The New Jersey Individual Health Coverage (IHC) Program, established in 1992, provides health insurance options for individuals lacking access to employer or government-sponsored plans. The Buyer's Guide details the selection process for health plans, eligibility criteria, enrollment procedures, and key features of the IHC Program. Individuals can purchase managed care plans, specifically Health Maintenance Organization (HMO) or Exclusive Provider Organization (EPO) plans, from various private carriers. To obtain coverage, individuals must review the guide, compare participating carriers and their rates, and apply through the Marketplace or directly with a carrier. Eligibility for an individual plan requires New Jersey residency and not being entitled to Medicare coverage. Dependents eligible for coverage include a spouse and children under age 26, with specific definitions provided for each category. Individuals must provide proof of residency and cannot be covered under two individual plans simultaneously; existing coverage must be terminated before starting a new plan. The enrollment process involves submitting an application and premium payment, with coverage effective based on the application receipt date. The guide addresses frequently asked questions regarding eligibility, residency requirements, and options for dependents, aiming to ensure access to necessary health coverage.

The policy specifies that individuals cannot hold both an individual and a group plan at the same time, and coverage under the group plan must be terminated before the individual plan takes effect. For dependents, options include purchasing an individual plan, continuing group coverage through COBRA or New Jersey small group continuation for up to 36 months, or maintaining dependent coverage under the group plan until age 31. Children can typically be covered until the end of the month following their 26th birthday, with provisions for incapacitated dependents to be covered indefinitely. If an individual waives Medicare coverage, they can purchase an individual plan, though this may lead to higher out-of-pocket costs and increased premiums for late Medicare enrollment. Enrollment in individual plans is limited to specific periods, including an Annual Open Enrollment Period and Special Enrollment Periods triggered by life events, allowing a 60-day window to enroll or change plans.

The policy guarantees coverage and renewability regardless of health conditions, applying community rating to premiums, which means rates are not based on individual health status but may vary by age. Coverage begins immediately upon enrollment, with a 31-day grace period for premium payments during which coverage remains active. If premiums are not paid by the end of this period, coverage may terminate, and claims during the grace period may be reduced by unpaid premiums. The medical loss ratio requirement mandates carriers to pay at least 80 cents for medical care for every dollar collected in premiums. Premium rates for individual plans are adjusted based on overall utilization by all covered individuals under the same plan, with rates locked in until the end of the calendar year unless coverage changes occur. Managed care plans provide comprehensive benefits through a network of healthcare providers, often requiring the selection of a Primary Care Provider (PCP) who coordinates care, with services outside the network generally not covered except in emergencies. Cost-sharing arrangements may include copayments, deductibles, and coinsurance, with specific limits on out-of-pocket expenses. Standard plans cover a range of services, including office visits, hospital care, maternity care, and prescription drugs, with pediatric dental services required to be included or purchased separately. Deductibles for individual plans are capped at $3,000 for Bronze plans and $2,500 for others, while catastrophic plans have higher deductibles. The maximum out-of-pocket limit for 2019 is set at $7,900 per person. The policy allows for a 30-day review period for new contracts, during which a full premium refund can be requested if dissatisfied. Switching from group to individual coverage or between individual plans requires notification to the existing carrier within 30 days, and continuous coverage is necessary to avoid new deductibles.

If a benefit is denied, individuals should inquire about the grievance and appeal process, providing necessary information to support their claim. Denials may occur for reasons such as the service not being covered or not deemed "medically necessary." If a denial is based on medical necessity, individuals have the right to pursue an independent appeal through the Independent Health Care Appeals Program. Pre-approval is required for many services, and failure to obtain it may result in a

50% reduction in benefits. New Jersey law mandates a minimum hospital stay of 48 hours after a routine delivery and 96 hours after a cesarean section, with possible extensions if deemed medically necessary. For those losing coverage under an employer's group health plan, both federal COBRA and New Jersey's Small Employer Group Continuation laws allow continuation of coverage for a specified period, with individuals responsible for the full premium plus a 2% administrative fee. Employees can continue coverage for up to 18 months after job loss or reduced hours, while dependents may continue for up to 36 months under certain conditions. NJ FamilyCare offers free or low-cost health coverage for uninsured children and certain low-income parents, with eligibility based on family size and income. Most children must be uninsured for three months before enrolling, though exceptions exist. Federally Qualified Health Centers provide access to medical care for those without insurance, charging based on income. Additional resources for further information include various state and federal websites related to health insurance, COBRA, NJ FamilyCare, and health centers.