Horizon Blue Cross Blue Shield of New Jersey

Making Healthcare Work

Horizon Blue Cross Blue Shield of New Jersey

Pre Existing Condition and Certificate of Creditable Coverage For Individual Insurance, Excluding Medigap

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Three Penn Plaza East, Newark, New Jersey 07105

Important Facts You and Your Client Need to Know

Pre Existing Condition and Certificate of Creditable Coverage For Individual Insurance, Excluding Medigap

Introduction

When an individual enrollment application is received, it is reviewed to validate the prospective enrollee's eligibility (and his or her eligible dependents, if applicable,) and to determine if the pre-existing condition limitation will apply to the coverage selected.

Except for certain federally defined eligible individuals, a person who enrolls in an individual plan is subject to a 12-month pre-existing condition limitation that may be waived or credited if he or she had prior creditable coverage and enrolled in their new coverage within 31 days of their prior coverage terminating.

Definition of Pre Existing Condition

A pre-existing condition is defined as an illness or injury which manifests itself in the six months before an individual's enrollment date, and for which in the six months before his or her enrollment date:

- He or she sees a practitioner, takes prescribed drugs, receives other medical care or treatment, or had medical care or treatment recommended by a practitioner; or
- An ordinarily prudent person would have sought medical advice, care, or treatment.

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Pre Existing Condition and Certificate of Creditable Coverage For Individual Insurance, Excluding Medigap, Continued

Definition of Pre Existing Condition Limitation

A pre-existing condition limitation is a limitation or exclusion of benefits relating to a condition that was present before the enrollment date, whether or not any medical advice, diagnosis, care or treatment was recommended or received before that date.

Genetic information will not be treated as a pre-existing condition in the absence of a diagnosis of the condition related to that information.

If a pre-existing condition limitation applies, we will not cover services for pre-existing conditions for up to 12 months from the eligible individual's enrollment date.

Pre Existing Condition limitation for pregnancy

A pregnancy which exists on an individual's enrollment date is also a pre-existing condition.

When a pre existing condition limitation does not apply

A pre-existing condition limitation does not apply to the following:

- benefits for other unrelated conditions,
- birth defects in a covered dependent child,
- complications of pregnancy, as defined by N.J.A.C. 11:1-4.3 (see below for details);and
- a newborn child, an adopted child or a child placed in the household for adoption if:
  - The policyholder has Single or Two Adults coverage and the application to add the child is received within 31 days of the child's becoming eligible for coverage;
  - The policyholder has Adult and Child(ren) or Family coverage and we receive the application to add the child at any time; or
  - The newborn child is the policyholder and we received the application within 31 days of the newborn's date of birth.

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Complications of Pregnancy 11:1-4.3

N.J.A.C. 11:1-4.3 is a state regulation that is applicable to all persons engaged in the business of life and health insurance in the State of New Jersey. It defines "Complications of pregnancy" as follows:

1. Conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as, nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and
2. Nonelective caesarean section, ectopic pregnancy, which is terminated, and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

Requirements for Federally defined eligible individuals

An individual who is considered a federally defined eligible individual is not subject to the pre-existing condition limitation if he or she applies for individual coverage within 63 days of the date his or her prior creditable coverage terminated.

A “Federally defined eligible individual” is a person who meets all of the requirements described below:

- Must have 18 months or more of creditable coverage without a significant break in coverage, which is 63 days or more without any creditable coverage;
- The person’s most recent prior creditable coverage must have been under a group health plan, a governmental plan of the U.S., a church plan, or health insurance offered in connection with any such plan;
- the person cannot currently be eligible for a group health plan, Medicare, or Medicaid or any successor program, and does not have another health benefits plan, or hospital or medical service plan;
- the person’s most recent coverage could not have been terminated because of nonpayment of premiums or fraud;
- the person, if offered the option of continuation coverage, has both elected and exhausted any continuation coverage available under COBRA or a similar state continuation program.

NOTE:
A member will not be considered a federally defined eligible individual, if he or she is offered the option of continuation coverage and declines it.

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Pre Existing Condition and Certificate of Creditable Coverage For Individual Insurance, Excluding Medigap, Continued

Pre-existing condition limitation for Federally Defined Eligible Individuals

The determination of whether the pre-existing condition limitation applies to a federally defined eligible individual is based on when the person applies for coverage in relation to when their prior coverage terminated:

If a federally defined eligible individual applies for coverage	Then the pre-existing conditions limitation…
Less than 63 days from the date their prior group coverage terminated.	will not apply.
63 days or more from the date their prior group coverage terminated.	applies for **twelve months** from the person's enrollment date, which is the date the individual submits a substantially complete application.

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Pre-existing condition credit for prior coverage

A person who changes from creditable coverage to an individual plan, with no lapse in coverage of more than 31 days, measured from the last date the creditable coverage was in force on a premium paying basis, is subject to the following provisions:

- the pre-existing condition limitation is waived for the conditions for which the individual was treated or diagnosed for by a physician and received benefits for under the prior health benefits plan;
- The individual is given credit for the time he or she was previously covered under creditable coverage, regardless of the existence or length of the prior plan's pre-existing condition limitation clause.

Proof of prior creditable coverage *must* be provided for any credit to be given. Proof can be a Certificate of Creditable Coverage (COCC) or other documents if a COCC cannot be provided.

Determining the Pre-Existing Condition Limitation (a.k.a. pre-ex wait months)

The pre-existing condition limitation is determined upon enrollment.

If proof of prior creditable coverage is provided with the application, the pre-existing condition limitation will be reduced by the amount of months the person had prior creditable coverage.

If proof of prior creditable coverage is not provided with the application we will apply a 12-month pre-existing condition limitation. Upon receipt of proof, the pre-existing condition limitation will be reduced by the amount of months the person had prior creditable coverage.

Note: For existing customers, we can check our Enrollment System to determine the amount of months a person had prior creditable coverage.

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Credit is provided in monthly increments

Credit towards the pre-existing condition limitation is provided in monthly increments. Credit for partial months (for example 3.5 months) will be rounded up when the prior coverage ended on or after the 15th of the month and will be rounded down when the prior coverage ended before the 15th of the month.

Individual notification of pre-existing condition limitation

A file is generated weekly that identifies all new enrollees that have a pre-existing condition limitation. An individual notification letter is issued to this population identifying how many months of their pre-existing condition limitation remain to be satisfied.

In cases where proof of prior creditable coverage is received after the initial enrollment and this results in partial or full removal of the pre-existing condition limitation, a revised individual notification letter is sent to the member.

A sample of the letter issued is provided below.

SAMPLE:

Individual Pre-Existing Notification

Date
ID #
Customer Name
Address
City, State, Zip

Dear Valued Customer:

Thank you for choosing Horizon Blue Cross and Blue Shield of New Jersey as your health insurance carrier. Your application has been received and your identification card along with the post-enrollment information will be sent to you in a separate mailing.

Individual health insurance contracts in the State of New Jersey contain a 12-month pre-existing condition clause. This clause states that a condition is pre-existing when it is due to an illness or accidental injury that manifests in the six months before the coverage starts. The pre-existing condition limitation may not apply if you transfer from another health insurance plan and there has been no more than a 31-day lapse in coverage. The limitation also does not apply to Federally Defined Eligible Individuals who apply for coverage within 63 days of termination of prior coverage.

The information supplied on your application indicates that you have __________month (s) pre-existing period remaining, from the effective date of your contract. Any claims received during the pre-existing period will be reviewed to determine if the condition or diagnosis existed prior to the effective date of your contract. The last day on which the pre-existing condition limitation applies is (input date pre-ex period ends).

If your pre-existing period stated above is "0" months, it indicates that your pre-existing period has been waived. Claims will be honored in accordance with your benefits from the effective date of your policy.

YOU HAVE THE RIGHT TO SUBMIT ADDITIONAL EVIDENCE OF CREDITABLE COVERAGE. YOU HAVE THE RIGHT TO APPEAL THIS DECISION IF YOU BELIEVE THIS INFORMATION IS INCORRECT. IN ORDER TO APPEAL, A CERTIFICATE OF CREDITABLE COVERAGE (COCC) OR A LETTER ON THE PRIOR CARRIER'S LETTERHEAD MUST BE SUBMITTED INDICATING THE EFFECTIVE AND TERMINATION DATES OF COVERAGE.
This appeal can be mailed or faxed to:

Horizon Blue Cross Blue Shield of New Jersey
P.O. Box 1330
Newark NJ 07101-9845
Fax: 973-274-4450

Please allow 5 business days from our receipt date to review your request. If you have questions about your coverage, please call Member Services at 1-800-355-BLUE (2583). Thank you for choosing Horizon BCBSNJ as your health insurance carrier. We look forward to *Making Healthcare Work* for you.

Mary Ann Nagy
Director, Service Operations

Pre Existing Condition and Certificate of Creditable Coverage For Individual Insurance, Excluding Medigap, Continued

Definition of creditable coverage

A person's pre-existing condition limitation may be reduced if they had prior creditable coverage that consisted of any of the following:

- a group health plan (including a self-insured plan);
- a group or individual health benefits plan;
- Part A or Part B of Title XVIII of the federal Social Security Act (Medicare);
- Title XIX of the federal Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of Title XIX of the federal Social Security Act (the program for distribution of pediatric vaccines);
- Chapter 55 of Title 10, United States Code (TRICARE (previously CHAMPUS)- medical and dental care for members and certain former members of the uniformed services and their dependents);
- a medical care program of the Indian Health Service or of a tribal organization;
- a state health benefits risk pool;
- a health plan offered under chapter 89 of Title 5, United States Code (Federal Employee Health Benefits Program);
- a public health plan;

  For federally defined eligible individuals public health plan means any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan.

  For all others, public health plan means any plan established or maintained by a State, the U.S. government, or any political subdivision of a State, or the U.S. government that provides health coverage to individuals who are enrolled in the plan.

- a health benefits plan under section 5(e) of the Peace Corps Act;
- Title XXI of the federal Social Security Act (State Children's Health Insurance Program); or
- coverage under any other type of plan as set forth by the Commissioner of Banking and Insurance by regulation.

Note: Coverage does not necessarily have to be issued in the United States in order to be creditable.

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What creditable coverage does not include (excepted benefits)

Creditable coverage does not include coverage which consists solely of the following:

- coverage only for accident or disability income insurance, or any combination thereof;
- coverage issued as a supplement to liability insurance;
- liability insurance, including general liability insurance and automobile liability insurance;
- stop loss or excess risk insurance;
- workers' compensation or similar insurance;
- automobile medical payment insurance;
- credit only insurance;
- coverage for on-site medical clinics;
- other similar insurance coverage, as specified in federal regulation, under which benefits for medical care are secondary or incidental to other insurance benefits;
- limited scope dental or vision benefits, if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of the plan;
- benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof, if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of the plan;
- such other similar, limited benefits as specified in federal regulations (e.g., cancer only policies) if the benefits are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of the plan;

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What creditable coverage does not include, continued

- hospital confinement indemnity coverage, if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of benefits and any exclusion of benefits under any group health benefits plan maintained by the same plan sponsor and those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor;
- Medicare supplemental health insurance as defined under section 1882 (g)(1) of the federal Social Security Act if offered as a separate policy, certificate, or contract of insurance;
- coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code (CHAMPUS), if offered as a separate policy, certificate, or contract of insurance; and
- similar supplemental coverage provided to coverage under a group health plan.

Proof of prior creditable coverage: using a COCC (See below for Sample COCC)

An individual may reduce their pre-existing condition limitation by submitting a Certificate of Creditable Coverage (COCC) as proof of prior creditable coverage.

There is no time limit for individuals to submit a COCC or other evidence of creditable coverage to receive credit for prior creditable coverage.

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Pre Existing Condition and Certificate of Creditable Coverage For Individual Insurance, Excluding Medigap, Continued

Proof of prior creditable coverage: documents other than a COCC
(See below for Sample COCC)

If an individual cannot provide us with a COCC we will accept other documents as proof of prior creditable coverage if the individual:

- attests to the period of creditable coverage;
- presents relevant evidence confirming creditable coverage during the period; and
- cooperates with our efforts to verify their prior coverage.

The documents we will accept are:

- explanations of benefits (EOBs);
- other correspondence from a health plan or insurance issuer;
- pay stubs showing payroll deduction for health coverage;
- a health insurance identification card;
- a benefit certificate from a group health policy;
- records from medical care providers indicating health coverage;
- third party statements verifying periods of coverage; and
- any other relevant documents that evidence periods of health coverage.

When must a COCC be provided?

A certificate of creditable coverage must be provided:

- automatically when an individual's coverage under the plan terminates, whether or not the individual is eligible to elect COBRA continuation;
- automatically when an individual exhausts COBRA or other continuation coverage; and
- if requested, before the individual loses coverage or within 24 months after termination of coverage, whether or not a COCC was already received.

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Pre Existing Condition and Certificate of Creditable Coverage For Individual Insurance, Excluding Medigap, Continued

COCC not required for excepted benefits	No certificate is required to be furnished for excepted benefits unless they are provided concurrently with creditable coverage.
Other situations when a COCC is not required	There may be situations when we do not know of a dependent's cessation of coverage under the plan (e.g., a dependent child ceases to be eligible, but there is no change in contract type since there are other children covered and we do not receive notification of deletion). In these cases, a COCC is not required.
Multiple information	Information on all persons covered under the health plan can be combined on a single certificate. If information is not identical for all individuals covered, the form must provide all the required information for each individual and separately state the information that is not identical.
Where to send COCC's	COCC's for individual enrollment review should be forwarded to : P.O .Box 1330 Newark NJ 07101-9845 Or **Dedicated Fax Server : 973-274-4450** **Contact Number – 1-800-355 – 2583**

Horizon
Horizon Blue Cross Blue Shield of New Jersey
Making Healthcare Work℠

SAMPLE
Three Penn Plaza East
Newark, NJ 07105-2200
www.horizonblue.com

______________________ Date: ____________________

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CERTIFICATE OF INDIVUDUAL HEALTH INSURANCE COVERAGE

IMPORTANT - This certificate provides evidence of your prior health coverage. You may need to furnish this certificate if you become eligible under a group health plan that excludes coverage for certain medical conditions that you have before you enroll. This certificate may need to be provided if medical advice, diagnosis, care, or treatment was recommended or received for the condition within the 6-month period prior to your enrollment in the new plan. If you become covered under another group health plan, check with the plan administrator to see if you need to provide this certificate. You may also need this certificate to buy, yourself or your family, an insurance policy that does not exclude coverage for medical conditions that are present before you enroll.

1. Date of this certificate:

2 .Name of policy holder:

3. Identification number of policy holder:

4. Name of all members to whom this certificate applies:

Member Name	Date Coverage Began	Date Coverage Ended

5. For further information, call the Customer Service Department at 1-800-355- 2583

7. Name, address, and telephone number of plan administrator or issuer responsible for providing this certificate:

Horizon Blue Cross Blue Shield of New Jersey
3 Penn Plaza East
Newark, New Jersey 07105
1-800-355-BLUE (2583)

8. Date that a substantially completed application was received from the policy holder:

Note: Separate certificates may be furnished if information is not identical for the participant and each beneficiary.

Statement of HIPAA Portability Rights

IMPORTANT_KEEP THIS CERTIFICATE: This certificate is evidence of your coverage under this pan. Under a federal law know as HIPAA, you may need evidence of your coverage to reduce a preexisting conditions period under another plan, to help you get special enrollment in another plan, or get certain types of individual health coverage even if you have health problems.

Pre-existing condition exclusions. Some health group health plans restrict coverage for medical conditions present before an individual's enrollment. These restrictions are known as "preexisting condition exclusions". A preexisting condition can apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months before your "enrollment date". Your enrollment date is your first day of coverage under the plan, or, if there is a waiting period, the first day of your waiting period (typically, your first day of work). In addition, a preexisting condition exclusion cannot last for more than 12 months after your enrollment date (18 months if you are a late enrollee). Finally, a preexisting condition exclusion cannot apply to pregnancy and cannot apply to a child who is enrolled in health coverage within 30 days after birth, adoption, or placement for adoption.

If a plan imposes a preexisting condition exclusion, the length of the exclusion=ion must be reduced by the amount of your prior creditable coverage. Most health coverage is creditable coverage, including group health plan coverage, COBRA continuation coverage, coverage under an individual health policy, Medicare, Medicaid, State Children's health Insurance Program (SCHIP), and coverage through high-risks and the Peace Corps. Not all forms of creditable coverage are required to provide certificates like this one. If you do not receive a certificate for past coverage, talk to your new plan administrator.

You can add up any creditable coverage you have, including the coverage shown on this certificate. However, if at any time you went for 63 days or more without any coverage (called a break in coverage) a plan may not have to count the coverage you had before the break.

- Therefore, once your coverage ends, you should try to obtain alternative coverage as soon as possible to avoid a 63-day break. You may use this certificate as evidence of your creditable coverage reduce the length of any preexisting condition exclusion if you enroll in another plan.

Right to get special enrollment in another plan. Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. (additional special enrollment rights are triggered by marriage, birth, adoption and placement for adoption).

- Therefore, once your coverage ends, if you are eligible for coverage in another plan (such as a spouse's plan), you should request enrollment as soon as possible.

Probation against discrimination based on a health factor. Under HIPAA, a group health plan may not keep you (or your dependents) out of the plan based on anything related to your health. Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

Right to individual health coverage. Under HIPAA, if you are an "eligible individual," you have a right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool) without a preexisting condition exclusion. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more;
- Your most recent coverage was under a group health plan (which can be shown by this certificate);
- Your group coverage was not terminated because of fraud or nonpayment of premiums;
- You are not eligible for COBRA continuation coverage or you have exhausted your COBRA benefits (or continuation coverage under a similar state provisions); and
- You are not eligible for another group health plan, Medicare, or Medicaid, and do not have any health insurance coverage.

The right to buy individual coverage is the same whether you are laid off, fired, or quit your job.

- Therefore, if you are interested in obtaining individual coverage and you meet the other criteria to be an eligible, you should apply for this coverage as soon as possible to avoid losing your eligible individual status due to a 63-day break.

State Flexibility. This certificate describes minimum HIPAA protections under federal law. States may require insurers and HMOs to provide additional protections to individuals in that state.

For more information. If you have questions about your HIPAA rights, you may contact your state insurance department or the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) toll-free at 1-866-444-3272 (for free HIPAA publications ask for publications concerning changes in healthcare laws). You may also contact the CMS publication hotline at 1-800-633-4227 (ask for "Protecting Your Health Insurance Coverage"). These publications and other useful information are also available on the internet at http://wwww.dol.gov/ebsa, the DOL's interactive web pages – Health E Laws, or http://www.cms.hhs.gov/hipaal.