

**The New Jersey
Individual Health Coverage Program**

BUYER'S GUIDE

How to Select a Health Plan

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Individual Plans Summary

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 can be purchased for a Single person, Two Adults, a Family or an Adult and Child(ren). You will also want to review a [list of participating carriers, their current rates and their telephone numbers](#). Note that the rate comparison sheets only provide rates for new purchases for the current month.

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.

This Buyer's Guide is being updated to provide information about the Individual Health Coverage Program and individual plans offered as of September 23, 2010.

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

* 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:

1. Review this Buyer's Guide to learn more about individual health coverage in New Jersey, the plans available, and the benefits they provide.
2. Review the [list of participating carriers](#) and the [rate comparison sheets](#). Then contact the carriers to get more information, or contact a licensed insurance producer (also called an agent or broker), who can help you make an informed decision, at no additional cost to you. (Some carriers do not use insurance producers.)
3. Review the carrier's materials and select the carrier and individual plan that best meets your needs.
4. Complete the carrier's application form. All carriers use a standard application form (sometimes called the HINT form) so the application from one carrier should look very much like the application from another carrier.

5. 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.

Note that coverage applied for during November as part of an Open Enrollment Period does not take effect until the following January 1, so 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 ID card and a policy or contract that indicates the effective date of your coverage. Your effective date of coverage usually depends on the date your completed application materials and premium payment are received. Be sure to check the enrollment materials for your effective date of coverage. 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](#) for information regarding eligibility for group coverage after you already have an individual plan.

Eligibility

You are eligible to purchase an individual plan if you are:

1. A resident of New Jersey;
2. Not eligible for coverage under a group health plan, governmental plan or church plan; and
3. 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”, the person does not need to be present in New Jersey for at least six months. A "**federally defined eligible individual**" is 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.

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) must reside in the United States, but do not have to reside in New Jersey. (Note: 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), in addition to meeting the New Jersey residency requirement, all covered persons must ALSO reside in that HMO's service area.

2. Group Coverage:

You are eligible for group coverage (whether or not you are actually covered under the group health plan) when:

- ✓ your employer or union offers a group health plan and you meet all of the conditions to become covered, OR
- ✓ your spouse's employer or union offers a group health plan and you meet all of the conditions to become covered as a dependent, OR
- ✓ your parent's employer or union offers a group health plan and you meet all of the conditions to become covered as a dependent.

If you are eligible for group coverage you usually are ineligible to buy an individual plan. But note:

- ✓ There is an Open Enrollment Period every November during which people eligible for group coverage have an option to buy an individual plan. There are special rules for buying during the Open Enrollment Period; check with an insurance producer or the carrier for help.
- ✓ If you become eligible for group coverage AFTER you already have an individual plan, you can keep your individual coverage, even if you enroll in the group health plan. If you are covered by an individual and group plan, the individual plan will "coordinate benefits," meaning that the group plan will pay first, and the individual plan will be the secondary payor. You must pay the full premium for the individual plan even if it coordinates benefits and is a secondary payor.

You are NOT considered eligible for group coverage when:

- ✓ you no longer meet the group requirements for coverage, but may continue coverage under the group health plan through a COBRA or New Jersey Small Group Continuation election
- ✓ you no longer meet the group requirements for coverage, but may continue coverage under the group health plan through a Dependent Under 31 election

Under these conditions, you may purchase an individual plan without waiting for the Open Enrollment Period. You will, however, have to terminate any coverage under the group health plan.

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, so 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.

If you have an individual plan when you *become eligible* for Medicare, you may choose to keep your individual plan. But note:

- ✓ The individual plan will "coordinate benefits" as if it were a secondary payor whether or not you enroll in Medicare. In other words, the individual plan always pays as if Medicare were paying first.
- ✓ You will have to pay the full premium for the individual plan even though it is always the secondary payor.

For these reasons, the individual plan is not a substitute for Medicare, and it is not a Medicare Supplement Plan. People covered under an individual plan who become eligible for Medicare should consider all of their options. For help, you can:

- contact your County Office on Aging
- contact New Jersey's Division of Aging and Community Services at 1-800-792-8820 or go to www.state.nj.us/health/senior/ship.shtml.)
- go to www.Medicare.gov or www.healthcare.gov

If you are age 65 or older and state that you *are not* eligible for Medicare, you will be asked for proof that you are not eligible.

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 www.state.nj.us/dobi/division_insurance/ihcseh/sehmain.htm

Dependent Eligibility

Who is a Dependent Eligible to be Covered under an Individual Plan?

Individual health coverage may also cover your eligible family members, or dependents.

Dependent is defined to mean your:

1. Spouse; and
2. Dependent child who is under age 26

Defining "Spouse"

In the individual plans, the term "spouse" includes:

1. An individual legally married to you under the laws of the State of New Jersey or under the laws of another jurisdiction,
2. Your Domestic Partner pursuant to New Jersey law at P.L. 2003, c. 246,
3. Your Civil Union Partner pursuant to P.L. 2006, c. 103; and
4. 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.

Defining "Dependent Child"

In the individual plans, the term "dependent child" includes:

1. Your biological child,
2. Your legally adopted child (including children placed in the home for the purposes of adoption),
3. Your step-child
4. The child of Your Domestic Partner or Civil Union Partner,
5. Children under a court appointed guardianship;
6. 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; and

7. A child age 26 or older who has a mental, developmental or physical disability who is unmarried and incapable of earning a living, but only if: (a) the child's condition started prior to age 26 and while the child was covered under your plan; (b) the child remains continuously covered under your plan; and (c) the child depends on you for most of his or her support and maintenance.

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. The residency requirement does not apply to dependents. However, 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 coverage 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, because you will no longer meet the residency requirement. 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 is covered under the group plan I have from my employer but he will turn 26 soon. 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, your son still has options:

- He (or you) may purchase an individual plan for him and decide to keep it only until he becomes covered under a group plan.
- He could continue his coverage under your group health plan through a federal [COBRA](#) election or a New Jersey small group continuation election. Check with your employer. Both of these continuation laws allow your son to continue coverage under your group plan for up to 36 months.
- He may be eligible to continue coverage under your group plan as a dependent under 31 years old based on New Jersey law (P.L. 2005, c. 375, as amended). For more information see 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?

Typically, you may cover your child up to the child's 26th birthday. Dependent children 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](#).

Or you may want to explore whether your children are eligible for NJFamilyCare, which covers children in families with income up to 350% of the federal poverty level. For more information about NJFamilyCare, call 1-800-701-0710, or go online to <http://www.njfamilycare.org/index.html>.

In addition, for children in families with incomes above 350% of the federal poverty level, there is NJFamilyCare Advantage. In many instances, it will be more cost effective for a parent to purchase a NJFamilyCare Advantage plan. For more information about NJFamilyCare Advantage, call 1-800-637-2997, or go online to <http://www.horizonnjhealth.com/members/advantage.html>.

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 your County Office on Aging
- contacting New Jersey's Division of Aging and Community Services at 1-800-792-8820 or visit their website at www.state.nj.us/health/senior/ship.shtml
- going online to www.Medicare.gov
- going online to www.healthcare.gov

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 Small Group continuation elections result in continuation of coverage under a group plan, you are still eligible to purchase an individual plan. You may choose to continue your coverage under your employer's group plan through a COBRA or New Jersey Small Group continuation election for some, all, or none of the permissible continuation period. Once you purchase an individual plan, you will have to terminate your group health coverage elected under COBRA or New Jersey Small Group continuation, except that you may keep your group 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 when you make a Dependent Under 31 election, you are continuing coverage under a group plan, 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?

Generally, you are not allowed to purchase an individual plan if you are covered by or eligible for a group health plan. There are exceptions:

- You always can purchase an individual plan if you are no longer part of an employer's group, but are continuing coverage through a COBRA election, a New Jersey Small Group continuation election, or a Dependent Under 31 continuation election. You must terminate the group continuation coverage.
- You can purchase an individual plan during the annual Open Enrollment Period each November even if you are eligible for or covered under an employer's group plan, but
 - You cannot buy an individual plan that is the same as or similar to the group plan, and
 - You must terminate your coverage under the group plan no later than December 31 of the year you make the purchase of the individual plan

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.

Key Features of the Individual Health Coverage Program

To offer individual plans each carrier is required to:

- *issue* coverage to all eligible people without regard to anyone's past, existing or expected health conditions;
- *renew* coverage for all eligible people without regard to anyone's past, existing or expected health conditions;
- not apply a pre-existing condition limitation period to anyone who is younger than 19 years old;
- apply no more than a 12 month preexisting condition limitation period to other eligible people, looking back at no more than the six-month period prior to the effective date of coverage;
- reduce the pre-existing condition limitation period that may apply to a person by the period of creditable coverage the person previously had;
- establish modified community rates for individual plans, which may include age for the standard individual plans, and may include age, gender and geographic location for the Basic & Essential (B&E) individual plan;
- offer at least three of the standard plans (Plan A/50, Plan B, Plan C, Plan D or the HMO Plan), except that an HMO may offer the HMO Plan only; and
- offer a Basic and Essential Plan (B&E Plan).

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, claims history, occupation, age, gender or any other reason that may be related to your health or the health of any family member. What's more, 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."

Defining Pre-existing Condition

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

1. a person sees a doctor, takes prescribed drugs, receives other medical care or treatment or had medical treatment recommended by a doctor, or
2. 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. However, certain complications of pregnancy will not be excluded for coverage as pre-existing conditions.

Defining Pre-existing Condition Limitation Period

The maximum pre-existing condition limitation or waiting period allowed for the individual plans is 12 months from the enrollment date. The pre-existing condition limitation period may be less, or even eliminated, if you had prior "creditable coverage."

During the 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 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."

As long as no more than 31-days have passed between when your prior creditable coverage ended and the effective date of your new individual plan:

- ✓ the carrier will credit (reduce) the 12-month pre-existing condition limitation period by the length of time you were covered under your prior creditable coverage AND
- ✓ the carrier will waive the 12-month pre-existing condition limitation period for any pre-existing condition that was diagnosed and/or treated and covered under your prior creditable coverage

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.

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.

Exception to the 31-day requirement for federally-defined eligible individuals: 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.

Keep in mind: the method for counting breaks between coverage varies based on whether you are moving from a group health plan as a federally-defined eligible individual to an individual plan, or moving from a nongroup plan (for example, an individual plan, Medicaid, NJ FamilyCare) to an individual plan, because enrollment date is defined differently. For federally-defined eligible individuals, the break in coverage is measured from the date the

federally-defined eligible individual's coverage under the group health plan ended until he or she submitted a substantially complete application for coverage under the individual plan. For everyone else, the break in coverage is measured from the date the individual's coverage under the prior health plan ended until the effective date of coverage under the new individual health plan.

Rating

Carriers are required to community rate individual plans. This means that the rates are the same for everyone who purchases the particular individual plan, and are not based upon the actual or expected claims history of any single person. Carriers establish rates based on whether the coverage is for a single person, two adults, an adult plus child(ren) or a family, but carriers may not consider the health status of any specific person purchasing an individual plan. (So, for instance, there is no special rate for smokers versus non-smokers.) Carriers may consider a limited number of other factors, depending upon whether the plan is a standard plan or a B&E plan.

Modified Community Rating for Standard Plans

Carriers have the option to use age as a rating factor for the standard plans. Some carriers rate by age, and some do not. If a carrier rates by age, it must do so using 5-year rating bands from ages 25 to 65. So, 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 age, gender or geographic location in setting rates for the B&E plan. Carriers may use one, two or all three of those permissible rating factors. As with the standard individual plans, age bands are specified by regulation, as are geographic locations. Still, the rates for one carrier's B&E Plan may be very different from the rates for another carrier's B&E Plan. In addition, while the B&E Plan basically covers the same services and supplies, some carriers have designed riders to enhance the benefits under the B&E Plan, which results in some significant differences between the B&E Plans (with rider) offered by one carrier as compared to that of another, and further rate differences among carriers.

Caps on Rate Increases

As of January 5, 2009, and for the next four years, New Jersey law imposes two renewal rate caps. One limits the rate increase upon annual renewal to 15% for consumers who bought an individual plan prior to January 5, 2009. The other limits the annual renewal rate increase to 15% for consumers age 55 or older who buy a plan on January 5, 2009 or later. The cap, intended to cushion the transition to age rating for certain consumers, 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 12th 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 several factors: whether you were covered under prior creditable coverage, whether you are a federally-defined eligible individual, how long you had prior creditable coverage, and how much time passed between your old and new coverage.

There are several possible outcomes:

If you are **not** a federally defined eligible individual, (meaning you did not have at least 18 months of prior coverage under a group health plan), but you were covered for the condition under prior coverage and that coverage ended no more than 31 days before the effective date of your current 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 you submitted a substantially complete application for the individual plan (February 12th 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 effective date of your new individual plan (March 1, in this example), or your group coverage ended more than 63 days before the application date (February 12th in this example), the new coverage will not cover a pre-existing condition until the end of the required 12-month pre-existing condition limitation 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 (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 in the new individual plan, 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. This 80% requirement is referred to as the medical loss ratio.

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. For more specific information on 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 insurance producer for further assistance.

Indemnity plans typically require you to satisfy a deductible before the carrier will pay benefits based on the covered charge. After you have paid the deductible amount, you and the carrier share the covered charges for awhile by each paying a percentage of the allowed charge. This is referred to as coinsurance. You are responsible for your

coinsurance share until you reach the maximum out-of-pocket amount. After that, the carrier pays the full amount of the allowed charge for all covered charges. The standard individual plans have various deductibles and coinsurance options to choose from (see the Benefits section). Some carriers offer the B&E plan as an indemnity plan.

"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 additional "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 charges that are not covered under the individual plan, and for the balance of covered charges that exceed what the carrier considers reasonable and customary.

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.

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 Organizations (HMOs) offer individual plans with a network feature to provide network-based forms of managed care. The HMO has a network of physicians, hospitals and other health care professionals which provides members with medical treatment and care, subject to the terms of the individual plan. 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. An HMO may offer individual plans that do not require referrals. 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. Generally, there are no calendar year deductibles or coinsurance requirement; **however, the prescription drug benefits in the individual HMO Plan are subject to 50% coinsurance.**

HMOs must offer the HMO standard plan with a \$30 copayment option, but may offer other copayment options as well as other cost-sharing options, including:

- ✓ A "split copayment" for physician services, where the copayment for use of a specialist may be higher than the copayment for a PCP visit.
- ✓ A plan that applies deductible and coinsurance provisions to certain services (but deductibles, coinsurance and copayments can not all apply to the same services or supplies).

Some carriers are offering the B&E plan as an HMO product.

See the individual HMO Plan options available 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 more benefits and/or less cost sharing. If you seek care and treatment from providers that are outside of the network, you will be eligible for less benefits, which usually means 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. PPO plans that are offered are identified on the [rate comparison sheets](#). Contact the carriers directly for information concerning their PPO plan designs.

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 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 more 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 lower 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. Because POS plans are similar to PPO plans, POS plans are identified together with the PPO plans on the [rate comparison sheets](#). Contact the carriers directly for information concerning their POS plan designs.

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. However, only emergency services are covered outside of the network, even when a person is outside of the service area of the EPO.

The B&E plans sold as EPO plans include copayment, deductible, and coinsurance provisions. There are separate [rate comparison sheets](#) for the B&E Plan.

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 in one of the networks, 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 from your out-of-network providers, and still receive coverage, but benefits will be at the non-network level (which usually means more out-of-pocket cost to you). 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, based on the deductible, coinsurance or copayment requirements of each plan. 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. More

specifically, you can switch at any time: (a) from one individual plan to another individual plan with a lower premium, or (b) from a standard individual plan to the same type of standard individual plan with the same or greater deductible, same or greater coinsurance or same or greater copayments or (c) from a B&E Plan with a rider to a B&E Plan without a rider.

But you can only switch during the Open Enrollment Period in November: (a) from any individual plan to another individual plan with a greater premium (for example, from a B&E Plan to a standard Plan C), or (b) from an individual plan without a rider to an individual plan with a rider, or (c) from one rider to another rider, or (d) from an HMO Plan to a non-HMO standard plan (including those offered as PPO and POS products), or (e) from an HMO Plan to another HMO Plan with lower copayments.

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:

1. office visits
2. hospital care
3. prenatal and maternity care
4. immunizations and well-child care
5. screenings, including mammograms, pap smears and prostate examinations
6. x-ray and laboratory services
7. biologically based mental illness services
8. certain non-biologically based mental illness and substance abuse services

9. prescription drugs

Indemnity, including 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.

Carriers may offer the standard plans using a PPO or POS feature (that is, with both network and out-of-network benefits), but are not required to do so. The PPO or POS plans offered may require referrals to specialists in order for services to be covered at the network level, or the plans may be open access or direct access plans, in which case, the PPO or POS plan does not require referrals to specialists in the network to receive network benefits. You will need to contact a carrier directly to get more information about its PPO and/or POS plan designs.

Standard Plan Coinsurance

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. "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 plans A/50 through D have specified coinsurance requirements, but the actual coinsurance amount may vary depending on whether the plan is offered with or without a network feature. The coinsurance paid by the covered person towards allowed charges under each plan when offered without a network (that is, a plain indemnity plan) is as follows:

- | | |
|--------------|-----|
| 1. Plan A/50 | 50% |
| 2. Plan B | 40% |
| 3. Plan C | 30% |
| 4. Plan D | 20% |

However, when the standard plans are offered with a network feature (that is, as PPO or POS products), then the network and non-network coinsurance amounts can vary within a range of 50% to 100%, and the carrier may have a copayment requirement instead of a coinsurance requirement for network covered services. Varying cost-sharing designs are acceptable for PPO and POS products, so long as the plan-designated coinsurance applies to either the network or non-network benefits. So, a Plan C PPO could be a plan that requires the covered person to pay 30% for network services and 50% for non-network services, or it could be a plan that requires the covered person to pay 30% for non-network services, and a \$30 copayment for network services.

Standard Plan Deductibles

Deductibles are the amount of allowed charges for which the covered person is responsible before the carrier agrees to pay anything towards covered charges.

Carriers **MUST** offer these deductibles for Plans A/50, B, C and D:

- \$2500 per Person
- \$5000 per Family

Carriers **MAY** offer these deductibles for Plan A/50, B, C, and D:

- \$1000, \$5000, \$10,000 per Person
- \$2000, \$10,000, \$20,000 per Family

Standard Plan Maximum Out-of-Pocket (MOOP)

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 standard health benefits plans, allowed charges the covered person pays towards the deductible, coinsurance and copayments help to satisfy the MOOP.

The MOOP for plans A/50 through D is always stated as the sum of the selected deductible **plus** a specified dollar amount, as follows:

1. Plan A/50 MOOP = the Deductible + \$5,000 (of coinsurance and/or copayments)
2. Plan B MOOP = the Deductible + \$3,000 (of coinsurance and/or copayments)
3. Plan C MOOP = the Deductible + \$2,500 (of coinsurance and/or copayments)
4. Plan D MOOP = the Deductible + \$2,000 (of coinsurance and/or copayments)

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 (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.

PPO or POS plans may have a combined MOOP for network and non-network services, or may have separate MOOPs for network and non-network services. The MOOP for network services cannot exceed \$5,000 and the MOOP for non-network services cannot exceed three times the MOOP for network services. Please consult the carrier's benefit descriptions for information on how the MOOP provisions operate.

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.

See the Individual Plans Summary chart for a more detailed outline of the standard individual plans, coinsurance amounts, deductibles and copayments. See the [rate comparison sheet](#) for standard plan premiums.

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 HMOs must offer the HMO Plan with 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 Plans subject to deductible and coinsurance are identified on the [rate comparison sheet](#). The deductibles may be as follows:

- \$1000 or \$2500 per Person
- \$2000 or \$5000 per Family

The coinsurance offered with an HMO Plan may range from 20% to 50%. When a carrier offers an HMO Plan with deductibles and coinsurance, then a MOOP applies also. The MOOP will be satisfied by the charges the covered person pays towards the deductible and the coinsurance, and the carrier may specify that copayments will apply to the MOOP as well. The MOOP for the HMO Plan cannot exceed \$5,000. As with the other standard individual plans, the 50% coinsurance requirement for the prescription drug benefit remains in place even after the MOOP is satisfied for an HMO Plan.

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.”

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 Plan with an HMO or EPO delivery system, meaning you need to select doctors and hospitals within the carrier’s network in order to have the covered services paid for by the B&E Plan.

In addition to offering the B&E Plan, carriers are permitted to offer riders that enhance the benefits of the B&E Plan, and several carriers do:

AmeriHealth: www.amerihealth.com/health_plans/index.html

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

Oxford: www.oxhp.com/secure/brokers/nj/individual_pre_pin.htm

The B&E [rate comparison sheet](#) allows consumers to compare rates by age, gender and geographic territories for B&E Plans, with and without riders, but consumers must contact the carriers for more information about the delivery system associated with a carrier’s B&E Plan, and the enhanced benefits that a carrier’s rider may provide.

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 and federal 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 [earlier discussed](#). 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 [allowed charges](#), in the form of deductible, coinsurance and copayment requirements, during any calendar year. You may hear it referred to as the "MOOP," which is also the term we sometimes use in this Buyer's Guide. 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% of allowed charges by the carrier. 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 annual deductible and coinsurance requirement begins.

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 reduce or deny benefits initially because you or your doctor did

not submit all the necessary information. Carriers may deny benefits for different reasons, including: (a) because the health care service or supply is not covered under the contract; (b) because the service or supply is not rendered by an appropriate health care provider, and (c) because the carrier has determined the specific covered service or supply is not “medically necessary.” If a denial is based on a determination that the covered service or supply is or was not medically necessary, you have the right to pursue an independent appeal through the [Independent Health Care Appeals Program](#) if you are not satisfied with the outcome of the carrier’s internal appeal process. 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 609-292-7272.

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 when 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 standard 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; they are only required to offer 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 requirements. 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 -- plans offered with a PPO, POS, HMO or EPO delivery system (with respect to B&E Plans) -- a significant difference among carriers is the network of physicians and other health care providers. 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 unaffiliated HMOs, must offer Plan A/50. Such Plan A/50 may be offered as an indemnity, PPO or POS product. 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 by carriers (other than unaffiliated HMOs). The carriers may also decide whether to offer each additional plan as an indemnity, PPO or POS product. And, if a company has an affiliated HMO, one of the three required standard plan offerings may be an HMO plan, rather than Plan B, C or D.

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 Small Employer Group Continuation

Both federal and New Jersey law require that most employees and dependents who lose coverage under an employer's group health plan be given the opportunity to continue coverage under the group health plan for a period of time. The federal law, usually referred to as [COBRA](#), applies to most employers with 20 or more employees, while the New Jersey Small Employer Group continuation law applies to most employers with 2 to 50 employees. The two laws are very similar. Under both [COBRA](#) and New Jersey law, the person electing to continue coverage can be required to pay the full premium plus a 2% administrative fee; even so, group rates are often lower than an individual rate for a plan with similar benefits.

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. 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.

If you were covered under a group plan as a dependent and lost that coverage due to death of the employee, divorce, or because you no longer meet the dependent eligibility standards under the plan, you may elect to continue your coverage for up to 36 months. Your coverage will be the same as you had while covered as a dependent.

Information regarding New Jersey's Small Employer Group Continuation is provided in SEH Bulletin 07-SEH-02 and is available at 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 people 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 children who no longer meet the age requirements to be a child dependent under the group health coverage who also: are under 31 years old AND are not married AND have no children AND are either residents of New Jersey or are full-time students if not living in New Jersey AND are not actually covered under any other health benefits plan.

Information about coverage under this law is available on the Department of Banking and Insurance website: www.state.nj.us/dobi/division_consumers/du31.html

NJ FamilyCare

NJ FamilyCare is a federal and state funded program created to provide New Jersey's uninsured children 18 years old and younger and certain low-income parents and guardians free or low-cost health coverage. Eligibility is based on a family's size and monthly income. Most children are required to have been uninsured for 3 months before enrolling in NJ FamilyCare, but there are exceptions based on changed circumstances to a parent's job, and some other reasons. NJ FamilyCare is under the New Jersey Department of Human Services.

For more information about NJ FamilyCare or to get an application, call **1-800-701-0710** or visit the website: www.njfamilycare.org/ (where you can download or complete an application online).

NJ FamilyCare Advantage – Child-only Coverage

If your family's income does not meet the requirements for NJ FamilyCare (and your child is not otherwise eligible for Medicaid), then consider NJ FamilyCare Advantage. NJ FamilyCare Advantage is a child-only program that covers children whose monthly family income is too high for the family to qualify for NJ FamilyCare. **No family can earn too much to qualify for NJ FamilyCare Advantage!** However, there are still eligibility requirements:

- ✓ The family must reside in New Jersey AND
- ✓ The child must be younger than 19 years old AND
- ✓ The child must have been uninsured for at least 6 months, UNLESS
 - the child just lost eligibility for Medicaid, or
 - the child just lost eligibility for NJ FamilyCare, or
 - the parent recently lost employment due to staff reductions AND
- ✓ All children in the family eligible for NJ FamilyCare Advantage must be enrolled

For more information about NJ FamilyCare Advantage or to get an application, call **1-800-637-2997** or visit the website:

www.horizonnjhealth.com/members/advantage.html (where you can download an application).

NJ Protect (New Jersey's Pre-existing Condition Insurance Plan)

The federal Patient Protection and Affordable Care Act of 2010 (often called PPACA) requires all states to have an individual plan to address the needs of people who have been denied coverage because of a pre-existing condition. NJ Protect is the plan designed to comply with PPACA. NJ Protect coverage is based on a standard Plan C offered as a PPO product.

While no one can be denied coverage in New Jersey's individual market because of health issues, NJ Protect has several special features that make it different from other plans available:

- ✓ NJ Protect has no preexisting condition limitation period, so there is no waiting for coverage of treatment for a pre-existing condition to begin.
- ✓ NJ Protect has a rider that limits the cost-sharing requirements for prescription drugs – which means lower out-of-pocket costs for people who use many prescription drugs.
- ✓ The federal government provides a subsidy to the states to help lower the cost of the insurance – so the premium for NJ Protect is a little less than other Plan C options in the market.
- ✓ NJ Protect only covers individuals – there is no option to cover spouses or families on one policy.
- ✓ There are extra eligibility requirements to qualify for NJ Protect, so not only must you be a New Jersey resident who is not eligible for a group health plan or Medicare, but you must also:
 - Be a citizen or national or an alien legally present in the United States,
 - Be able to prove that you have a pre-existing condition, AND
 - Be without any creditable coverage for at least 6 months.

For more information or to download an application, go to the Department of Banking and Insurance's website at http://www.state.nj.us/dobi/division_insurance/njprotect/index.htm, or call Horizon Blue Cross and Blue Shield of New Jersey's toll-free number: **1-888-551-2130**

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 wide 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 Heath 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](#) (following) 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, www.state.nj.us/dobi/division_insurance/ihcseh/ihcforms.html.

Individual Plans Summary

Cost-sharing and Services Description	Standard Individual Plans				HMO Plan	Basic & Essential Plan (w/out riders)
	Plans A/50 through D (may be offered with or without a PPO-feature)					
Cost-sharing	A/50	B	C	D		
Deductible carriers <i>must</i> offer	Per person: \$2500 Per family: \$5000				None	N/A
Deductible options carrier <i>may</i> offer	Per person: \$1000, \$5000 and/or \$10,000 Per family: \$2000, \$10,000 and/or \$20,000				Person: \$1000 or \$2500 Family: \$2000 or \$5000	N/A
Coinsurance paid by the covered person (you)	50%	40%	30%	20%	Options: 50%, 40%, 30%, 20%	30% for treatment of substance abuse and biologically-based mental illness 20% for wellness visits
Max Out-of-Pocket (paid by you) MOOP = the Deductible + →	\$5000	\$3000	\$2500	\$2000	No greater than \$5000	None
so, the range of the MOOP per person can be →	\$6000-\$15,000	\$4500-\$13,000	\$3500-\$12,500	\$3000-\$12,000		
so, the range of the MOOP per family can be →	\$7,000-\$25,000	\$5000-\$23,000	\$4500-\$22,500	\$4000-\$22,000		
ER Copayment (waived if admitted w/in 24 hrs) → in addition to the deductible and coinsurance (if any)	\$100	\$100	\$100	\$100	\$100	\$100
Copayments (per visit/day/confinement):						
>Hospital Confinement – max 5 copays/confinement; max 10 copays/year	When offering these plans with a PPO feature, carriers <i>may</i> use HMO copayment for in-network services, following the rules for the HMO plan (instead of deductible and coinsurance). Out-of-network services will be subject to deductible and coinsurance requirements. <i>If the PPO plan uses deductible and coinsurance for both in-network and out-of-network services, the deductible and/or coinsurance out-of-network will more than the deductible and coinsurance for in-network services.</i>				Carrier <i>must</i> offer: \$300/day Carrier <i>may</i> offer: \$150, \$400 and \$500/day	\$500/confinement (no maximums)
>Pre-natal Care – copayment charged <i>only</i> for initial visit					\$25 OR same copayment as physician visit	Not covered
>Other services & supplies					Carriers <i>must</i> offer: \$30/visit Carriers <i>may</i> offer: \$15, \$40, and \$50/visit Carriers <i>may</i> offer a split copay → higher copays for specialist visits	Not applicable except for physical therapy → \$20/visit
Lifetime Maximum Benefit	Unlimited				Unlimited	Unlimited

Individual Plans Summary

Cost-sharing and Services Description	Standard Individual Plans		Basic & Essential Plan (w/out riders)
Covered Charges/Covered Services and Supplies	Plans A/50 – D	HMO Plan	
Hospital	Covered	Covered	covered up to 90 days/year
Emergency and urgent care	Covered	Covered	Emergency covered
Preadmission testing	Covered	Covered	Covered
Ambulatory surgical center	Covered	Covered	Not covered
Extended Care or Rehabilitation	Up to 120 days/year; requires preapproval	Covered; requires preapproval	Not covered
Home health care	Covered; requires preapproval	Covered; requires preapproval	Not covered
Hospice care	Covered; requires preapproval	Covered; requires preapproval	Not covered
Practitioner charges – surgical and nonsurgical, including second opinions	Covered	Covered	Up to \$700/year; second opinion not covered
Preventive care (as required by federal law); Wellness care in the Basic & Essential plans	Covered – no deductible or copayments apply; for PPO plans: unlimited in-network; \$500/person/year or \$750 through 1 year old out-of-network	Covered	Up to \$600/person/year
Mammogram	Covered; age and frequency limits may apply	Covered	Diagnostic tests limited to \$500/year
Colorectal cancer screenings	Covered; age limits apply	Covered	Diagnostic tests limited to \$500/year
Dialysis center/treatments	Covered	Covered	Covered
Prescription drugs (outpatient)	Covered; may require preapproval; coinsurance for Rx does not apply to the MOOP	Covered at 50% coinsurance; may require preapproval	Not covered
Supplies to administer Rx drugs	Covered	Covered	Not covered
Alcohol abuse treatment	Covered	Covered	30 days inpatient; 30 visits outpatient
Biologically-based mental illness treatment (including autism)	Covered	Covered	90 days inpatient; 30 visits outpatient
Non-biologically-based mental illness treatment and substance abuse treatment	30 days inpatient; 20 visits outpatient; may exchange inpatient days for outpatient visits; requires preapproval	30 days inpatient; 20 visits outpatient; may exchange inpatient days for outpatient visits; requires preapproval	Non-biologically based mental illness treatment is not covered; for substance abuse, see alcohol abuse treatment
Pregnancy	Covered	Covered	Covered: delivery and use of the delivery room only
Birth center	Covered	Covered	Not covered

Covered Charges/Covered Services and Supplies	Plans A/50 – D	HMO Plan	Basic & Essential Plan (w/out riders)
Newborn child coverage	Unless the child is added to the policy, covered for first 31 days only	Unless the child is added to the policy, covered for first 31 days only	Unless the child is added to the policy, covered for first 31 days only
Specialized infant formula	Covered	Covered	Not covered
Immunizations and lead screening	Covered; deductible does not apply	Covered	Covered
Newborn hearing screening	Covered; limited benefit	Covered; limited benefit	Not covered
Anesthesia	Covered	Covered	Covered
Blood	Covered	Covered	Covered
Ambulance	Covered	Covered	Not covered
Durable medical equipment	Covered; requires preapproval	Covered	Not covered
Nutritional counseling	Covered; requires preapproval	Covered	Not covered
Food and food products for inherited metabolic diseases	Covered	Covered	Not covered
X-rays and laboratory tests	Covered	Covered	Covered
Dental care and treatment	Covered for tumors, cysts, bony impacted teeth, injury to teeth or jaw	Covered for tumors, cysts, bony impacted teeth, injury to teeth or jaw	Not covered
TMJ	Covered, but excludes orthodontia, crowns, bridgework	Covered, but excludes orthodontia, crowns, bridgework	Not covered
Orthotic appliances and prosthetic devices	Covered; requires preapproval	Covered	Not covered
Hearing aids	Up to \$1000/ear every 24 months for children under 16 years old	Up to \$1000/ear every 24 months for children under 16 years old	Not covered
Treatment of autism and other developmental disabilities:			
Physical therapy	Up to 30 visits/year	Up to 30 visits/year	Not covered
Occupational therapy	Up to 30 visits/year	Up to 30 visits/year	Not covered
Speech therapy	Up to 30 visits/year	Up to 30 visits/year	Not covered
Cognitive therapy	Up to 30 visits/year	Up to 30 visits/year	Not covered
Applied behavior analysis	Up to \$36,000/year (w/ annual adjustment) for treatment of autism in individuals under 21 years old	Up to \$36,000/year (w/ annual adjustment) for treatment of autism in individuals under 21 years old	Not covered
Family cost share for NJ Early Intervention Services	Covered for PT, OT, and ST to treat a diagnosed developmental disability or autism only	Covered for PT, OT, and ST to treat a diagnosed developmental disability or autism only	Not covered

Covered Charges/Covered Services and Supplies	Plans A/50 – D	HMO Plan	Basic & Essential Plan (w/out riders)
Transplant benefits	Covered, but specified procedures only	Covered, but specified procedures only	Not covered
Surgical treatment of morbid obesity	Covered but specific criteria must be met	Covered but specific criteria must be met	Not covered
Physical therapy	Up to 30 visits/year; may require preapproval	Up to 30 visits/year; may require preapproval	Up to 30 visits/year
Occupational therapy	Up to 30 visits/year; may require preapproval	Up to 30 visits/year; may require preapproval	Not covered
Speech therapy	Up to 30 visits/year; may require preapproval	Up to 30 visits/year; may require preapproval	Not covered
Cognitive rehabilitation therapy	Up to 30 visits/year; may require preapproval	Up to 30 visits/year; may require preapproval	Not covered
Chelation therapy	Covered	Covered	Not covered
Chemotherapy	Covered	Covered	Not covered
Radiation therapy	Covered	Covered	Covered
Respiration therapy	Covered	Covered	Not covered
Visions screening	Covered; limited benefit; eye exams not covered	Covered; limited benefit; eye exams not covered	Not covered
Therapeutic Manipulation (chiropractic)	Up to 30 visits/year	Up to 30 visits/year	Not covered