**Frequently Asked Questions**

<u>**Health Insurance Basics**</u>

**Q: What is an HMO?**

A: In an **HMO**, you choose a family doctor, called a **primary care physician (PCP)**, who provides the services you need. Your **PCP** refers you to other doctors or health care providers within the HMO network when you need specialized care. Typically, only emergency services are covered if you go outside of the plan **network**. **HMOs** usually have the lowest **premiums**.

**Q: What is an EPO?**

A: An EPO has no out-of network benefits, except in the case of an emergency situation. An **EPO** is an Exclusive Provider Organization. An **EPO** does not require referrals or the selection of a PCP. EPO members are free to receive benefi ts anywhere In-Network without a referral. An **EPO** plan only has In-Network benefi ts.

**Q: What is a premium?**

A: The fee you pay to your insurance company each month to pay your share of your health plan's costs. This is separate from the deductible, copayments, and coinsurance amounts you pay when you use your benefits to receive covered services.

**Q: What is Copayment (Copay)**

A: The fee you pay when you see a doctor or get other services.

**Q: What is coinsurance?**

A: The percentage you pay for some covered services. If your coinsurance is 20 percent, your health insurance company will pay 80 percent of the cost of covered services, and you will pay the remaining 20 percent.

**Q: What are out-of-pocket costs?**

A: The amount you pay for your health care services. The health care law sets a limit on your out-of-pocket costs, called an out-of-pocket maximum. Once you pay this amount, your health plan will pay 100 percent of the additional covered services you receive.

**Q: What is a primary care physician (PCP)?**

A: The doctor you see for most of your health care needs. HMO plans require you to choose a PCP, who will refer you to a specialist when needed. PPOs do not require that you choose a primary care physician.

**Q: Can I change my primary care physician (PCP) after I have chosen one?**
A: Yes. Once you are a member, it's easy to change your PCP. Simply login to AmeriHealthexpress.com to make the change, or call 1-888-968-7241. PCP changes become effective on the first day of the following month.

**Q: What is a specialist?**
A: A specialist provides medical care for certain conditions in addition to the treatment provided by your primary care physician (PCP). For example, you may need to see an allergist for allergies or an orthopedic surgeon for a knee injury. Under an HMO plan, you need to obtain a referral from your PCP to receive benefits for care provided by a specialist. Under our EPO plans, you never need a referral to see a specialist who participates in our EPO Network.

**Q: What is a referral?**
A: If you have an HMO, (or other plan that requires a referral) your family doctor (or PCP) will provide one before you see other network providers, such as a dermatologist. Our referrals are completed electronically.

**Q: What does precertification mean?**
A: This may also be called pre-approval or prior authorization. Basically, you may need additional approval from your health plan before you receive certain tests, procedures, or medications. It's a way to make sure the services you're getting are safe and effective.

**Q: What is durable medical equipment?**
A: Durable medical equipment includes, but is not limited to, the following: hospital beds, crutches, canes, wheelchairs, walkers, peripheral circulatory aids, cervical collars, traction equipment, physiotherapy equipment, oxygen equipment, and ostomy supplies. You should always check with both your provider and AmeriHealth New Jersey to determine whether an item is considered to be durable medical equipment.

**Q: What does in network mean?**
A: Your health care coverage is considered in network when you use a provider who participates in our network.

**Q: What does out of network mean?**
A: Your health care coverage is considered out of network when you visit a doctor or hospital that does not participate in one of our Provider networks. With an HMO plan, you only have coverage for in-network providers, while POS+ plans allow you the freedom to see both in- and out-of-network providers.

**Q: What is an Urgent Care center?**
A: Urgent care centers are stand-alone clinics where board-certified doctors treat illness or injury requiring immediate medical attention. You can use these centers when your doctor is not available immediately and your illness or injury is not life threatening, such as a cut requiring stitches or continual nausea. Care in an urgent care center will cost you less than the same care in a hospital emergency room. For conditions that feel life threatening, such as severe shortness of breath or chest pain, sudden or unexplained loss of consciousness, severe abdominal pain, or a cut or wound that won't stop bleeding, seek the care of the closest emergency room.

**Q: What is a Retail Clinic?**

A: retail clinic is a space within a pharmacy or other retail store that is staffed by nurse practitioners. You can use these clinics when your doctor is not available and your injury or illness is minor, such as a sore throat, earache, or skin rash. Care at a retail clinic will cost you less than the same care in a hospital emergency room.

**Q. What is an HSA account?**
A. A health savings account, or HSA, helps you save money for health expenses, tax-free. You don't pay taxes on the money you put in, the money you take out, or any money you earn on the account. The IRS determines what qualifies as a health expense, which includes your out-of-pocket costs (copays, deductibles, coinsurance), along with some services not covered by a health plan, such as Lasik surgery.

**Q. What is a deductible?**
A. A deductible is the amount you pay before your health plan starts paying for covered services.

**Q. How can I find a doctor?**
A. The Provider Finder tool allows you to search for doctors within the AmeriHealth New Jersey networks.

**Q. Is my current doctor in network?**
A. When you search for a doctor, you will need to select the plan network. You will then be able to see which doctors are in and out of network for that plan.

**Q. Can I choose any doctor?**
A. If you have an HMO plan, you are only covered for doctors and hospitals within the HMO network. With a POS+ plan, you are covered for doctors and hospitals both in and out of network. If the doctor or hospital you choose is out of network, you may have higher out of pocket costs for your health service.

## Covered Benefits

**Q. What services do all plans cover?**
A. In 2014, all **health plans** offered to people who purchase their own health insurance and small businesses (2-50 employees) must include a core set of **essential health benefits**. There are no annual lifetime limits on the amount your **health plan** spends on these core services for you and your family. **Essential health benefits** include these ten categories of services:

| Essential health benefits | Example |
|---|---|
| Preventive, wellness and disease management services | Physical, fl u shot, gynecological exam, birth control |
| Emergency care | Treatment for broken bones, heart attacks and more at a hospital emergency room |
| Ambulatory services | Minor surgeries, blood tests, X-rays |
| Hospitalization | Treatment at a hospital for a condition that requires you to stay overnight or multiple days |
| Maternity and newborn services | Care through the course of a pregnancy, delivery of the baby and checkups after the baby is born |
| Pediatric services, including dental and vision | Well visits, shots to prevent serious health conditions, teeth cleanings, braces, exams, glasses and contact lenses |
| Prescription drugs | High blood pressure medicine, insulin, antibiotics, birth control pills |
| Laboratory services | Blood test |
| Mental health and substance abuse services, including behavioral health treatment | Getting help to deal with conditions like depression, alcohol abuse, and drug abuse |
| Rehabilitation and habilitation services | Physical therapy, speech therapy, occupational therapy |

**Q. What do the metallic tiers mean?**

A. The federal government created four levels of coverage, or metallic tiers, as a way to help you compare health plans across companies. All plans will include a core set of essential health benefits, but will have differences in the monthly cost of the plan and how much of the cost the health insurance company will cover for health care services. The metallic tiers are: platinum, gold, silver, and bronze. Platinum plans will have the highest monthly cost and lowest cost when you receive care, while the bronze plans will have the lowest monthly costs and highest cost when you receive care. Determining the plan that is the best value for you will depend on the type and amount of health care services you expect to use over the course of the plan year.

With the new **health care law**, the federal government created four levels of coverage or **metallic tiers** for plans offered to small businesses (2-50 employees) and people that purchase their own insurance. Plans will be assigned one of these **metallic tiers** based on how much of the cost for health care services is covered by the health insurance company. These "metal" categories — bronze, silver, gold and platinum — will make it easier for you to compare health plans among **health insurance companies**. All products will cover essential health benefits like doctor visits, prescription drugs, X-rays, and hospital stays. The major differences will be in what you pay when you need these services and the monthly cost of the health plan.

How the metal tiers compare on costs:

| | Platinum | Gold | Silver | Bronze |
|---|---|---|---|---|
| Monthly Cost | $$$$ | $$$ | $$ | $ |
| Cost When You Get Care | $ | $$ | $$$ | $$$$ |
| Good Option If You… | plan to use a lot of health care services | want to save on monthly premiums while keeping your out-of-pocket costs low | need to balance your monthly premium with your out-of-pocket costs | don't plan to need a lot of health care services |

**Q. What is a tiered network?**

A: If you haven't heard of a tiered network plan, that's because it's relatively new to New Jersey. It works just like a typical EPO, in that you can visit any doctors and hospitals in the network, and you select a primary care physician who refers to you specialists. You can save on your out-of-pockets costs when you visit certain health care providers.

Members can pay the lowest out of pocket expenses by using Tier 1 facilities and professional providers.

Members also have the option of paying higher out of pocket costs by using Tier 2 providers which consists of AmeriHealth New Jersey Value Network facilities and professional providers.

**Q: Is routine eye care covered?**
A: Routine eye care for children under age 19 is considered an essential health benefit and available with all plans. To learn more, refer to the Benefits at a Glance for each plan.

**Q: Are emergency services covered?**
A: Yes. You are covered for medically necessary services for unexpected illnesses or emergency care no matter where you are.

**Q: Is maternity covered?**
A: Maternity and newborn services are considered an essential health benefit and are covered by all plans.

**Q: Is mental health covered?**
A: Mental health and substance abuse services, including behavioral health treatment, is considered an essential health benefit and available with all plans.

## Prescription Drugs

**Q: Are prescription drugs covered?**
A: Yes, prescription drugs are covered for all of the individual plans. Please refer to your plan details for more information.

**Q: How does my prescription drug benefit work?**
A: The prescription drug program is administered by FutureScripts®, an independent pharmacy benefits management company. The FutureScripts network includes more than 50,000 retail pharmacies, including most national and regional chain pharmacies and many neighborhood pharmacies.

Each time you go to a participating pharmacy to fill a prescription, simply present your ID card. How you will be charged will depend on your plan type.

- *Copay plans* – You pay either the copay or coinsurance specified for the generic formulary, brand formulary, or non-formulary brand drug you have been prescribed. If your plan has a maximum copay amount, that means that AmeriHealth New Jersey will cover any expenses beyond that amount for a particular prescription, and you only need to pay that maximum copay amount.
- *HSA plans* – These plans have a prescription deductible that is integrated with the medical deductible. This means that you pay for prescriptions in full until your medical deductible has been reached. Once the deductible has been met, you are either covered 100% or you pay the copay specified for generic formulary, brand formulary, or non-formulary brand drugs from in-network pharmacies.
- *NOTE: The metal tier of your health plan will also impact your prescription costs*

**Q: Is there a maximum prescription drug benefit?**
A: No. In accordance with health care reform provisions effective October 1, 2010, all of our plans have unlimited prescription drug benefits.

**Q: What is the difference between generic and brand medications?**
A: A generic drug is an equivalent version of a brand drug with the same active chemical ingredients and equivalency in strength. A brand drug has a patented marketing name.

**Q: Do my benefits include mail-order service?**
A: Yes, as long as you use a participating pharmacy in-network. You can receive a 90-day supply of maintenance medications for two applicable copayments (generic/brand/non-formulary) through the mail-order service. (Typically, this represents a savings of one copayment.) To get started with mail-order service, login to AmeriHealthexpress.com.

**Q: Are birth control pills covered under my plan?**
A: Yes. Birth control pills (oral contraceptives) and injectable contraceptives are examples of preventive, wellness and disease management services under the list of essential health benefits and covered 100 percent by all plans.

**Q: What is a formulary?**
A: The formulary is a list of medications that have been selected for their medical effectiveness, positive results, and value. The formulary includes all generic medications and a defined list of brand medications. You maximize your benefits when you purchase formulary medications.

**Q: How many pharmacies are available in the FutureScripts Preferred Pharmacy Network?**
A: With this preferred network, members will continue to have access to more than 50,000 pharmacies, including CVS, Wal-Mart, and Target, in addition to independent pharmacies.

**Q: Are low-cost generics available?**
A: Yes, many of our health plans feature a low member cost share for certain designated prescription drugs at participating retail and mail order pharmacies. Generic drugs are as safe and effective as brand name drugs and they cost less.

**Q: Does the prescription plan cover non-formulary medications?**
A: Yes. You have access to non-formulary medications; however, you pay less when you select formulary medications. You maximize cost savings when selecting a generic drug.

## HSA Plans

**Q: What is a health savings account (HSA)?**
A: An HSA is a tax-advantaged savings account that can be used to save for health care expenses. You must be enrolled in an HSA-qualified high-deductible health plan to be eligible to open an HSA. There is a maximum amount that you can contribute to an HSA each year, but if you don't use all of the money within your benefit period, it rolls over to the next year.

**Q: What is a high-deductible health plan (HDHP)?**
A: An HDHP is a health insurance plan with a minimum deductible of $1,250* (for self-only coverage) or $2,500* (for family coverage). The annual out-of-pocket cost (including deductibles and copays) cannot exceed $6,350* (for self-only coverage) or $12,700* (for family coverage). HDHPs have first-dollar coverage or no deductible for preventive care and higher out-of-pocket cost (copays and coinsurance) for non-network services.

*These amounts are indexed annually for inflation.

**Q: What are the benefits of an HSA?**
A: An HSA provides several benefits including:

- tax-free interest or other earnings on your assets;
- a tax deduction for the contributions you make (You are eligible for a deduction even if you don’t itemize your tax deductions on Internal Revenue Service [IRS] Form 1040.);
- ability to build funds for your medical care needs (contributions remain in your HSA from year to year until you use them).

**Q: Which bank should I use to set up a health savings account (HSA)?**
A: You can use our preferred vendor, Bancorp, to set up an HSA or you can pick any bank you like.

**Q: If I open an HSA, are there any limits on the amount I can contribute to it?**
A: Yes, there are limits on the amount that you may contribute to an HSA. These limits are set by the federal government and are generally updated each year to account for inflation.

For 2014, HSA contribution limits are:

- $3,300 for individual coverage;
- $6,550 for family coverage;
- $1,000 in additional catch-up contributions for individuals between ages 55 to 65.

The contribution limits include all contributions made on behalf of the individual (including contributions made by an employee, an employer, a self-employed person, or a family member).

If you have more than one HSA, the annual contribution limit applies to the total of all HSAs. You can decide how to contribute to your HSA (one time or multiple times throughout the year) as long as you don't exceed the maximum allowable annual contribution.

## Applying

**Q: How do I apply for coverage?**
A: You can apply online or you can request an application kit be mailed to you. Applying online is simple and secure. In addition, online applications are processed more quickly and you can check the status of your application at any time.

**Q: Can I apply for health coverage for my family?**
A: Yes. You can apply for health coverage as a(n):

- individual;
- individual and spouse;
- individual and child(ren);
- family.

**Q: Can I add my spouse or child at a later date?**
A: Yes. You can apply to add a spouse or child at a later date if you experience a significant life event, such as marriage, birth or adoption of a child, or change in employment.

**Q: Can I add my Civil Union partner to my health plan?**
A: Yes.

**Q: Can I add my fiancée to my health plan?**
A: No. Your fiancée can apply individually for coverage. Once you are married, you can request that your spouse be added to your existing coverage.

**Q: Can I apply for multiple plans?**
A: No. You must select one plan when you apply for an individual health plan.

**Q: Who should I contact if I have questions about how to fill out an application?**
A: Please call 1-888-879-5331 between 8 a.m. and 8 p.m. or email us your question or comment.

**Q: How long will it take to apply and enroll in a health plan?**
A. On average it takes between 20 – 30 minutes to apply and enroll for a health plan depending on your family's needs.

**Q. Do I need to give my Social Security number?**
A. Yes. We need your Social Security number to verify your identity. Our site uses the latest security methods to protect the information you give us.

**Q. What if I don't have an email address?**
A. There are many free email services where you can register for an email account. Some examples are Gmail and Yahoo Mail. If you prefer not to create an email address, paper applications are available by request. You can request a hard copy application by calling 1-888-968-7241 or our secure web-based form.

**Q. What happens if I don't purchase health insurance?**
A. Unless you meet certain requirements, you will pay a penalty to the government if you do not have a health plan. The greater of these amounts will be charged for the years listed:

- 2014 penalty: $95 or 1% of your taxable income
- 2015 penalty: $325 or 2% of your taxable income
- 2016 penalty: $695 or 2.5% of your taxable income

You may be able to avoid the penalty if you are facing serious financial problems, have certain religious beliefs, or meet other rules. To get more information, visit healthcare.gov.

**Q. When do I need to purchase health insurance?**
A. The new health care law requires that you have health insurance beginning January 1, 2014. You may begin shopping for plans on October 1, 2013 through March 31, 2014. However, in order to have coverage that begins January 1, 2014, you will need to purchase your plan by December 15, 2013. If you experience a life event change, you will be able to apply for a plan after March 31, 2014. Life event changes can include the birth of a baby, moving to a different state, losing your employer insurance, or becoming eligible for different products due to income changes.

**Q. Is financial help available for purchasing health plans?**
A. The government will be providing advance tax credits, or subsidies, to help people who purchase their own insurance, including working families. The subsidies will be based on how much money you make each year, the number of people in your family, and the age of the people in your family. If you qualify, you may be able to get one of the following:

- free health insurance through Medical Assistance, also known as Medicaid;
- lower monthly premium costs plus a break on the cost-sharing you pay each time you need medical care;
- lower monthly premium costs.

The chart below shows guidelines for subsidy eligibility. If your yearly income is at or below the threshold shown below, then you may qualify for a subsidy. The enrollment process will include checking whether you are eligible.

| Family Size | Yearly Income Threshold |
|---:|---:|
| 1 | $45,960 |
| 2 | $62,040 |
| 3 | $78,120 |
| 4 | $94,200 |
| 5 | $110,280 |
| 6 | $126,360 |
| 7 | $142,440 |
| 8 | $158,520 |

## Premiums

**Q: What are my payment options?**
A: If you apply online, you have the option to pay monthly using electronic payments, credit/debit card payment (1st payment only – Visa or MasterCard) form or you can select the "Bill Me" option to pay by check at a later date. If submitting a paper application, you can include a check for the first month's premium, complete the credit/debit card payment (1st payment only – Visa or MasterCard) form or complete the Electronic Payments form to authorize monthly electronic payments.

**Q: Will my actual rate be different from my rate quote?**
A: All of the rates provided on our website are final rates. If you navigate from our site to the Health Insurance Marketplace to register for and are approved for a subsidy, your subsidy amount will be provided by the government to AmeriHealth New Jersey and will be reflected in your quoted rates.

**Q: How long are the rates valid?**
A: Rates are valid for one year and will be updated annually on January 1.

**Q: How do electronic payments through ACH work?**
A: With electronic payments, you authorize your monthly payment to be automatically withdrawn from your account. It's a worry-free way to help ensure you won't miss a payment and risk losing your health insurance coverage. You don't have to write and send checks. With electronic payment, your premium is taken care of even when you're away on business or vacation.

**Q: When will the initial payment come out of my account?**
A: Credit and debit card payments are processed for approval at time of purchase. Payment by automatic checking may take several days to complete. Generally, the initial payment will come out of the customer's account within 1-3 business days (which is typical bank processing time). Any payment that fails to clear due to insufficient funds could impact your coverage effective date.

## Online Application Process

**Q: Who do I contact for technical questions about using ahnj4u.com?**
A: Please call 888-879-5331 between 8:00 a.m. and 8:00 p.m. Or, email us your question or comments.