 100 percent for the rest of the calendar year. Covered charges for prescription drugs are handled differently than covered charges for other services and supplies. Covered charges for prescription drugs will continue to be covered at the plan coinsurance (70% in this example) even after the MOOP has been satisfied, and will not be paid at 100%.

In the example above, the carrier considered the entire amount of the bill as a "covered charge." Sometimes the amount the provider bills exceeds the "allowed charge" for the service. When this

happens, the carrier only pays benefits based on the "reasonable and customary charge." The covered person is responsible for the balance.

Health care services and treatments are covered as stated in the individual policy. There also may be limitations on the amount that is reimbursed for a provided service.

#### *High Deductible Health Plans for use with a Health Savings Account (HSA)*

Carriers may, but are not required to, offer the standard plans as high deductible health plans that could be used with an HSA. The deductible and maximum out of pocket provisions would operate differently than under a standard indemnity plan, as required by the Internal Revenue Code. Carriers, if any, that are making high deductible health plans available are identified on the rate comparison sheet. Please note that a standard plan bought with a \$2,500 deductible does not satisfy the requirements for a high deductible health plan.

#### ***Managed Care Plans***

Carriers that offer managed care plans typically provide comprehensive benefits by contracting with a network of physicians, hospitals and other health care professionals. There are several types of managed care plans, as described below.

#### ***HMO Plans***

Health Maintenance Organization (HMO) plans are network-based forms of managed care. An HMO consists of a network of physicians, hospitals and other health care professionals which provides members with medical treatment and care. You choose a Primary Care Provider or Primary Care Physician (PCP) from those participating in the HMO network. That PCP coordinates your health care, referring you to specialists in the network, when necessary. Services not provided by or referred by a PCP are not covered, except for emergency medical care. HMO plans that do not require referrals may be offered. These no referral plans are often marketed as "direct access" or "open access" plans.

You are responsible for a copayment for specified services, for example, a \$30 copayment for a physician visit or a \$300 per day copayment for hospitalization. There are generally no calendar year deductibles. There is generally no coinsurance requirement except that carriers provide prescription drug benefits subject to 50 percent coinsurance.

HMO plans may feature a "split copayment" for physician services, where the copayment for use of a specialist may be higher than the copayment for a PCP visit.

In addition to offering an HMO plan using a copayment for specified services, an HMO carrier may offer a plan that applies deductible and coinsurance provisions to certain services. The rate comparison sheet indicates which carriers offer deductible and coinsurance options with HMO plans.

Some carriers are offering the B&E plan as an HMO. Those carriers are identified on the rate comparison sheet.

Please note: An HMO is not required to offer coverage to persons who do not reside in its approved service area. If a person covered under an HMO is outside the service area on vacation or attending school, or otherwise temporarily out of the service area, the only coverage available to the person while outside the service area is for emergency or urgent care.

## ***PPO Plans***

Preferred Provider Organization (PPO) plans are network-based forms of managed care which allow you to seek medical care and treatment either from within a network of physicians, hospitals and other health care professionals or from physicians, hospitals and other health care professionals that are outside of the PPO network. If you seek medical care and treatment from network providers, you generally will be eligible for a richer level of benefits or less cost sharing. If you seek care and treatment from providers that are outside of the network, you will be eligible for a lower level of benefits or more cost sharing. In other words, you will probably have to pay more of the cost of services received outside of the network than you would if you obtained services within the network.

The network benefits under the plan may be subject to copayments, just as is the case with HMO coverage and/or there may be deductible and coinsurance requirements. Non-network benefits will always be subject to a deductible and coinsurance.

Carriers are not required to sell PPO plans. Carriers that do offer PPO plans are identified on the rate comparison sheets. Contact the carriers directly for information concerning their PPO plan designs.

Currently, only Oxford Health Insurance is offering PPO plans. You can visit the following website for details regarding the PPO plans that are offered.

[www.oxhp.com/secure/brokers/nj/individual\\_pre\\_pin.html](http://www.oxhp.com/secure/brokers/nj/individual_pre_pin.html)

## ***POS Plans***

Point-of-Service (POS) plans are network-based forms of managed care which allow you to seek medical care and treatment either from within a network of physicians, hospitals and other health care professionals or from physicians, hospitals and other health care professionals that are outside of the PPO network. If you seek medical care and treatment from network providers other than your designated primary care physician (PCP) you will need to get a referral from your PCP. When you use network services you generally will be eligible for a richer level of benefits or less cost sharing than if you seek care outside the network. If you seek care and treatment from providers that are outside of the network, you will be eligible for a lower level of benefits or more cost sharing. In other words, you will probably have to pay more of the cost of services received outside of the network than you would if you obtained services within the network.

Sometimes a POS plan may be available that does not require referrals to visit a network provider other than your PCP. These plans are often marketed as “open access” or “direct access” plans.

The network benefits under the plan may be subject to copayments, just as is the case with HMO coverage and/or there may be deductible and coinsurance requirements. Non-network benefits will always be subject to a deductible and coinsurance.

Carriers are not required to sell POS plans. Carriers that do offer POS plans are identified on the rate comparison sheets. Contact the carriers directly for information concerning their POS plan designs.

Currently, only Horizon is offering POS plans. You can visit the following website for details regarding the PPO plans that are offered.

<http://www.horizon-bcbsnj.com/members/presale/coverage/health/individuals.html>

## ***EPO Plans***

Exclusive Provider Organization (EPO) Plans are available only in connection with the B&E product. EPO plans are similar to HMO plans in that there is a network of physicians, hospitals and other health care professionals which provides members with medical treatment and care. While a member is encouraged to select a PCP, it is not required. Members can seek treatment directly from any physician in the network.

The B&E plans sold as EPO plans include copayment, deductible for wellness benefits only, and coinsurance provisions.

If a person covered under an EPO plan is outside the service area on vacation or attending school, or otherwise temporarily out of the service area, the only coverage available to the person while outside the service area is for emergency care.

Currently, Aetna, Horizon and Oxford offer the B&E plan as an EPO.

## **Frequently Asked Questions About Delivery Systems**

### ***Question 1: What plan should I choose if I want to keep my present doctors?***

Check with your doctors to find out if they participate in any HMO, PPO, POS or EPO plans listed as available through the New Jersey Individual Health Coverage Program. If they do not participate and you are unwilling to select new doctors, you may want to avoid HMO or EPO plans since those plans do not provide non-network coverage. If you select a PPO or POS plan, you would be able to access care as non-network care. With an indemnity plan, you may use any doctor you choose.

### ***Question 2: How can I compare costs between an indemnity plan and a managed care plan or even one managed care plan to another?***

You should compare not only the premium cost of the plans, but also your potential out-of-pocket costs for various services. Consider your medical care utilization over the course of an average year. How many doctor visits do you generally have? Be sure to include visits to specialists. What would those visits cost under the terms of various plans you are considering?

### ***Question 3: What are Allowed Charges?***

Allowed charges are the allowances carriers use for various services under an indemnity plan and non-network services under a PPO or POS plan. For example, a provider may bill you \$500 for a service. The carrier will determine what the allowed charge is for that service. If the allowed charge for the service is \$460, the carrier will calculate benefits based on the \$460 charge. The provider may require you to pay the \$40 difference. Carriers are required to use standards established in accordance with the IHC Program rules to determine the amount of an allowed charge. While the IHC Program requires carriers to determine allowed charges according to specific rules, the IHC Program cannot give you information on what the allowed charge will be for a service you plan to use.

***Question 4: What if I want to change from one individual plan to another? Can I do it whenever I like?***

It depends on the plan you have and the plan with which you want to replace it. You must wait for the November Open Enrollment period to make certain plan changes. For example, if you have an HMO plan, you can only switch to an HMO plan with a lower copayment or to a non-HMO plan during the November Open Enrollment period. However, if you bought an individual HMO for the first time, and realize the plan is not for you during the first 90 days, you may replace the HMO with a non-HMO at any time during the first 90 days. If you have a B&E plan, either with or without a rider, you may only replace it with a standard individual plan or with a B&E plan with a different rider during the November Open Enrollment period. You can only switch to a plan that has a higher monthly premium during the November Open Enrollment period.

Except as stated above, you can switch to a plan with a lower premium at any time or you can switch to a plan with the same or greater deductible, same or greater coinsurance or same or greater copayments, at any time, provided the new plan has no lower deductible, coinsurance or copayment.

If you are covered under a B&E plan with a rider, you can switch to a B&E plan without a rider at any time.

***Question 5: Am I covered under my HMO plan if I need to use a doctor or hospital outside of New Jersey?***

Coverage for services provided outside the service area of the HMO is generally limited to medical emergencies and urgent care. Sometimes HMO carriers allow members to use doctors or hospitals located in another state if the doctor or hospital belongs to that HMO's network in that other state. Contact your HMO for details.

***Question 6: If I am covered under Plan C issued as an indemnity plan and admitted to the hospital on an emergency basis and am not able to call to notify the carrier, can the carrier still apply a penalty for not requesting authorization?***

It depends, the standard plans issued as indemnity coverage require that you request authorization for an emergency admission within 48 hours after admission, or the next business day, whichever is later, or as soon as reasonably possible. If you are not able to call, a hospital representative, your doctor or a family member may call on your behalf. If authorization is not requested, as required, and it was reasonably possible for you to have provided notice, your benefits will be reduced by 50%.

***Question 7: If I use the services of an emergency room or facility, but am not admitted, must I call the carrier to request authorization?***

Yes, the standard plans issued as indemnity coverage require that you request authorization for emergency treatment within 48 hours after treatment, or the next business day, whichever is later, or as soon as reasonably possible. If authorization is not requested, as required, your benefits will be reduced by 50%.

## ***Benefits***

All standard plans (A/50, B, C, D whether issued as indemnity, PPO, or POS and the HMO plan) provide comprehensive medical coverage which includes the following:

- 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
- biologically based mental illness services
- certain non-biologically based mental illness and substance abuse services
- prescription drugs

### ***Indemnity PPO and POS Plans***

Plans A/50, B, C, and D whether issued as indemnity or as PPO or POS also cover the cost of routine physicals and other preventive care -- up to \$500 per year per covered person and up to \$750 during the first year of a newborn's life. The deductible and coinsurance do not apply to preventive care services. However, to the extent a PPO or POS plan applies a copayment to network physician services, the copayment is required to be paid for network preventive care services. There is no dollar limit associated with the amount of preventive services a covered person seeks from his or her network physician.

Plans A/50, B, C, and D and any PPO or POS developed using these plans provide benefits for similar services, but they have varying coinsurance requirements and maximum out of pocket amounts. The coinsurance paid by the covered person under each plan is as follows:

- Plan A/50      50%
- Plan B            40%
- Plan C            30%
- Plan D            20%

When offered as PPO or POS the coinsurance applies to the network and/or non-network benefits. So, a Plan C PPO could be a plan that requires the covered person to pay 30% for network services, or it could be a plan that requires the covered person to pay 30% for non-network services.

Carriers that are offering Plans A/50, B, C and/or D must offer a \$2,500 deductible. Carriers may offer \$1,000, \$5,000 and/or \$10,000 deductible levels. Please refer to the rate comparison sheet for information on which plans the carriers are offering and the deductible levels available with each.

The maximum out of pocket for each plan offered as an indemnity plan is the **sum** of the selected deductible **plus** the following amount, according to plan:

- Plan A/50            \$5,000
- Plan B                \$3,000
- Plan C                \$2,500
- Plan D                \$2,000

For example, if you buy a Plan C with a \$1,000 deductible, after meeting the \$1,000 deductible, the carrier will pay 70% and you will pay 30% of covered charges. The maximum out of pocket will be

\$1,000 which is your deductible **plus** another \$2,500 due to your 30% coinsurance requirement, for a total of \$3,500. Please note that while most covered charges are paid at 100% after the maximum out of pocket has been reached, prescription drug charges continue to be paid at the plan coinsurance even after the maximum out of pocket has been reached. Therefore, in this example you would continue to be responsible for 30% of your prescription drug bills.

For plans offered as PPO or POS plans the maximum out-of-pocket for network services cannot exceed \$5,000 and the maximum out of pocket for non-network services cannot exceed three times the maximum for network services. The plans may have a combined maximum out of pocket for both network and non-network services or may have separate out of pockets for network and non-network services. Please consult the carrier's benefit descriptions for information on how the maximum out of pocket provisions operate.

Note: Under Plan B, in addition to the selected calendar year deductible, a \$200 per day hospital confinement deductible applies for each of the first five days of hospitalization, to a maximum of \$2,000 per person in each year.

Further explanation and details of the standard individual plans, coinsurance amounts, deductibles and copayments are outlined at the end of this Buyer's Guide.

### ***HMO Plans***

HMO Plans cover many of the same services as Plans A/50 through D. Unlike Plans A/50 through D, however, there are generally no deductibles with an HMO Plan. You pay a copayment rather than coinsurance when services are rendered, but you must use the pre-approved network of physicians. All HMO plans must offer the \$30 copayment option, and each HMO determines which other copayment amounts, \$15, \$40 and/or \$50 to offer. The rate comparison sheet specifies the options each carrier has selected. Other copayments apply to inpatient hospitalizations, emergency room visits and maternity care, and carriers may apply a higher copayment for use of specialist services. Rates vary based on the copayment selected. Prescription drugs are covered subject to 50% coinsurance.

In addition to offering an HMO with a copayment feature, an HMO may offer HMO coverage that applies deductible and coinsurance to many services and supplies. The deductible and coinsurance are applied to the negotiated charge between the HMO and your provider, so you will not receive any balance billing above your deductible and coinsurance payments. Carriers offering HMO subject to deductible and coinsurance are identified on the rate comparison sheet.

As discussed above, the HMO plan may be offered such that no referrals are required. Such a design is often referred to as "direct access" or "open access."

### ***PPO and POS Plans***

PPO and POS plans are consistent with the standard indemnity plans described above except that carriers may structure the PPO and POS plans using a variety of deductible, copayment and coinsurance features. Some of these features depend on whether or not you obtain medical care and treatment from network physicians, hospitals and other health care professionals inside of the network. As mentioned earlier in this Buyer's Guide, if you obtain medical care and treatment from network providers, you generally will be eligible for a richer level of benefits or lower cost sharing. If you seek care and treatment from

providers that are outside of the network, you will be eligible for a lower level of benefits or higher cost sharing.

The network benefits under the plan may be subject to copayments, just as is the case with HMO coverage, or may be subject to deductible and coinsurance as with an indemnity plan. Non-network benefits will always be subject to a deductible and coinsurance.

Carriers are not required to sell PPO or POS plans. Carriers that do offer PPO or POS plans are identified on the rate comparison sheets. Contact the carriers directly for information concerning their PPO or POS plan designs.

As noted earlier in this Buyer's Guide, the POS plan may be purchased as a direct access or open access plan, meaning referrals are not required.

### ***Basic and Essential Health Care Plan (NOT a standard plan)***

In addition to offering the standard plans described above, carriers must offer a Basic and Essential Health Care Plan (B&E Plan) which is a limited benefit plan. B&E Plans do not provide comprehensive benefits like the standard plans described above. The B&E plan covers only 90 days per year for hospitalization, \$600 per year for wellness services, \$700 per year for office visits for illness or injury, \$500 per year for out of hospital testing, and limited benefits for mental health services, alcohol and substance abuse treatment and physical therapy. Some carriers offer B&E plans as indemnity policies allowing you to select which providers to go to, while other carriers offer the B&E as HMO or EPO meaning you need to select doctors and hospitals within the carrier's network. Carriers are permitted to offer enhanced benefits to the B&E plan, and several carriers have offer riders with enhanced benefits.

The rate comparison sheet provides information on the type of B&E plan each carrier offers and also indicates which carriers offer the B&E plan with riders. Please note that since the rates may vary based on age, gender and geographic location, we cannot provide comprehensive rate information. The rate comparison sheets include information for sample ages and locations. Contact the carriers for detailed rate information.

Links to the carrier website for those carriers offering the B&E plan with an optional benefit rider are provided below.

AmeriHealth: [www.amerhealth.com/searchPlanResults.html](http://www.amerhealth.com/searchPlanResults.html)

Horizon: <http://www.horizon-bcbsnj.com/members/presale/coverage/health/individuals.html>

Oxford: [www.oxhp.com/secure/brokers/nj/individual\\_pre\\_pin.html](http://www.oxhp.com/secure/brokers/nj/individual_pre_pin.html)

## **Frequently Asked Questions About Benefits**

### ***Question 1: Does the list of covered services ever change?***

The New Jersey Individual Health Coverage (IHC) Program Board reviews the standard individual plans regularly to ensure that the plans meet the changing requirements of state law and the needs of New Jersey residents. Your carrier will notify you of any changes that may affect your plan.

***Question 2: What if I receive my contract and I am not satisfied with the level of benefits provided?***

You have a 30-day period during which you may examine the policy or contract and the benefits included. If you are dissatisfied, you may return your policy or contract for a full premium refund, less any claims paid or services provided.

***Question 3: Is there anything I must do if I want to switch from group coverage to individual coverage or from one individual plan to another?***

You cannot be covered by more than one health plan at a time if one of the plans is an individual plan. If you are switching from group coverage to individual coverage, or if you are changing from one individual plan to another, you must notify the existing carrier within 30 days of the date your new plan takes effect to request that your existing coverage be canceled. To avoid being subject to a new pre-existing conditions exclusion, you should make sure there is no more than a 31-day gap between the date the existing coverage ends and the date the new coverage begins. As an exception to this rule, a "federally defined eligible individual" may have a lapse in coverage of up to 63 days.

However, there are some restrictions regarding switching from one individual plan to another, as discussed above. For some plan changes, you will be required to wait until the November Open Enrollment Period.

***Question 4: If I switch individual plans or change to a new carrier, and there is no lapse in coverage, will I have to satisfy a new deductible?***

No. The standard individual plans include a deductible credit provision which applies to charges incurred during the same calendar year. However, you must switch with no lapse in coverage from one plan to another -- or from one carrier to another -- to qualify for the credit. That is, you must have continuous coverage. If there is a lapse in coverage of a period as brief as one day, there will not be any deductible credit. You must provide proof to the new carrier that you incurred charges toward the deductible under the prior plan.

***Question 5: I am confused with maximum out of pocket. What is it?***

Maximum out of pocket refers to the limit on how much you will have to pay for deductible, coinsurance and copayment during any calendar year. You may hear it referred to as the "MOOP." After the maximum out of pocket has been reached, all covered charges, except those for prescription drugs, during the rest of that calendar year will be paid at 100%. Coinsurance for prescription drugs does not count toward the maximum out of pocket and must continue to be paid even after the maximum out of pocket has been reached.

To calculate the maximum out of pocket for an indemnity plan, you ADD the selected deductible to the specific amount shown in the indemnity plan section of this Buyer's Guide. Let's say you select a Plan C with a \$1,000 deductible. You will add the \$1,000 deductible to the amount shown for Plan C which is \$2,500. The maximum out of pocket is \$1,000 + \$2,500 which is \$3,500. The maximum out of pocket for network plans cannot exceed \$5,000 with the maximum out of pocket for non-network services limited to 3X the network level.

***Question 6: I have satisfied my deductible and reached the maximum out of pocket under my plan, but I want to switch coverage to another carrier or switch to another plan with the same carrier. Will I receive credit under my new plan for both the deductible and coinsurance I already met?***

As explained above, you will be entitled to deductible credit, provided there is no lapse in coverage between the date the first plan ends and the new plan begins. But while there is deductible credit, please note that there is no coinsurance credit. So, if you have already applied coinsurance charges toward satisfying the maximum out of pocket, or entirely satisfied the maximum out of pocket, you should carefully consider whether it makes sense to switch immediately, or wait until January 1 when a new deductible and coinsurance begins anew.

***Question 7: What are my rights if, for example, my carrier does not pay a benefit for something I think is covered?***

Ask your carrier about its grievance and appeal process. Provide all information you, your doctor or other provider have to support your position. Sometimes carriers deny benefits initially because you or your doctor did not submit all the necessary information. Additionally, you may contact the Department of Banking and Insurance. For concerns about quality of care, choice of providers or access to network providers, or medical necessity denials, call 609-777-9470. For concerns with claims denials, or enrollment or termination matters, call 609-291-7272

***Question 8: What does Pre-Approval mean?***

Many services and supplies require carrier pre-approval. Pre-approval gives the carrier the opportunity to evaluate the medical need before you incur charges and to advise you, up front, what will be covered. If you do not secure pre-approval, as required, the carrier has no obligation to provide benefits. Examples of services for which pre-approval is required include: home health care, hospice care, durable medical equipment, the exchange of unused inpatient days for additional outpatient visits for treatment of non-biologically based mental illness. Carriers may require pre-approval for certain prescription drugs and for certain therapies.

***Question 9: Are there any differences between the plans offered by the carriers?***

There are some options available to carriers when they offer the standard plans. For one thing, carriers are not required to offer all of the standard plans. Carriers are only required to offer at least three of the standard plans. So, the plans offered by one carrier may not be the same as the plans offered by another carrier. Plans A/50 – D, as offered, must feature a \$2,500 deductible. Carriers may choose to make \$1,000, \$5,000 or \$10,000 deductibles available. HMO carriers must make the \$30 copay plan available, but may make other copays available and may offer the HMO with deductible and coinsurance. Additionally, an HMO has the option to apply a higher copay to specialist services as compared to the copay required for visits to a PCP. As discussed above, there are some options regarding the list of services for which pre-approval is required.

For managed care plans, a significant difference among carriers is the network of physicians. When considering a plan you may find it helpful to contact your doctor's office to find out what plans the doctor belongs to. For HMO and EPO plans, you will generally be limited to seeking care from providers in the network, so if your doctor does not belong to the plan you will have to select another doctor.

***Question 10: Do I have to wait to change carriers if I still have a claim outstanding?***

No. Your previous carrier will still process claims incurred while your plan was in effect and reimburse you, as appropriate.

***Question 11: I'm due to deliver my baby next month. How long can I stay in the hospital?***

Congratulations! By law in New Jersey, carriers must cover a minimum of 48 hours following a routine delivery and 96 hours following a cesarean section. Your doctor may determine that a longer stay is medically necessary, which would entitle you to additional time in the hospital.

***Question 12: Which plan should I buy to get coverage for infertility?***

None of the individual plans will cover treatment for infertility.

***Question 13: Why are there so many differences between the plans each company is selling? Aren't all of the companies required to sell the same things?***

Carriers are no longer required to offer all of the standard plans and all of the deductible options associated with the standard plans. All carriers other than HMO only carriers must offer Plan A/50. Such Plan A/50 may be offered as indemnity, PPO or POS. So, while the plan will be a Plan A/50, how it is delivered can be different. In addition to Plan A/50, at least two additional plans must be offered. Those offerings may be indemnity, PPO or POS. And, if a company has an affiliated HMO, one of the three required offerings may be an HMO plan.

## ***Some Alternatives to Individual Health Coverage***

Although you may be eligible to purchase an individual policy, you may want to consider alternatives that may be available to you.

### ***COBRA or State Continuation***

If you lost coverage under an employer group plan as an employee due to termination of employment or a reduction in hours, you may elect to continue your group coverage for up to 18 months. You will be required to pay the full premium, and may be required to pay a 2% administrative fee. Coverage will be the same as you had while covered as an active employee, and any dependents who were covered under your plan may also be covered under your continued coverage. The rate charged for COBRA and State continuation coverage is the group rate, which is often lower than an individual rate.

If you were covered under a group plan as a dependent and lost that coverage due to death of the employee, divorce, or you ceased to meet the dependent eligibility standards under the plan, you may elect to continue your coverage for up to 36 months. You will be required to pay the full premium for single coverage, and may be required to pay a 2% administrative fee. Your coverage will be the same as you had while covered as a dependent. The rate charged for COBRA and State continuation coverage is the group rate, which is often lower than an individual rate.

Information regarding New Jersey Continuation is provided in SEH Bulletin 07-SEH-02 and is available at [www.state.nj.us/dobi/division\\_uinsurance/ihcseh/sehbulletins.htm](http://www.state.nj.us/dobi/division_uinsurance/ihcseh/sehbulletins.htm)

### ***Continuation of Coverage for Dependents Under 31***

New Jersey law (P.L. 2005, c. 375) permits certain children of persons covered under group health benefits plans the opportunity to maintain dependent coverage after reaching the limiting age specified in the group plan. The law applies to a covered employee's dependents who lost coverage under a group health benefits plan issued in New Jersey due to age who: are under 30 years old; are not married; have no children; are either residents of New Jersey or are full-time students; and are not actually covered under any other health benefits plan.

Information about coverage under this law on the Department of Banking and Insurance website which is [www.state.nj.us/dobi/division\\_consumers/du31.html](http://www.state.nj.us/dobi/division_consumers/du31.html)

### ***NJ FamilyCare***

NJ FamilyCare is a federal and state funded health insurance program created to help New Jersey's uninsured children and certain low-income parents and guardians to have affordable health coverage. It is not a welfare program. NJ FamilyCare is for families who do not have available or affordable employer insurance, and cannot afford to pay the high cost of private health insurance.

Information about NJ FamilyCare is available by calling 1-800-701-0710 or by visiting the website which is [www.njfamilycare.org/](http://www.njfamilycare.org/)

### ***NJ FamilyCare Advantage***

Eligibility for this program requires that the family:

- Have been uninsured for at least 6 months;
- Have a child or children under age 19; and
- Meet household income and family size guidelines.

Information about NJ FamilyCare Advantage is available by calling 1-800-637-2997 or by visiting the website which is: [www.horizonnjhealth.com/members/advantage.html](http://www.horizonnjhealth.com/members/advantage.html)

### ***Federally Qualified Health Centers***

Although not health insurance, Health Centers are a way for people without health coverage to access quality medical care. Located in various parts of the state, Health Centers are staffed with medical providers to enable them to provide a full range of medical care. The Health Centers will charge patients for the care provided using a sliding fee scale based on the patient's income.

As an attachment to the rate comparison sheet we include a list of the Health Centers with their phone numbers.

## ***Individual Plans Summary***

These summaries highlight benefits and features of standard individual plans and the B&E Plan without any riders providing enhanced benefits. The Summary is not an insurance contract, an exhaustive list of provisions, or a proposal of benefits. A complete benefit description of the standard individual plans is contained in the policy forms which were adopted by the Individual Health Coverage Board. The standard plans are available on the website, [http://www.state.nj.us/dobi/division\\_insurance/ihcseh/ihcforms.html](http://www.state.nj.us/dobi/division_insurance/ihcseh/ihcforms.html).