

**The New Jersey
Individual Health Coverage Program**

Buyer's Guide

How to Select a Health Plan

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INTRODUCTION

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

Since 1993, 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.

This Buyer's Guide provides general information on individual health benefits plans and is designed to help you shop for the plan that best meets your needs. Before you decide what plan to purchase, you will also want to review a list of participating carriers, their current rates and their telephone numbers and other contact information. (Carrier contact information is included under the **Additional Resources section** of this Buyer's Guide.) You should get more information about the healthcare providers that participate in a carrier's network(s). And keep in mind that the contract provisions of the plan actually purchased will govern the terms and conditions of coverage, so it is important to become familiar with the contract terms of the plan you buy.

Individual plans may be purchased from a variety of carriers. Currently, all of the individual plans offered are managed care plans (referred to as a Health Maintenance Organization (HMO) or an Exclusive Provider Organization (EPO) plan). These plan options are explained in detail in this Buyer's Guide.

This Buyer's Guide provides information about the Individual Health Coverage Program and individual plans offered as of January 1, 2019.

You can learn more about the New Jersey IHC Program online at: www.dobi.nj.gov/ihc

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 compare rates. 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 carriers' materials and select the carrier and individual plan that best meets your needs.
4. If you are buying a plan through the Marketplace, you will need to set up an account and apply through healthcare.gov or by calling 1-800-318-2596. You will receive a premium invoice from the carrier you selected.
5. If you are buying a plan off the marketplace, you will need to 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. Send 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.

Whether you buy through the Marketplace or off the Marketplace, 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 payments 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.

A few notes:

- ❖ A **Rate Comparison Chart** showing the plans available by carrier, and the base rates are available online. Use the premium calculator to see the rates for your age. See the **Additional Resources section** for the link to the website.
- ❖ Coverage applied for by December 15 during the Annual 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.
- ❖ You cannot be covered under two individual plans at the same time. If you decide to change your individual coverage, and you purchase coverage from another carrier, the carrier that issued your old plan must be notified that you want to terminate the old plan. If the carrier that issued the old plan is notified within 30 days after the new coverage takes effect, the carrier will retroactively terminate the old plan 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 you must terminate the current group coverage no later than the day before the individual plan will take effect.

ELIGIBILITY

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

1. A resident of New Jersey; and
2. Not entitled to coverage under Medicare

Residency:

A New Jersey resident is defined as **someone whose primary residence is in New Jersey**. 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.

If you choose to purchase HMO coverage, in addition to meeting the New Jersey residency requirement, **all** covered persons must ALSO reside in that HMO's service area.

You must provide **proof** that you are a resident of New Jersey. The proof often takes the form of a utility bill, a bank account, a NJ driver's license or a student ID. A letter addressed to you at a NJ address is not proof of residence.

Medicare:

You are not eligible to purchase an individual plan if you are already covered under Medicare, regardless of whether you have Parts A and B or only have Part A of Medicare. Thus, if you are age 65 and eligible for Medicare, but do not sign up for Medicare, you are not covered for Medicare, so you are eligible to purchase an individual plan. If you are eligible for Medicare and thinking of buying an individual policy instead of enrolling for Medicare, there are two important facts you should consider.

1. The individual plan will “coordinate benefits” with Medicare. The individual plan will be the secondary payor even though you do not have coverage under Medicare. For example, for a physician bill of \$1000, assuming Medicare allows the full, \$1,000 charge; Medicare Part B would pay \$800. The individual policy will consider the \$800 benefit Medicare would have paid and only pay benefits based on the \$200 difference. In other words, you will be out of pocket whatever Medicare would have paid for your services.
2. If you are eligible for Medicare but do not enroll when you are first eligible, when you later enroll for Medicare your monthly cost will be increased because you enrolled after you were first eligible.

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 the secondary payor whether or not you enroll in Medicare. In other words, the individual plan always pays assuming Medicare pays 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.

If you are Medicare-eligible, and need help:

- ✓ Contact your County Office on Aging
- ✓ Contact New Jersey’s Division of Aging and Community Services at 1-800-792-8820 or go to the **Additional Resources section** to find the link to their website
- ✓ Go to the federal Medicare website (see the **Additional Resources section** for the link)

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.

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

Individual health coverage may also cover your eligible dependents. Dependent is defined to mean your:

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

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 New Jersey law at 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.

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 purposes of adoption),
3. Your step-child,
4. Your foster child,
5. The child of your domestic partner or civil union partner,
6. Children under a court-appointed guardianship,
7. 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; (If you buy an individual policy through the Marketplace the children listed in this item 7 are not eligible.)and
8. 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 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.

A couple of notes:

- Children older than 26 years old → → → →
- Business owners →→

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.

If you are an **employer** with at least one employee (owners, partners, proprietors and their spouses do not count as employees), you may be eligible for group coverage. If you would like information on Small Employer Health Benefits Plans, visit the website at www.dobi.nj.gov/seh.

Frequently Asked Questions about Eligibility and Dependent Eligibility

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. 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.
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.
I just moved to New Jersey; may I purchase an individual plan?	Yes, if you relocate to New Jersey with the intention of making New Jersey your primary residence, and meet all other eligibility requirements, you may purchase individual coverage. The move to New Jersey is a triggering event which means you may be eligible for a Special Enrollment Period.
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 or another 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.
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 not 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.
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.
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. If you continue through a Dependent Under 31 election you can later purchase an individual plan during the Annual Open Enrollment Period or during a Special Enrollment Period, if any applies.
May I purchase an individual plan if I actually have group coverage?	Yes. Just remember, you cannot be covered under both an individual and group plan. You must terminate your coverage under the group plan no later than the day before the individual plan will take effect. See the section on Enrollment for information concerning when you may purchase an individual plan

<p>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?</p>	<p>No, there are no "short-term" plans available in New Jersey. However, your son still has options:</p> <ul style="list-style-type: none"> • 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). See the Additional Resources section to find access to more information.
<p>If I cover my children under my individual plan, up to what age will they be covered?</p>	<p>Typically, you may cover your child until the end of the month following 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.</p>
<p>Can I purchase coverage for a child or children only?</p>	<p>Yes. The plans available to cover an individual adult or family can also be purchased to cover a child or children without any adult covered under the policy. All plans have a child rate applicable to children under the age of 21. To compare the child rates of all of the plans, see the rate comparison chart.</p> <p>Or you may want to explore whether your children are eligible for NJFamilyCare, which covers children in families with incomes up to 350% of the federal poverty level. For more information about NJFamilyCare, call 1-800-701-0710 or go online to www.njfamilycare.org.</p>
<p>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?</p>	<p>Yes, but only if your individual plan was not purchased through the Marketplace. 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.</p> <p>If you bought your individual plan through the marketplace your grandchildren are not eligible dependents unless you have legal guardianship.</p>

If I waive coverage under Medicare, may I purchase an individual plan?

Yes, but this may not be a wise choice. If you are eligible for Medicare and thinking of buying an individual policy instead of enrolling for Medicare, there are two important facts you should consider.

1. The individual plan will “coordinate benefits” with Medicare. The individual plan will be the secondary payor even though you do not have coverage under Medicare. For example, for a physician bill of \$1000, assuming Medicare allows the full, \$1,000 charge; Medicare Part B would pay \$800. The individual policy will consider the \$800 benefit Medicare would have paid and only pay benefits based on the \$200 difference. In other words, you will be out of pocket whatever Medicare would have paid for your services.
2. If you are eligible for Medicare but do not enroll when you are first eligible, when you later enroll for Medicare your monthly cost will be increased because you enrolled after you were first eligible.

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 web site (see the **Additional Resources section** for the link)
- going to the federal Medicare website (see the **Additional Resources section** for the link)

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. See the section on Enrollment for information concerning when you may purchase an individual plan. Once you purchase an individual plan, you will have to terminate your group health coverage elected under COBRA or New Jersey Small Group continuation.

ENROLLMENT

There are limited times when you can enroll in an individual plan.

Annual Open Enrollment Period

Everyone can apply for, or change plans, once every year

During the Annual Open Enrollment Period, people can buy individual insurance. It does not matter whether you are buying your very first individual plan, or replacing individual coverage that you already have. For 2019, the Annual Open Enrollment Period starts November 1, 2018 and continues through December 15, 2018. Coverage applied for between November 1 and December 15 of the Annual Open Enrollment Period will begin January 1 of the year following the Annual Open Enrollment Period. Applications must be **submitted** during the Annual Open Enrollment Period to be considered.

Special Enrollment Period

Personal events mean special enrollment When certain events happen in your life, you have the right to buy an individual policy or change your current coverage without waiting for the Annual Open Enrollment Period. These “triggering” events create 60-day Special Enrollment Periods. The 60-day period starts on the date of the triggering event, although when the triggering event is an involuntary loss of coverage the special enrollment period begins 60 days prior to the loss of coverage and continues during the 60 days following the loss of coverage. This gives you the chance to buy a replacement plan that will begin on the day after your prior plan ends.

Triggering Events

Generally, a triggering event is one that results in a change in your family, a change in your location, or one that results in a loss of minimum essential coverage for a family member. It can also include a change in your eligibility for coverage. It does NOT include a loss of minimum essential coverage because you failed to pay premiums, or misrepresented material facts, or committed fraud. If you lose coverage, contact the carrier that issued the coverage you lost to ask if the loss of coverage is considered to be a triggering event. When there is a change in your family, such as a birth or marriage, or if you move your primary residence, contact your current carrier and ask if the event entitles you to a special enrollment period.

Notice Required When Replacing Coverage

You cannot be covered under two individual plans. If you are replacing an individual plan, be sure to notify the carrier of the plan being replaced that the individual policy should be terminated as of the day before the new policy takes effect. So, if you are replacing coverage during an Annual Open Enrollment Period for a January 1 effective date, this means you should give notice no later than 30 days after January 1 that the old policy needs to be terminated as of midnight on December 31.

If you are buying an individual policy to replace group coverage, be sure to notify the group plan that you are waiving group coverage. You must waive group coverage as of the day before the new individual policy takes effect. So, if you are buying an individual policy to replace group coverage during the individual Annual Open Enrollment Period for a January 1 effective date, you must waive the group coverage as of December 31.

Frequently Asked Questions about Enrollment

If I decide not to buy coverage during the Annual Open Enrollment Period, can I buy coverage later?	No, if you do not purchase or renew coverage during the Annual Open Enrollment Period, you will not be able to buy coverage in the individual market until the next Annual Open Enrollment Period, unless you have a triggering event that creates a Special Enrollment Period for you.
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Does the Annual Open Enrollment Period apply to NJFamilyCare?	No. The Annual Open Enrollment Period applies to individual coverage offered by commercial health carriers. NJFamilyCare is a separate program, and someone who is possibly eligible for coverage through NJFamilyCare may apply to that program at any time throughout the year.
If I lose employer coverage, but can make a COBRA election, can I still buy an individual plan? What about a New Jersey Small Group continuation election, or a Dependent Under 31 election?	Yes, you can choose to buy an individual plan during the Special Enrollment Period triggered by the loss of the employer’s coverage, or make the continuation election. Please carefully review the continuation options available to you in terms of benefits and costs and compare them to individual coverage options; then select the option that best suits your needs. Once you make an election for COBRA, NJ continuation or an Under 31 election, your coverage under the group plan is in place. If you change your mind and want to apply for an individual plan, you will need to wait for the next Annual Open Enrollment Period, unless you qualify for another Special Enrollment Period.
If I buy a plan, and a few months later, decide I want to change it, can I make a change outside of the Annual Open Enrollment Period?	You can make changes only during the Annual Open Enrollment Period OR during a Special Enrollment Period. A Special Enrollment Period only occurs if there is a triggering event. Wanting to change a plan is not a triggering event. But if a triggering event is part of the reason you want to change your plan, then you have a Special Enrollment Period. For example, if you get married, you can change from covering just yourself to covering yourself and your spouse during the Special Enrollment Period, rather than waiting for the Annual Open Enrollment Period.

KEY FEATURES OF THE INDIVIDUAL HEALTH COVERAGE PROGRAM

When offering individual plans, a carrier:

- Must **issue** coverage to all eligible people without regard to anyone's past, existing or expected health conditions;
- Must **renew** coverage for all eligible people without regard to anyone's past, existing or expected health conditions;
- Must establish modified community rates for individual plans, which may include age.

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, your policy will be renewed provided you remain a resident of New Jersey, your premium is paid in a timely fashion and you do not commit fraud.

Note: The policy will **not** be renewed for anyone if the carrier files to withdraw the plan or withdraws from the individual market, or if the law precludes renewal of the 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 particular person. In addition, 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. Also, carriers do not rate based on gender or where someone lives in New Jersey.

However, carriers use age as a rating factor for individual plans. Carriers are required to use a child rate for ages 0 through 20 years old (the child rate is the same rate for each child ages 0 – 14, then increases each year from age 15 through age 20), and then incrementally increase rates every year from age 21 through 64. Each carrier must set its rates so that its highest rate is not more than 3 times its lowest adult rate for a specific individual plan. (This is referred to as a 3:1 rate band.)

Each person covered under a plan is rated individually, except that a family is not charged for more than three children under the age of 21, even if they cover more than three children under the age of 21. So, if a family has two adults (one being 45 years old and the other being 42 years old) and *four* children under the age of 21, to determine the monthly cost of a plan to cover the entire family, the family would add the monthly premium for each adult and add the child premium, appropriate to age, for *three* children to get the total for the family's monthly premium, as follows:

45 year old premium + 42 year old premium + child premium + child premium + child premium = family premium.

The New Jersey Individual Health Coverage program publishes the monthly premium rates for selected ages for all of the individual plans offered in New Jersey in a rate comparison chart. There is also a calculator available to help people find the premium for ages not included on the chart. See the Additional Resources section to find the links to the chart and calculator online.

To find out if you might qualify for a subsidy to assist you with purchasing an individual policy, visit www.healthcare.gov.

Frequently Asked Questions about IHC Plan Features and Rates

If I purchase an individual plan with an effective date of March 1 and I get sick or am injured on March 3, would I be covered for treatment of the sickness or injury?	Yes. The individual plans provide coverage from day one for all conditions that are covered under the policy. Coverage will be subject to the applicable deductible, copayment and/or coinsurance under the plan.
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. Carriers decide whether to terminate coverage as of the date through which premiums have been paid (April 30 for this example), or as of the end of the grace period (May 31 in this example). If a carrier terminates coverage as of the date the grace period ends, and 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. But note that if you buy a plan through the marketplace and receive a subsidy the grace period is 90 days. However, if you need to use this 90-day grace period, it is important to understand

	that claims for days 31 – 90 are held in suspense until you pay all premiums due for the 90-day grace period.
Why do rates for plans that look the same vary from carrier to carrier?	The various plans have different cost-sharing requirements and use different networks that may have tiers. Each carrier evaluates the benefits required to be provided under each of the individual plans, along with the cost-sharing, other design features of the plan, and the network 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 for medical care (that is, benefits, services or supplies) provided to their covered individuals for every dollar collected in premiums. This 80% requirement is referred to as the medical loss ratio.
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.
Are rates locked-in for any length of time?	All individual plan premium rates are based on a calendar year, and will not change until January 1 of the following calendar year. If you buy a plan on February 1, the rate will be “locked-in” until the following December 31. Of course, if you change your plan to add delete coverage for a dependent, the premium you pay will be adjusted.

MANAGED CARE PLAN TYPES

Individual plans may be purchased from a variety of carriers with different types of managed care plan designs. Carriers that offer managed care plans provide comprehensive benefits by contracting with a network of physicians, hospitals and other health care professionals. There are several types of managed care plans. This Guide describes the two types that are available in the individual market.

HMO and EPO Plans

The term Health Maintenance Organization (HMO) refers to a type of carrier, as well as the type of product that the carrier offers to customers. An Exclusive Provider Organization (EPO) plan is a similar type of product offered by companies that are not HMOs. HMO plans and EPO plans are designed similarly. Both HMO and EPO plans include a network of physicians, hospitals and other health care professionals that provides medical treatment and care, subject to the terms of the individual plan.

You may be required to choose a Primary Care Provider (PCP) from those participating in the network, and that PCP coordinates your health care, referring you to specialists in the network when necessary. If choice of a PCP is required and services are not provided by the PCP or through the PCP’s referral, services are not covered, except for emergency medical care. However, both HMO plans and EPO plans may offer coverage that does not require referrals, and some plans may not require selection of a PCP. When an HMO plan or EPO plan allows covered persons to see providers in the network without referrals, the plans are often marketed as “direct access” or “open access” plans. Healthcare services are not covered outside of the plan network, except in the case of an emergency.

Carriers may offer the HMO and EPO plans with copayment options (for example, \$30 for all physician visits), but may offer other cost-sharing arrangements, 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, coinsurances and copayments cannot all apply to the same services or supplies).

Note: Carriers are not required to offer coverage to people who do not reside in the approved service area of a plan.

Multi-Tier Plans

Carriers may offer plan designs that include multiple in-network tiers, with different cost-sharing requirements by tier. Multiple tiers may apply to only a single category of providers (for example, hospitals), or to all categories. For example, a carrier may offer an EPO plan that has X specialist physicians in tier 1, and Y specialist physicians in tier 2. All of the tier 1 and tier 2 specialists are in-network, but the person might have a little less cost-sharing if they use the doctors in tier 1 than when they use the doctors in tier 2: perhaps a \$30 copayment per visit to see the tier 1 physician versus a \$50 copayment per visit to see the tier 2 physician. As with any EPO (or HMO) plan, services of specialists that are not in the network are not covered.

Frequently Asked Questions about Managed Care Plans

What plan should I choose if I want to keep my present doctors?	Check with your doctors to find out if they participate in the networks of the carriers offering any HMO or EPO plans listed on the New Jersey Individual Health Coverage Program rate comparison chart.
How can I compare costs between one managed care plan and 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? The “Which individual health insurance plan is best for you?” guide includes tips to help you make a decision. www.state.nj.us/dobi/division_insurance/ihcseh/whichindividualplanbest/whichplan.html
Will an HMO or EPO plan cover me if I need to use a doctor or hospital outside of New Jersey?	Coverage for services provided outside the service area of the HMO or EPO is generally limited to medical emergencies and urgent care. Sometimes carriers allow members covered under an HMO or EPO plan to use doctors or hospitals located in another state if the doctor or hospital belongs to that carrier’s network in that other state. In addition, if there are no doctors or hospitals in the carrier’s network that can provide the care you need, you can request an “in-plan exception.” Contact your carrier for details.
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 individual plans 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%.

The Coverage

The Individual Health Coverage Program Board has established standard plans for the individual market. The plans are standard in that they all cover the same services, supplies, and medical conditions under the same terms. The Individual Health Coverage Program Board has given carriers flexibility in deciding how to structure the managed care components of the plans (discussed earlier), and in how the cost-sharing is structured, but within certain limits.

Covered Services

All standard plans (whether issued as an HMO or EPO plan) provide comprehensive medical coverage which includes the following:

1. office visits
2. hospital care, including emergency services
3. prenatal, maternity and newborn care
4. immunizations and well-child care
5. screenings, including mammograms, pap smears and prostate examinations
6. x-ray and laboratory services
7. mental illness and substance use disorder services
8. various therapy services
9. prescription drugs
10. pediatric vision services

The above list identifies some of the services and supplies that are covered under the standard plans. Pediatric dental services must be included in the plan or bought as a separate plan. If you are interested in finding out if the standard plans cover a certain service or supply, you can read the text of the standard plans on the IHC Board's website – select either of the first two listed documents under the Program Forms heading. (See the Additional Resources section of this Buyer's Guide for the link to the website.)

Cost-sharing

Cost-sharing refers to how the costs of services covered under the plan are allocated between the carrier and the covered person. It does not refer to the costs of services NOT covered under the plan. Cost-sharing is usually divided into three categories: deductibles, coinsurance, and copayments. Standard plans can have one, two or all three types of cost-sharing. However, coinsurance and copayments cannot apply to the same services at the same time.

All standard plans have a maximum amount of cost-sharing required for the covered person – referred to as a maximum out-of-pocket (MOOP) – and when the MOOP is reached, the carrier pays all of the remaining costs for covered services for the rest of the plan year. Cost-sharing requirements begin again at the start of each calendar year.

Deductibles

Deductibles are the amount of allowed charges for which the covered person is responsible **before** the carrier pays anything towards covered charges. For the standard individual plans, the per person deductible may not exceed \$3,000 for Bronze plans and \$2,500 for all other plans. For the catastrophic plan, the deductible is determined by Federal law and is much greater than \$2,500 or \$3,000. In 2019 the deductible for the catastrophic plan is \$7,900. The family deductible is double the per person deductible.

Coinsurance

"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. Most of the time, coinsurance applies

after the deductible is satisfied. For example, a plan might have a \$1,000 deductible, then 70% coinsurance, which means that the covered person must pay \$1,000 in covered charges before the carrier pays anything, then the carrier pays 70% of the covered charges and the covered person pays 30% of the covered charges (until the MOOP is met).

The standard plans may have coinsurance requirements that vary within a range of **50% to 100%**. If a carrier is offering a plan with tiers, different coinsurance could apply to each tier.

Copayments

Copayments are fixed dollar amounts that you pay per visit or service. So, for instance, the copayment for a visit to your PCP may be \$30, the copayment for filling a 30-day supply of a prescription using generic drugs might be \$10, and if you are admitted to a hospital, you might pay \$300 per day (for up to 5 days). Sometimes copayments are used in a plan instead of deductibles and coinsurance. Sometimes copayments apply after the deductible is satisfied.

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. All charges the covered person pays towards the deductible, coinsurance and copayments help to satisfy the MOOP. In 2019, the per person MOOP cannot exceed \$7,900. The family MOOP is two times the per person MOOP.

Visit each carrier's website so that you can get more information about the cost-sharing for each individual plan. The Summary of Benefits and Coverage (SBC) will give you a good overview of each plan.

Different Levels of Coverage

Individual plans have been designed to meet specific "actuarial values". The idea is that **on average** the plans are supposed to cover a designated percentage of the costs of the care received by the people covered under than plan.

A lower actuarial value typically means more cost-sharing, but lower premium.

Bronze is the lowest level of coverage has an actuarial value between **56%** and **65%**

Silver is the next higher level of coverage has an actuarial value between **66%** and **72%**

Gold is the next higher level of coverage has an actuarial value between **76%** and **82%**

Platinum is the highest level of coverage has an actuarial value between **86%** and **92%**

The percentages are NOT necessarily the coinsurance percentages in the plans, and cannot be used to determine any details about cost-sharing in a plan. However, plans with lower actuarial value generally have more cost-sharing than plans with higher actuarial value. In addition, plans with lower actuarial value generally have lower monthly premiums than plans with higher actuarial value.

Actuarial values can help you compare plans. If you are considering two plans with approximately the same actuarial value, it means the plans are expected to cover, on average, the same percentage of the cost of care.

Carriers may also offer a "catastrophic" plan. Catastrophic plans cover the same services as plans with a specific actuarial value. So, what makes the plan catastrophic? The deductible. Catastrophic plans have a deductible that is equal to the MOOP. In 2019, this means the deductible is \$7,900 per person. Catastrophic plans cover preventive services, and three primary care visits per year without being subject to a deductible.

Catastrophic plans can only be purchased by certain classes of people:

1. People under 30 years old
2. People age 30 and older who have received a “hardship exemption” allowing them to forego health insurance.

Note: In 2019 no Platinum level plans are available.

Frequently Asked Questions about Benefits

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.
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.
Is there anything I must do if I want to switch from group coverage to individual coverage or from one individual plan to another?	<p>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.</p> <p>However, changes can be made only during the Annual Open Enrollment Period or a Special Enrollment Period.</p>
If I switch individual plans or change to a new carrier during a calendar year, 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.
I am confused about maximum out of pocket. What is it?	Maximum out of pocket refers to the limit on how much you will have to pay in the form of deductible, coinsurance and copayment requirements during any calendar year. You may hear it referred to as the “MOOP.” After the maximum out of pocket has been reached, all covered charges you incur during the rest of that calendar year will be paid at 100% of allowed charges by the carrier.

<p>What are my rights if, for example, my carrier does not pay a benefit for something I think is covered?</p>	<p>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.</p>
<p>What does pre-approval mean?</p>	<p>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 may reduce benefits by 50%. Examples of services for which pre-approval is required include: home health care, hospice care, and durable medical equipment. Carriers may require pre-approval for certain prescription drugs and for certain therapies.</p>
<p>Do I have to wait to change carriers if I still have a claim outstanding?</p>	<p>No. Your previous carrier will still process claims incurred while your plan was in effect and reimburse you, as appropriate.</p>
<p>I’m due to deliver my baby next month. How long can I stay in the hospital?</p>	<p>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.</p>

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 1 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.

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](#). See the **Additional Resources section** for a link to the information.

Continuation of Coverage for Dependents Under 31

New Jersey law (P.L. 2005, c. 375, as amended) permits certain dependents 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. See the **Additional Resources section** for the link to the information.

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 operates 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 (where you can download or complete an application online). Find the link in the **Additional Resources section**.

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.

See the **Additional Resources section** for the link to more information about Health Centers.

Additional Resources

The following are provided to help you find more information that may be useful to you. The URLs were current when the 2019 Edition of this Buyer's Guide was published, but may change over time.

Carrier contact information – www.state.nj.us/dobi/division_insurance/ihcseh/ihcrates.htm

Catastrophic Illness in Children Relief Fund – www.nj.gov/humanservices/cicrf/home/index.html

COBRA – www.dol.gov/dol/topic/health-plans/cobra.htm

Appeal and Complaint Guide – www.state.nj.us/dobi/division_consumers/insurance/appealcomplaintguide.pdf

Dependent Under 31 continuation election – www.state.nj.us/dobi/division_consumers/du31.html

Division of Aging's State Health Insurance Assistance Program (SHIP) for Medicare beneficiaries – www.state.nj.us/humanservices/doas/services/ship/index.html

Health Centers – www.state.nj.us/health/fhs/primarycare/fqhc/

IHC Standard Plan Forms – www.state.nj.us/dobi/division_insurance/ihcseh/ihcforms.html

Independent Health Care Appeals Program (to appeal medical necessity determinations) – www.state.nj.us/dobi/division_insurance/managedcare/ihcap.htm

Information about hardship exemptions in 2018– www.healthcare.gov/fees-exemptions/hardship-exemptions

Information about subsidies based on income – www.healthcare.gov

Medicare – www.Medicare.gov

Medicaid (and NJ FamilyCare) – www.state.nj.us/humanservices/dmahs/clients/medicaid

New Jersey's Division of Aging Services – www.state.nj.us/humanservices/doas/home

NJ FamilyCare (learn details and download an application) – www.njfamilycare.org

Rate Comparison Chart and Calculator – www.state.nj.us/dobi/division_insurance/ihcseh/ihcrates.htm

SEH Bulletin 07-SEH-02 – www.state.nj.us/dobi/division_insurance/ihcseh/bulletins/sehblt07_02.pdf

Special Child Health and Early Intervention Services – www.state.nj.us/health/fhs/sch/index.shtml