

Understanding HIPAA continuous coverage options



Did you know that individuals who were enrolled in a group health insurance plan may continue coverage with designated Individual plans through Independence Blue Cross (IBC)? This includes coverage for preexisting conditions. IBC provides this coverage for its members in accordance with the requirements of the Health Insurance Portability and Accountability Act (HIPAA).*

How do I know if I qualify?

- You were enrolled in a health plan for the past 18 months.
- Your most recent coverage was group coverage.
- You have exhausted COBRA benefits (if COBRA was available to you).
- You apply for continuous coverage within 63 days of the termination date from your group plan.
- You no longer qualify for any other group health coverage, Medicare or Medicaid, or coverage under a spouse's policy and have exhausted all other alternatives (e.g., COBRA).
- You are not enrolled in individual (non-group) or other health insurance coverage.
- You are not eligible if your most recent coverage was terminated because of nonpayment of premium or fraud.

In order to apply, you must provide proof of prior coverage through any of the following three options:

- Submit with the IBC application a copy of a *Certificate of Coverage* supplied by the previous insurer or employer (often these certificates are called *Certificates of Creditable Coverage*);
- Submit with the IBC application a *Certification of Group Health Plan Coverage* form and alternative documentation of previous group coverage, such as explanations of benefits or other correspondence from a plan or issuer indicating coverage; pay stubs showing a payroll deduction for health coverage; a health insurance identification card; records from medical care providers indicating health coverage; third-party statements verifying periods of coverage; and any other relevant documents that prove periods of group health coverage;
- Call IBC Customer Service at 1-800-ASK-BLUE (1-800-275-2583) for a copy of the *Certification of Group Health Plan Coverage* form or to discuss how best to provide non-documentary evidence of creditable coverage, such as verifying enrollment by calling the former employer or prior insurer that provided group coverage.

Please note that unlike most insurance plans under which a dependent may be covered only if a parent is covered, a dependent may be covered in these plans even if the parent does not enroll in this coverage, as long as the dependent meets the above qualifications.

These health plans don't change coverage for preexisting conditions.

*Applies to individuals who reside in Bucks, Chester, Delaware, Montgomery, and Philadelphia counties.

Individual Personal Choice[®] benefits at a glance

	Basic II		HospitalCare I	
Benefits per calendar year	You pay in-network	You pay out-of-network ¹	You pay in-network	You pay out-of-network ¹
Deductible, individual/family	\$1,000/\$2,000	\$5,000/\$10,000	None	\$5,000/\$10,000
Out-of-pocket maximum, individual/family ²	\$4,500/\$9,000	\$10,000/\$20,000	\$3,000/\$6,000	\$10,000/\$20,000
Lifetime maximum	Unlimited	Unlimited	Unlimited	Unlimited

Preventive services

Preventive care for adults and children	\$0, no deductible	50%, no deductible	\$0	50%, after deductible
Mammogram				
Routine gynecological exam/Pap test (1 per calendar year)				
Pediatric immunizations		50%, no deductible		
Nutrition counseling (6 visits per benefit period ³)		50%, after deductible		

Physician services

Primary care office visit	\$35 copayment, no deductible	50%, after deductible	\$40 copayment ⁶	50%, after deductible ⁶
Specialist office visit	\$60 copayment, no deductible		\$75 copayment ⁶	50%, after deductible ⁶
Spinal manipulations (20 visits per calendar year ³)	\$50 copayment, no deductible		Not covered	
Physical/occupational therapy (20 visits per calendar year ³)	\$50 copayment, no deductible		40%	50%, after deductible

Hospital/other medical services

Inpatient hospital services/days ⁵	20%, after deductible/unlimited days	50%, after deductible/70 days	\$1,000 per admission/unlimited days	50%, after deductible/70 days
Emergency room (not waived if admitted)	20%, after deductible	20%, after in-network deductible	\$150	\$150, no deductible
Maternity hospitalization ⁵		50%, after deductible	\$1,000 per admission	50%, after deductible
Outpatient surgery		20%, after deductible	\$150 copayment (facility)	\$0, after deductible
Ambulance (emergency)		20%, after deductible	\$0	50%, after deductible
Outpatient lab/pathology		50%, after deductible	20%	
Routine radiology/diagnostic				
MRI/MRA, CT/CTA scan, PET scan ⁵				
Durable medical equipment	20%, after deductible ⁵	50%, after deductible ⁵	20%, up to 30 days rental per calendar year ³	50%, after deductible, up to 30 days rental per calendar year ³
Outpatient mental health care ⁵	20%, after deductible/30 visits per calendar year ³	50%, after deductible/20 visits per calendar year max ³	Not covered	
Inpatient mental health care ⁵	20%, after deductible/30 days per calendar year ³	50%, after deductible/20 days per calendar year max ³	\$1,000 copayment per admission ⁴	50%, after deductible ⁴
Substance abuse treatment				
Detox ⁵	20%, after deductible, 7 days per admission/4 admissions lifetime maximum ³	50%, after deductible, 7 days per admission/4 admissions lifetime maximum ³	\$1,000 copayment per admission ⁴	50%, after deductible ⁴
Rehabilitation ⁵	20%, after deductible, 30 days per benefit period/90 days lifetime maximum ³	50%, after deductible, 30 days per benefit period/90 days lifetime maximum ³		
Outpatient ⁵	20%, after deductible, 60 visits per year/120 visits lifetime maximum ³	50%, after deductible, 60 visits per year/120 visits lifetime maximum ³	Not covered	
Prescription drug	No deductible: \$10 generic/50% brand, \$250 copay max per prescription	50%, no deductible		

Questions? Call us at 1-800-ASK-BLUE (1-800-275-2583).

Basic II and HospitalCare I rates

Below are monthly premium rates for Personal Choice Basic II and HospitalCare I plans. Rates are based on the age of the oldest family member covered under the policy.*

To determine your new rate, find the age category of the oldest member covered under the policy, select the plan you would like, and locate the rate that corresponds with your current coverage type (Individual, Individual and child, etc.).

	Basic II	HospitalCare I
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Age 18 to 29

Individual	\$240.46	\$164.90
Individual and spouse	\$480.93	\$329.80
Individual and child	\$360.69	\$247.35
Individual and children	\$480.93	\$329.80
Family	\$721.39	\$494.70

Age 30 to 39

Individual	\$328.97	\$202.47
Individual and spouse	\$657.93	\$404.94
Individual and child	\$449.20	\$284.92
Individual and children	\$569.43	\$367.37
Family	\$898.39	\$569.84

Age 40 to 49

Individual	\$416.57	\$263.15
Individual and spouse	\$833.13	\$526.30
Individual and child	\$536.80	\$345.60
Individual and children	\$657.03	\$428.05
Family	\$1,073.60	\$691.20

Age 50 to 59

Individual	\$580.16	\$364.30
Individual and spouse	\$1,160.31	\$728.61
Individual and child	\$700.39	\$446.75
Individual and children	\$820.62	\$529.20
Family	\$1,400.78	\$893.51

Age 60 and over

Individual	\$722.29	\$466.17
Individual and spouse	\$1,444.58	\$932.34
Individual and child	\$842.52	\$548.62
Individual and children	\$962.75	\$631.07
Family	\$1,685.05	\$1,097.24

* Rates effective March 1, 2011

Benefits and rates are subject to change upon the approval by the Pennsylvania Insurance Department.

What's not covered?

- services not medically necessary;
- services or supplies that are experimental or investigative, except routine costs associated with clinical trials;
- hearing aids, hearing examinations/tests for the prescription/fitting of hearing aids, and cochlear electromagnetic hearing devices;
- assisted fertilization techniques such as in vitro fertilization, GIFT, and ZIFT;
- alternative therapies/complementary medicine;
- dental care, including dental implants, and nonsurgical treatment of temporomandibular joint syndrome (TMJ);
- routine foot care, unless medically necessary or associated with the treatment of diabetes;
- foot orthotics, except for orthotics and podiatric appliances required for the prevention of complications associated with diabetes;
- contraceptive devices;
- immunizations for travel or employment;
- service or supplies payable under workers' compensation, motor vehicle insurance, Medicare, or other legislation of similar purpose;
- cosmetic services/supplies;
- self-injectable drugs (except as specified under the prescription drug benefits);
- prescription medications (HospitalCare I only);
- vision care.

¹ It is important to note that all percentages are percentages of the plan allowance, not the provider's actual charge. Non-preferred providers may bill you for differences between the plan allowance, which is the amount paid by Personal Choice, and the provider's actual charge. This amount may be significant. Claims payments for non-preferred professional providers (physicians) are based on the lesser of the Medicare Professional Allowable Payment or the provider's actual charge. For covered services that are not recognized or reimbursed by Medicare, the payment is based on the lesser of IBC's applicable proprietary fee schedule or the provider's charges. For covered services not recognized or reimbursed by Medicare or IBC's fee schedule, payment is 50 percent of the provider's charges. For services rendered by hospitals and other facility providers, the allowance may not refer to the actual amount paid by Personal Choice to the provider. Under IBC contracts with hospitals and other facility providers, IBC pays using bulk purchasing arrangements that save money at the end of the year but do not produce a uniform discount for each individual claim. Therefore, the amount paid by IBC at the time of any given claim may be more or it may be less than the amount used to calculate your liability.

² Out-of-pocket maximum includes coinsurance and deductible. The dollar amount specified does not include any expense incurred for copays, penalties or outpatient mental/psychiatric/serious mental illness care services for Basic II.

³ Combined in- and out-of-network.

⁴ Up to 30 days per calendar year combined in- and out-of-network for mental health and substance abuse care.

⁵ Some benefits require precertification. If you use an out-of-network provider and do not obtain a precertification, the penalty is a 50% reduction in benefit.

⁶ Limited to three per year for specialist and primary care physician visits, combined in- and out-of-network.

This summary represents only a partial listing of benefits and exclusions of the Personal Choice program. These managed care plans may not cover all of your health care expenses. Read your contract, member handbook, and/or benefit booklet carefully to determine which health care services are covered. If you need more information, please call 1-800-ASK-BLUE (1-800-275-2583).



We're here for you every step of the way.

www.ibx.com

Personal Choice PPO products are underwritten and administered by QCC Insurance Company, a subsidiary of Independence Blue Cross — independent licensees of the Blue Cross and Blue Shield Association.