A CONSUMER'S GUIDE
TO
GETTING AND KEEPING HEALTH INSURANCE
IN
INDIANA

By

Karen Pollitz
Stephanie Lewis
Mila Kofman
Kevin Lucia
Eliza Bangit

GEORGETOWN UNIVERSITY
INSTITUTE FOR HEALTH CARE RESEARCH AND POLICY

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This guide is intended to help consumers understand their protections under federal and state law. The authors have made every attempt to assure that the information presented in this guide is accurate as of the date of publication. However, the guide is a summary, and should not be used as a substitute for legal, accounting, or other expert professional advice. Readers should consult insurance regulators or other competent professionals for guidance in making health insurance decisions. The authors, Georgetown University, and the Institute for Health Care Research and Policy specifically disclaim any personal liability, loss or risk incurred as a consequence of the use and application, either directly or indirectly, of any information presented herein.

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As an Indiana resident, you have rights under federal and state law that will protect you when you seek to buy, keep, or switch your health insurance, even if you have a serious health condition.

This guide describes your protections as an Indiana resident. Chapter 1 gives an overview of your protections. Chapters 2 and 3 explain your protections under group and individual health plans. Chapter 4 highlights your protections as a small employer. Chapter 5 summarizes help that may be available to you if you cannot afford health coverage. If you move away from Indiana, your protections may change. Since this guide is a summary, it may not answer all of your questions. For places to contact for more information, see page 29. For information about how to find consumer guides for other states on the Internet, see page 29. A list of helpful terms and their definitions begins on page 29. These terms are in **boldface type** the first time they appear.

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CHAPTER 1
A SUMMARY OF YOUR PROTECTIONS

Numerous state and federal laws make it easier for people with pre-existing conditions to get or keep health insurance, or to change from one health plan to another. A federal law, known as the Health Insurance Portability and Accountability Act (HIPAA) sets national standards for all health plans. In addition, states can pass different reforms for the health plans they regulate (fully insured group health plans and individual health plans), so your protections may vary if you leave Indiana. Neither federal nor state laws protect your access to health insurance in all circumstances. So please read this guide carefully.

The following information summarizes how federal and state laws do – or do not – protect you as an Indiana resident.

HOW AM I PROTECTED?

In Indiana, as in many other states, your health insurance options are somewhat dependent on your health status. Even if you are sick, however the laws protect you in the following ways.

- *Coverage under your **group health plan** (if your employer offers one) cannot be denied or limited, nor can you be required to pay more, because of your health status.* This is called **nondiscrimination**. (See page 5.)

- *All group health plans in Indiana must limit exclusion of pre-existing conditions*. There are rules about what counts as a pre-existing condition and how long you must wait before a new group health plan will begin to pay for care for that condition. Generally, if you join a new group health plan, your old coverage will be credited toward the **pre-existing condition exclusion period**, provided you did not have a long break in coverage. (See page 11.)

- *Your health insurance cannot be canceled because you get sick. Most health insurance is **guaranteed renewable**.* (See pages 14 and 22.)

- *If you leave your job, you may be able to remain in your old group health plan for a certain length of time.* This is called **COBRA** continuation coverage. It can help when you are between jobs or waiting for a new health plan to cover your pre-existing condition. There are limits on what you can be charged for this coverage. (See page 14.) If you lose your group health insurance and meet other qualifications, you will be **federally eligible**.

If so, you can buy an individual health plan from the **Indiana Comprehensive Health Insurance Association (ICHIA)**. You will not have a pre-existing condition exclusion period. (See page 19.)

- *You may also be able to buy insurance from ICHIA if you have had difficulty obtaining affordable health insurance from private companies because of your health condition*. In this case you may face a new pre-existing condition exclusion period. There are limits on what you can be charged for an ICHIA policy. (See page 21.)

- *If you lose coverage under a fully insured **small group health plan** in Indiana, you can buy a **conversion policy***. You will not face a new preexisting condition exclusion period. There are limits on what you can be charged for a conversion policy. (See page 18.)

- *If you are a small employer buying a group health plan, you cannot be turned down because of the health status, age, or any factor that might predict the use of health services of those in your group*. All health plans for small employers must be sold on a **guaranteed issue** basis. (See page 22.)

- *If you are a small employer buying a group health plan, there are limits on what you can be charged due to the health status, age, gender, or occupation of those in your group*. (See page 22.)

- *If you have low or modest household income, you may be eligible for free or subsidized health coverage for yourself or members of your family*. The Indiana Medicaid program offers free or reduced price health coverage for certain families, children, pregnant women, elderly, and disabled individuals. (See page 24.)

WHAT ARE THE LIMITS ON MY PROTECTIONS?

As important as they are, the federal and state health insurance reforms are limited. Therefore, you also should understand how the laws do *not* protect you.

- *If you change jobs, you usually cannot take your old health benefits with you*. Except when you exercise your federal COBRA rights, you are not entitled to take your actual group health coverage with you when you leave a job. Your new health plan may not cover all of the benefits or the same doctors that your old plan did.

- *If you change jobs, your new employer may not offer a health insurance plan*. If an employer offers a health insurance plan to its employees, the employer cannot consider factors related to health status in determining whether to offer coverage under the health insurance plan.

- *If you get a new job with health benefits, your coverage may not start right away*. Employers can require **waiting periods** before your health benefits begin. (See page 6.)

- *If you are joining a new group health plan, you may have to satisfy a new pre-existing condition period if you have a break in coverage of 2 months or more*. (See page 7.)

- *Even if you have **continuous coverage**, there may be a pre-existing condition exclusion period for some benefits if you join a **group health plan** that covers benefits your old plan did not*. For example, say you move from a group plan that does not cover prescription drugs to one that does. You may have to wait up to one year before your new health plan will pay for drugs prescribed to treat a pre-existing condition. (See page 7.)

- *If you work for a non-federal public employer in Indiana, such as a state or municipal government, not all of the group health plan protections may apply to you*. (See page 10.)

- *In Indiana, your access to individual health insurance may depend on your health status*. Private insurers are not prohibited from turning you down, or charging more because of your pre-existing conditions. If you are federally eligible, ICHIA is your only guaranteed access to individual health insurance though you may be able to buy individual health insurance from other insurance companies.

  Once you obtain coverage, your ability to switch plans may be limited as well. While you have protections when you move from an individual policy to a group plan, neither federal nor Indiana law protects you from the imposition of pre-existing condition exclusions when you move from one individual plan to another, even if you had prior continuous coverage. Furthermore, you are not assured the right to buy another individual policy. (See page 13.)

CHAPTER 2
YOUR PROTECTIONS UNDER GROUP HEALTH PLANS

This chapter describes the protections that you have in group health plans, such as those offered by employers or labor unions. Your protections will vary somewhat, depending on whether your plan is a fully insured group health plan or a **self-insured group health plan**. The plan's benefits information must indicate whether the plan is self-insured.

WHEN DOES A GROUP HEALTH PLAN HAVE TO LET ME IN?

- *You have to be eligible for the group health plan.* For example, your employer may not give health benefits to all employees such as part time, non-permanent, or seasonal employees.

- *You cannot be turned away or charged more because of your health status*. Health status means your medical condition or history, **genetic information**, or disability. This protection is called nondiscrimination. Employers may refuse or restrict coverage for other reasons (such as part time employment), as long as these are unrelated to health status and applied consistently.

Discrimination due to health status is not permitted

The Acme Company offers two different health plans. Full time employees are offered a high option plan that covers prescription drugs; part time employees are offered a low option plan that does not. This is *permitted* under the law. By contrast, in a cost-cutting move, Acme restricts its high option plan to those employees who can pass a physical examination. This is *not permitted* under the law.

- *You must be given a special opportunity to sign up for your group health plan if certain changes happen to your family*. In addition to any regular **enrollment period** your employer or group health plan offers, you must be offered a special, 30-day opportunity to enroll in your group health plan after certain events. You can elect coverage at this time. If your group plan offers family coverage, your dependents can elect coverage as well. Enrollment during a **special enrollment period** is not considered **late enrollment.**

Certain changes can trigger a special enrollment opportunity

- The birth, adoption, or placement for adoption of a child
- Marriage
- Loss of other coverage (for example, that you or your dependents had through yourself or another family member and lost because of death, divorce, legal separation, termination, retirement, or reduction in hours worked)

- *Under Indiana law, newborns, adopted children and children placed for adoption are automatically covered under the parents' fully insured health plan for the first 31 days, if the plan covers dependents.* The insurer may require that the parent enroll the child within the 31 days in order to continue coverage beyond the 31 days.

- *If you have a disabled child, that child may remain covered under your fully insured group health plan after he or she reaches the age at which dependent coverage is usually terminated*. To qualify, your adult son or daughter must be incapable of self-support because of mental retardation or physical disability and must be chiefly dependent on the policyholder for support. Proof of incapacity must be furnished to the insurer within 120 days of reaching the limiting age and may be required subsequently in the future.

- *When you begin a new job, your employer may require a waiting period before you can sign up for health coverage*. This waiting period, however, must be applied consistently and cannot vary due to your health status.

- *If you have to take leave from your job due to illness, the birth or adoption of a child, or to care for a seriously ill family member, you may be able to keep your group health coverage for a limited time.* A federal law known as the **Family and Medical Leave Act (FMLA)** guarantees you up to 12 weeks of job-protected leave in these circumstances.

  The FMLA applies to you if you work at a company with 50 or more employees.

  If you qualify for leave under FMLA, your employer must continue your health benefits. You will have to continue paying your share of the premium.

  If you decide not to return to work at the end of the leave period, your employer may require you to pay back the employer's share of the health insurance premium. However, if you don't return to work because of factors outside of your control (such as a need to continue caring for a sick family member, or because your spouse is transferred to a job in a distant city), you will not have to repay the premium.

For more information about your rights under the FMLA, contact the U.S. Department of Labor.

CAN A GROUP HEALTH PLAN LIMIT MY COVERAGE FOR PRE-EXISTING CONDITIONS?

When you first enroll in a group health plan, the employer or insurance company may ask if you have any pre-existing conditions. Or, if you make a claim during the first year of coverage, the plan may look back to see whether it was for such a condition. If so, it may try to exclude coverage for services related to that condition for a certain length of time. However, federal and state laws protect you by placing limits on these pre-existing condition exclusion periods under group health plans. In some cases, your protections will vary depending on the type of group health plan you belong to.

- *A group health plan can count as pre-existing conditions only those for which you actually received (or were recommended to receive) a diagnosis, treatment or medical advice within the 6 months immediately before you joined that plan*. This period is also called the **look back** period.

- *Group health plans cannot apply a pre-existing condition exclusion period for pregnancy, newborns, newly adopted children, children placed for adoption, or genetic information***.**

- *Under group health plans, coverage for pre-existing conditions can be excluded only for a limited time.* The maximum exclusion period depends on the type of group health plan you are joining. (See box below.)

  If you enroll late (after you were hired and not during a regular or special enrollment period), you may have a longer preexisting condition exclusion period. (Note that fully insured small group health plans in Indiana are required to accept late enrollees.) Ask your prospective employer if you are not sure what limit applies to you.

The maximum pre-existing condition exclusion period varies

Type of group health plan	Maximum exclusion period
Self-insured group health plan, any size	12 months (regular enrollees)
Self-insured group health plan, any size	18 months (late enrollees)
Fully insured group plan, 2-50 eligible workers	9 months (regular enrollees)
Fully insured group plan, 2-50 eligible workers	15 months (late enrollees)
Fully insured group plan, 51+ eligible workers	12 months (regular enrollees)
Fully insured group plan, 51+ eligible workers	18 months (late enrollees)

- *If you join a new group health plan, the law protects you from a new pre-existing condition exclusion period, provided you maintain **continuous creditable coverage**.*

What is creditable coverage?

Most health insurance counts as creditable coverage, including:

Federal Employees Health Benefits (FEHBP)
Group health insurance (including COBRA)
Indian Health Service
Individual health insurance
Medicaid
Medicare
Military health coverage (CHAMPUS,TRICARE)
State high risk pools

In most cases, you should get a **certificate of creditable coverage** when you leave a health plan. You also can request certificates at other times. If you cannot get one, you can submit other proof, such as old health plan ID cards or statements from your doctor showing bills paid by your health insurance plan.

- *Coverage counts as continuous if it is not interrupted by a break of 63 or more days in a row.*

  In determining continuous coverage, employer-imposed waiting periods do not count as a break in coverage. If your new plan imposes a pre-existing condition exclusion period, you can credit time under your prior coverage toward it. If your employer requires a waiting period, the pre-existing condition exclusion period begins on the first day of the waiting period.

What is continuous coverage?

You can get continuous coverage under one plan or under several plans as long as you don't have a lapse of 63 or more consecutive days.

Take Art, who has diabetes. Ajax Company covered him under its group health plan for 9 months, but he lost his job and health coverage. Then, *45 days later*, Art found a new job at Beta Corporation and had health coverage for 9 more months. Art changed jobs again. His new company, Charter, has a health plan that covers care for diabetes but excludes preexisting conditions for 12 months. Charter must cover Art's diabetes care immediately, because his 18 months of prior continuous coverage are credited against the 12-month exclusion.

Now consider a slightly different situation. Assume Art was uninsured for *90 days* between his jobs at Ajax and Beta. In this case, Charter will credit coverage only under Beta's plan toward the 12-month preexisting condition exclusion period. Charter's plan will begin paying for Art's diabetes care in 3 months (1 year minus 9 months). Art does not get credit for his coverage at Ajax since he had a break of *more than 63 consecutive days.*

- *No pre-existing condition exclusion period can be applied without appropriate notice*. Your group health plan must inform you, in writing, if it intends to impose such a period. Also, if needed, it must help you get a certificate of creditable coverage from your old health plan.

- *Your protections may differ if you move to a group health plan that offers more benefits than your old one did*. Plans can look back to determine whether your previous plan covered prescription drugs, mental health, substance abuse, dental care, or vision care. If you did not have continuous coverage for one or more of these categories of benefits, your new group plan may impose a pre-existing condition exclusion period for that category. Plans that use this method of crediting prior coverage must use it for everyone and must disclose this to you when you enroll.

Even if coverage is continuous, there may be an exclusion for certain benefits

Sue needs prescription medication to control her blood pressure. She had 2 years of continuous coverage under her employer's group health plan, which did not cover prescription drugs. Sue changes jobs, and her new employer's fully insured plan does cover prescription drugs. However, because her prior policy did not, the new plan refuses to cover her blood pressure medicine for 6 months.

Question: Is this permitted?

Answer: Yes. However, the plan must pay for covered doctor visits, hospital care, and other services for Sue's high blood pressure. It also must pay for covered prescription drugs she needs for other conditions that were not pre-existing.

LIMITS TO PROTECTIONS FOR CERTAIN GOVERNMENT WORKERS

Federal law permits state, county, and local governments to exempt their employees in self-insured plans from some of the protections discussed previously in this chapter. Public employers must make this choice annually. When they do so, they are required to notify the federal government and specify which health insurance protections will not apply to their employees' health insurance plan.

According to the latest list available from the federal government, eighteen public employers in Indiana have decided that certain health insurance protections will *not* apply to their employees. If you have group health coverage through these employers, you should contact them for more information. Other non-federal public employers in Indiana may have made this choice after this guide was written. If you are not sure about your protections under your public employee health plan, you should contact your employer.

Indiana public employers electing to exempt their covered employees from group health plan protections

Citizens Gas and Coke Utility
City of Evansville
City of Goshen
City of Martinsville
City of Portland
County of Elkhart
County of LaGrange
County of Morgan
County School Corporation of Brown County
DeKalb County Central United School District
Indiana State University
Knox Community School Corporation
Kokomo Center Township Consolidated School Corporation
Middlebury Community Schools
School Employees Benefit Trust
Wawasee Community School Corporation
Woodlawn Hospital

AS YOU ARE LEAVING GROUP COVERAGE…

- *If you are leaving your job or otherwise losing access to your group health coverage, you may be able to remain covered under the group health plan for a limited time.* In addition, you may have special protections when buying certain kinds of individual health coverage. See Chapter 3 for more information about COBRA coverage, conversion coverage, and ICHIA coverage for "federally eligible individuals."

CHAPTER 3
YOUR PROTECTIONS WHEN BUYING INDIVIDUAL HEALTH INSURANCE

If you do not have access to employer-sponsored group insurance, you may want to buy an individual health plan from a private health insurance company. However, in Indiana – as in most other states – you have limited guaranteed access to individual health insurance. There are some alternatives to individual health insurance coverage in the private market – such as COBRA coverage and ICHIA coverage. This chapter summarizes your protections under different kinds of health plan coverage.

INDIVIDUAL HEALTH INSURANCE SOLD BY PRIVATE INSURERS

WHEN DO INDIVIDUAL HEALTH INSURERS HAVE TO SELL ME COVERAGE?

In Indiana, your ability to buy individual health coverage may depend on your health status.

- *In general, companies that sell individual health insurance in Indiana are free to turn you down because of your health status and other factors*. When applying for individual coverage, you may be asked questions about health conditions you have now or had in the past. Depending on your health status, insurers might refuse to sell you coverage or they might offer to sell you a policy that has special limitations on what it covers.

- *In Indiana, newborns, adopted children, and children placed for adoption are automatically covered under the parents' individual health plan for the first 31 days, if the plan provides coverage for dependents.* The insurer may require that the parent enroll the child within the 31 days in order to continue coverage beyond the 31 days.

- *If you have a disabled child, that child may remain covered under your individual health plan after he or she reaches the age at which dependent coverage is usually terminated*. To qualify, your adult son or daughter must be incapable of self-support because of mental retardation or physical disability and must be chiefly dependent on the policyholder for support. Proof of incapacity must be furnished to the insurer within 31 days of reaching the limiting age and may be required subsequently in the future.

WHAT WILL MY INDIVIDUAL HEALTH PLAN COVER?

- *It depends on what you buy*. Indiana does not require health insurers in the individual market to sell standardized policies. Health plans can design different policies and you will have to read and compare them carefully. Sometimes, individual health plans provide less comprehensive coverage than group health plans, especially for certain services such as maternity care, mental health care, or prescription drugs. However, Indiana does require all health plans to cover certain benefits – such as cancer screening and diabetic supplies and services. Check with the Indiana Department of Insurance for more information about mandated benefits.

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *There are limits on the pre-existing condition exclusion periods that individual health plans can impose*. If they agree to sell you a policy, insurers cannot exclude coverage for your pre-existing condition for longer than 12 months. Health insurers in Indiana may not impose **elimination riders,** which are amendments to your health insurance contract that permanently exclude coverage for a health condition, body part, or body system.

- *There are rules about what counts as a pre-existing condition in individual health plans in Indiana.* A pre-existing condition is anything for which you received medical advice, care, treatment, or diagnosis in the 12 months prior to purchasing coverage. In addition, insurers can count as pre-existing any condition for which the insurer believes most people would have sought care. This is called the **prudent person rule**.

  Pregnancy can be a pre-existing condition in individual health plans, but genetic information cannot. Individual health plans cannot impose pre-existing condition exclusion periods on newborns, newly adopted children, or children placed for adoption.

- *You will get credit toward your pre-existing condition exclusion period for any prior coverage you had under a small group health plan.* You must not have had a lapse of more than 30 days between your old and new coverage. However, individual insurance plans are not required to credit your prior coverage in large group health plans, self-insured group health plans, or other individual plans. Also, individual health plans can refuse to cover you altogether if you have a pre-existing condition.

WHAT CAN I BE CHARGED FOR INDIVIDUAL HEALTH COVERAGE?

- *Indiana law does not limit what insurers can charge you for health coverage*. You can be charged more because of your health status, age, and other factors.

  When your policy is renewed, the premium increases will be based on the claim experience of the pool of people who bought the same policy that you bought. This means that your rates will depend on the health of the entire pool of people with the policy, not your health alone.

CAN MY INDIVIDUAL HEALTH INSURANCE POLICY BE CANCELLED?

- *Your coverage cannot be canceled because you get sick*. This is called guaranteed renewability. You have this protection provided that you pay the premiums, do not defraud the company, and, in the case of managed care plans, continue to live in the plan service area.

- *Some insurance companies sell temporary health insurance policies*. Temporary policies are not guaranteed renewable. They will only cover you for a limited time, such as 6 months. If you want to renew coverage under a temporary policy after it expires, you will have to reapply and there is no guarantee that coverage will be re-issued at all or at the same price.

COBRA CONTINUATION COVERAGE

WHEN DO I HAVE TO BE OFFERED COBRA COVERAGE?

If you are leaving your job and you had group coverage, you may be able to stay in your group plan for an extended time through COBRA coverage. The information presented below was taken from publications prepared by the U.S. Department of Labor. You should contact them for more information about your rights under COBRA.

- *To qualify for COBRA continuation coverage, you must meet 3 criteria*:

  First, you must work for an employer with 20 or more employees. If you work for an employer with 2-19 employees, you may qualify for state continuation coverage. (See below.)

Second, you must be covered under the employer's group health plan as an employee or as the spouse or dependent child of an employee.

Finally, you must have a qualifying event that would cause you to lose your group health coverage.

COBRA QUALIFYING EVENTS

For employees
- Voluntary or involuntary termination of employment for reasons other than gross misconduct
- Reduction in numbers of hours worked

For spouses
- Loss of coverage by the employee because of one of the qualifying events listed above
- Covered employee becomes eligible for Medicare
- Divorce or legal separation of the covered employee
- Death of the covered employee

For dependent children
- Loss of coverage because of any of the qualifying events listed for spouses
- Loss of status as a dependent child under the plan rules

- *Each person who is eligible for COBRA continuation can make his or her own decision*. If your dependents were covered under your employer plan, they may elect COBRA coverage even if you do not.

- *You must be notified of your COBRA rights when you join the group health plan, and again if you qualify for COBRA coverage*. The notice rules are somewhat complicated and you should contact the U.S. Department of Labor for more information. The Indiana Department of Insurance also has COBRA information on its website at www.IN.gov.idoi.

  In general, if the event that qualifies you for COBRA coverage involves the death, termination, reduction in hours worked, or Medicare eligibility of a covered worker, the employer has 30 days to notify the group health plan of this event. However, if the qualifying event involves divorce or legal separation or loss of dependent status, YOU have 60 days to notify the group health plan. Once it has been notified of the qualifying event, the group health plan has 14 days to send you a notice about how to elect COBRA coverage. Each member of your family eligible for COBRA coverage then has 60 days to make this election.

Once you elect COBRA, coverage will begin retroactive to the qualifying event. You will have to pay premiums dating back to this period.

- *To qualify as federally eligible, you must choose and use up any COBRA or state continuation coverage available to you*.

WHAT WILL COBRA COVER?

- *Your covered health benefits under COBRA will be the same as those you had before you qualified for COBRA*. For example, if you had coverage for medical, hospitalization, dental, vision, and prescription drug benefits before COBRA, you can continue coverage for all of these benefits under COBRA. If these benefits were covered under more than one plan (for example, a separate health insurance and dental insurance plan) you can choose to continue coverage under any or all of the plans. Life insurance is not covered by COBRA.

  If your employer changes the health benefits package after your qualifying event, you must be offered coverage identical to that available to other active employees who are covered under the plan.

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *Because your group coverage is continuing, you will not have a new pre-existing condition exclusion period under COBRA*. However, if you were in the middle of a pre-existing condition exclusion period when your qualifying event occurred, you will have to finish it.

WHAT CAN I BE CHARGED FOR COBRA COVERAGE?

- *You must pay the entire premium (employer and employee share, plus a 2% administrative fee) for COBRA continuation coverage*. The first premium must be paid within 45 days of electing COBRA coverage.

- *If you elect the 11-month disability extension, the premium will increase to 150% of the total cost of coverage*. See below for more information about the disability extension.

HOW LONG DOES COBRA COVERAGE LAST?

- *COBRA coverage generally lasts up to 18 months and cannot be renewed*. However, certain disabled people can opt for coverage up to 29 months, and dependents are sometimes eligible for up to 36 months of COBRA continuation coverage, depending on their qualifying event.

  In addition, special rules for disabled individuals may extend the maximum period of coverage to 29 months. To qualify for the disability extension, you must have been disabled at the time of your COBRA qualifying event (such as termination of employment or reduction in hours) or within 60 days of that qualifying event. You must obtain this disability determination from the Social Security Administration, and you must notify your group health plan of this disability determination

How long can COBRA coverage last?

Qualifying event(s)	*Eligible person(s)*	*Coverage*
Termination Reduced hours	Employee Spouse Dependent child	18 months *
Employee enrolls in Medicare Divorce or legal separation Death of covered employee	Spouse Dependent child	36 months
Loss of "dependent child" status	Dependent child	36 months

* Certain disabled persons and their eligible family members can extend coverage an additional 11 months, for a total of up to 29 months.

- *Usually, COBRA continuation coverage ends when you join a new health plan*. However, if your new plan has a waiting period or a pre-existing condition exclusion period, you can keep whatever COBRA continuation coverage you have left during that period. For specifics, ask your former employer or contact the U.S. Department of Labor.

- *COBRA coverage also ends if your old employer stops offering a health benefit plan to its other employees*.

- *COBRA coverage might end if you are in a managed care plan that is available only to people living in a limited geographic area and you move out of that area*.

However, if you are eligible for COBRA and are moving out of your current health plan's service area, your employer must provide you with the opportunity to switch to a different plan, but only if the employer already offers other plans to its employees. Examples of the other plans your employer may offer you are a managed care plan whose service area includes the area you are moving to, or another plan that does not have a limited service area.

CONVERSION COVERAGE

WHEN DO INSURERS HAVE TO SELL ME CONVERSION COVERAGE?

- *In Indiana, if you have coverage through a small employer's fully insured group health plan and you leave that job, you are eligible to buy conversion coverage.* This is an individual policy you get from the company that insured your employer's group plan.

- *To qualify for a conversion policy, you must have had at least 90 days of continuous coverage through an employer's small group health plan.* In addition, you must not be eligible for group health coverage, and you must request the conversion policy within 30 days of becoming eligible for it.

- *You do not have to elect COBRA continuation coverage before you are allowed to buy a conversion policy.* If you do elect COBRA continuation coverage, however, you will have the right to buy a conversion policy when COBRA coverage ends.

- *You do not need to be federally eligible to buy a conversion policy.*

WHAT WILL CONVERSION POLICIES COVER?

- *Conversion policy benefits may not be the same as those under your former employer group health plan*. However, at a minimum, conversion policies must cover inpatient hospital and physician care, outpatient hospital and physician care, diagnostic laboratory services, diagnostic and therapeutic radiological services, and emergency care.

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *Conversion policies cannot impose new pre-existing condition exclusion periods.* However, if you were in the middle of a pre-existing condition exclusion period under your group health plan when it ended, you will have to finish it.

WHAT CAN I BE CHARGED FOR CONVERSION COVERAGE?

- *Premiums for conversion coverage are limited to one and one half times (150%) the rate an eligible employee would have been charged under the small employer's health plan.* If you have questions about conversion policy premiums, contact the Indiana Department of Insurance.

CAN A CONVERSION POLICY BE CANCELLED?

- *Your conversion coverage cannot be cancelled because you get sick.* This is called guaranteed renewability. You have this protection provided that you pay the premiums, do not defraud the company, and, in the case of managed care plans, continue to live in the plan service area.

INDIANA COMPREHENSIVE HEALTH INSURANCE ASSOCIATION (ICHIA)

Indiana has a high risk pool program, called the Indiana Comprehensive Health Insurance Association (ICHIA), that offers insurance for people with health conditions who are unable to buy private health insurance coverage and for people who are federally eligible.

WHEN CAN I GET COVERAGE FROM ICHIA?

- *ICHIA does not offer family coverage. Each member of your family who wants to enroll in ICHIA will have to qualify on his or her own.*

- *There are two ways to qualify for ICHIA coverage. If you are federally eligible, you will be able to purchase ICHIA coverage*. You will not have a pre-existing condition exclusion period.

- *If you are not federally eligible, you can buy coverage from ICHIA if you are "uninsurable."* You are considered uninsurable if you: 1) have been diagnosed with a specific, listed condition, such as cancer or AIDS; 2) have been turned down for coverage

that is similar to ICHIA coverage; or 3) are unable to find private health insurance coverage that is cheaper than ICHIA health insurance.

In addition, to buy coverage from ICHIA you must be an Indiana resident and not be eligible for Medicaid or any other health insurance coverage.

To be federally eligible, you must meet certain criteria

If you are federally eligible in Indiana, you are guaranteed the right to buy an individual health plan from ICHIA and are exempted from pre-existing condition exclusion periods. To be federally eligible, you must meet all of the following:

- You must have had 18 months of continuous creditable coverage*, at least the last day of which was under a group health plan*.
- You also must have used up any COBRA or state continuation coverage for which you were eligible.
- You must not be eligible for Medicare, Medicaid or a group health plan.
- You must not have health insurance. (Note, however, if you know your group coverage is about to end, you can apply for coverage for which you *will* be federally eligible.)
- You must apply for health insurance for which you are federally eligible within 63 days of losing your prior coverage.

Federal eligibility ends when you enroll in ICHIA or an individual plan, because the last day of your continuous health coverage must have been in a group plan. You can become federally eligible again by maintaining continuous coverage and rejoining a group health plan.

WHAT WILL ICHIA COVER?

- *ICHIA coverage includes hospital and physician care, diagnostic tests and x-rays, prescription drugs, and other services*.

- *ICHIA offers you a choice of three cost-sharing arrangements.* The annual deductible options are $500, $1,000, or $1,500.

  All three ICHIA plans have a Preferred Provider Network (PPN) of doctors and hospitals in your area. You will be charged 20% coinsurance for care from a PPN provider and 40% coinsurance for care from a non-PPN provider, when available. After you have paid a maximum amount for covered services (also called the out-of-pocket limit) ICHIA will pay 100% of the cost of care when you use a PPN provider and 75% when you go to a

non-PPN provider when a PPN provider was available. ICHIA's out-of-pocket limits range from $1,500 to $4,000.

Separate coverage limits apply to mental health and substance abuse benefits.

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *If you are federally eligible, you will not have a pre-existing condition exclusion when you enroll in ICHIA*. Elimination riders are not permitted on ICHIA plans.

- *If you are not federally eligible, ICHIA will exclude coverage for your pre-existing condition for 3 months.* ICHIA will look back 3 months before you enrolled to see if you had a condition for which you actually received a diagnosis, medical advice, or treatment. ICHIA can impose pre-existing condition exclusions on pregnancy.

  ICHIA will credit prior continuous coverage toward your pre-existing condition exclusion if you apply for ICHIA coverage within 6 months of losing your prior coverage.

WHAT CAN I BE CHARGED FOR ICHIA COVERAGE?

- *Premiums will vary based on the plan you choose*. In addition, ICHIA charges enrollees different rates based on their age, gender and the geographic area they live in. Under Indiana law, ICHIA rates are not allowed to be more than 150% of the amount that a healthy person would pay if he or she bought a similar plan sold by a private insurer.

  For example, the monthly premium for a 24-year-old male ranges from $142 to $261, depending on which plan option is selected and where you live. By contrast, the monthly premium for a 64-year-old male ranges from $499 to $901, depending on which plan option is selected and where you live.

  Contact ICHIA for the most current information about premium and coverage options.

HOW LONG DOES ICHIA COVERAGE LAST?

- *ICHIA policies are renewable as long as you pay your premiums, continue to reside in Indiana, and meet other eligibility requirements.*

CHAPTER 4
YOUR PROTECTIONS AS A SMALL EMPLOYER OR SELF-EMPLOYED PERSON

Federal law extends certain protections to employers seeking to buy health insurance for themselves and their workers. Indiana has enacted reforms to expand some of these protections. Generally, small employers are those that employ 2-50 employees. Please note, however, that the definitions of small employer and employee are somewhat different under federal and state law. Check with the Indiana Department of Insurance to be sure that you know which protections apply to your group.

DO INSURANCE COMPANIES HAVE TO SELL ME HEALTH INSURANCE?

- *With few exceptions, small employers cannot be turned down. This is called guaranteed issue*. If you employ at least 2 people, but not more than 50 eligible employees, health insurance companies must sell you any small group health plan they sell to other small employers. However, they can require that a minimum percentage of your eligible employees sign up for coverage. They can also require you to pay a minimum share of your workers' premiums. If you wish to buy a **large group health plan** (one that covers more than 50 eligible employees), insurers are allowed to refuse to sell you a policy.

- *Your insurance cannot be canceled because someone in your group becomes sick*. This is called guaranteed renewability and it applies to group plans of all sizes. Insurers can impose other conditions, however. They can require you to meet minimum participation and contribution rates in order to renew your coverage. Additionally, they can refuse to renew your coverage for nonpayment of premiums or if you commit fraud, or if they are discontinuing that insurance product. In the latter case, they must give you a chance to buy other plans they sell to groups of your size.

CAN I BE CHARGED MORE BECAUSE OF MY GROUP'S HEALTH STATUS?

- *Within limits, you can be charged higher premiums based on the health, risk, and demographic characteristics of your group*. For small employers, Indiana limits the difference in premiums and the annual increase that can be charged. For groups with more than 50 employees, Indiana does not limit premium variation or increases. If you have questions about your group health insurance premiums, contact the Indiana Department of Insurance.

WHAT IF I AM SELF-EMPLOYED?

- *If you are self-employed with no other workers, you are not eligible to buy a group health plan on your own (though you may be able to join another group health plan through a family member)*. Therefore, the laws that protect employers' access to group health plans do not apply to you. Your access to health insurance is protected by the laws that apply to individuals. (See Chapter 3.)

- *If you are self-employed and buy your own health insurance, you are eligible to deduct an increasing percentage of the cost of your premium from your federal income tax*. This deduction is 70% for 2002 and 100% in 2003 and thereafter.

A WORD ABOUT ASSOCIATION PLANS

- *Some small employers, self-employed people, and other individuals buy health insurance through professional or trade associations*. The laws applying to association health coverage can be different than those for other health plans. Check with the Indiana Department of Insurance about your protections in association health plans.

CHAPTER 5
FINANCIAL ASSISTANCE

Help is available to certain low-income residents of Indiana who cannot afford to buy health insurance. Medicaid offer frees or subsidized health insurance coverage, direct medical services and other help. This chapter provides summary information about these programs and contact information for further assistance.

MEDICAID

Medicaid is a program that provides health coverage to some low-income Indiana residents. **Hoosier Healthwise** is the Medicaid managed care program that covers families with children and pregnant women if state and federal guidelines are met. The elderly, and people with disabilities can also enroll in Medicaid if state and federal guidelines are met. Legal residents who are not U.S. citizens may be eligible for Medicaid. Non-citizens who do not have immigration documents cannot enroll in Medicaid, but may be covered if treated for an emergency condition.

- *For certain categories of people, eligibility for Medicaid is based on the amount of your household income.*

  In Indiana you may be eligible for Hoosier Healthwise if you are a child, a pregnant woman, or a parent of a child and your family income meets the Medicaid income standards. If you are in one of these categories of people and your income is below 150% of the federal poverty level (FPL) you may qualify for Hoosier Healthwise and not be charged a premium. If you are a child and live in a family with an income between 150% and 200% of the FPL, you may qualify for Hoosier Healthwise and you will have to pay a small premium for coverage.

  Income eligibility levels for these categories are described below. Your assets and some expenses also may be taken into account, so you should contact the Indiana Family and Social Services Administration for more information.

Low income persons eligible for Medicaid in Indiana*

Category	Income eligibility (as percent of federal poverty level)
Child 0-18 (no premium)	150% (monthly income of about $1,829 for family of 3)
Child 0-18 (premium)	151%-200% (monthly income of about$2,439 for family of 3)
Pregnant woman	150%

* Eligibility information was compiled from secondary sources, including Center for Budget and Policy Priorities, the Henry J. Kaiser Family Foundation, Families USA, and the Robert Wood Johnson Foundation Covering Kids Program, and may have changed since this guide was published. Contact your state Medicaid program for the most up to date information and for other eligibility requirements that may apply.

To get an idea of how your income compares to the federal poverty level, use the federal poverty guideline issued by the U.S. Department of Health and Human Services for the year 2001:

Size of Family Unit	U.S. Poverty Guideline (annual income)
1	$ 8,590
2	11,610
3	14,630

For larger families add $3,020 for each additional person.

Contact your state Medicaid program for the most up to date information and for other eligibility requirements that may apply.

- *Families who get cash benefits from **TANF (Temporary Assistance for Needy Families)** are probably also eligible for Hoosier Healthwise.*

  Parents should know that when you get a job, you may qualify for transitional coverage under Hoosier Healthwise for a 12-month period.

- *Poor elderly or disabled people who get **Supplemental Security Income (SSI)** benefits are eligible for Medicaid.*

Disabled individuals should know that if your income earned from a job increases so that you no longer qualify for SSI, you may be able to continue your Medicaid coverage under a different eligibility category that may require payment of a premium.

- *Retired or disabled people who have low incomes and are enrolled in Medicare may also qualify for help from Medicaid*. Even though your income may be too high to qualify for Medicaid insurance coverage, Medicaid may be able to help you with your Medicare expenses.

  If your household income is below the poverty level, Medicaid will pay your Medicare monthly premium and your Medicare deductibles and coinsurance. This is called the Qualified Medicare Beneficiary (QMB) program.

  If your household income is below 120% of the poverty level, Medicaid will pay for your monthly Medicare Part B premiums only. This is called the Specified Low-Income Medicare Beneficiary (SLMB) program.

  Contact the Indiana Family and Social Services Administration for more information about other eligibility requirements.

- *There may be other ways that Medicaid can help*. To find out if you or other members of your family qualify for Medicaid, contact the Indiana Family and Social Services Administration.

HOOSIER RX

Hoosier Rx is a program to provide limited financial assistance to low-income elderly who purchase prescription drugs.

- *To qualify for Hoosier Rx, you must be 65 or older and have limited monthly income.* The monthly income standard for a single person is $967 or less, and for a couple is $1,307 or less. Income is measured net of taxes and Medicare premiums.

- *If you qualify, Hoosier Rx will reimburse you for a portion of your prescription drug expenses*. You will be refunded for half of your covered expenses, up to a limit of $500, $750, or $1,000, depending on your income. You will have to save your receipts and submit them quarterly to Hoosier Rx for reimbursement.

- *For more information, contact the Hoosier Rx program directly.* You may reach the program via telephone at 1-317-234-1381, or toll free at 1-866-267-4679, between the hours of 8 am and 4:30 pm, EST, Monday through Friday.

FOR MORE INFORMATION…

As a summary, this guide will not answer every question for every person in every circumstance. In addition, it is not a substitute for legal advice. If you have more questions, contact the agencies listed below or consult an attorney.

For questions about:	Contact:
Individual health insurance Fully insured group health insurance COBRA continuation coverage	*Indiana Department of Insurance* 1-800-622-4461 (Indiana only) (317) 232-2385 http://www.ai.org/idoi/
Self-insured group health plans COBRA continuation coverage Family and Medical Leave Act	*U.S. Department of Labor, Chicago Regional Office (for Northern Indiana)* (312) 353-0900, or *Cincinnati Regional Office (for Southern Indiana)* (859) 578-4680, or *U.S. Department of Labor, Division of Technical Assistance and Inquiries, Washington, D.C.* (202) 219-8776 *For Department of Labor publications:* (800) 998-7542 http://www.dol.gov/dol/pwba
Indiana Comprehensive Health Insurance Association (ICHIA)	*ICHIA* *P.O. Box 33730* *Indianapolis, IN 46203-0730* (800) 552-7921 or (317) 614-2133 http://www.onlinehealthplan.com/oasys/ichia/
Medicaid (including Hoosier Healthwise)	*Indiana Family and Social Services Administration* (800) 889-9949 http://www.IN.gov/fssa/
Hoosier Rx	*Hoosier Rx* *P.O. Box 6224* *Indianapolis, IN 46206-6224* (866) 267-4679 (toll free) (317) 234-1381 http://www.IN.gov/fssa/rxprogram/rxhome.htm

Finally, if you would like to obtain a consumer guide for a different state, visit the web at http://www.healthinsuranceinfo.net.

HELPFUL TERMS

Certificate of Creditable Coverage. A document provided by your health plan that lets you prove you had coverage under that plan. Certificates of creditable coverage will usually be provided automatically when you leave a health plan. You can obtain certificates at other times as well. See also Creditable Coverage.

COBRA. Stands for the Consolidated Omnibus Budget Reconciliation Act, a federal law in effect since 1986. COBRA permits you and your dependents to continue in your employer's group health plan after your job ends. If your employer has 20 or more employees, you may be eligible for COBRA continuation coverage when you retire, quit, are fired, or work reduced hours. Continuation coverage also extends to surviving, divorced or separated spouses; dependent children; and children who lose their dependent status under their parent's plan rules. You may choose to continue in the group health plan for a limited time and pay the full premium (including the share your employer used to pay on your behalf). COBRA continuation coverage generally lasts 18 months, or 36 months for dependents in certain circumstances.

Continuous Coverage. In general, health insurance coverage that is not interrupted by a break of 63 or more consecutive days. Employer waiting periods do not count as gaps in health insurance coverage for the purpose of determining if coverage is continuous. If you are buying ICHIA coverage and you are not federally eligible, you must apply within 6 months of losing prior coverage. See also ICHIA.

***Creditable Coverage* (ICHIA).** Health insurance coverage that was involuntarily terminated and that had a similar pre-existing condition exclusion. See also Continuous Coverage, ICHIA.

***Creditable Coverage* (Group Health Insurance).** Health insurance coverage under any of the following: a group health plan; an individual health plan; Medicare; Medicaid; CHAMPUS and TRICARE (health coverage for military personnel, retirees, and dependents); the Federal Employees Health Benefits Program; Indian Health Service; the Peace Corps; or a state health insurance high risk pool. See also Continuous Coverage, Group Health Plan, Individual Health Plan.

Elimination Rider. An amendment permitted in individual health plan contracts that permanently excludes your coverage for a health condition, body part, or body system. Elimination riders are not permitted in Indiana.

Enrollment Period. The period during which all employees and their dependents can sign up for coverage under an employer group health plan. Besides permitting workers to elect health benefits when first hired, many employers and group health insurers hold an annual enrollment period, during which all employees can enroll in or change their health coverage. See also Group Health Plan, Special Enrollment Period.

Family and Medical Leave Act (FMLA). A federal law that guarantees up to 12 weeks of job-protected leave for certain employees when they need to take time off due to serious illness, to have or adopt a child, or to care for another family member. When you qualify for leave under FMLA, you can continue coverage under your group health plan.

Federally Eligible. Status you attain once you have had 18 months of continuous creditable health coverage. Under federal law, to be federally eligible you also must have used up any COBRA or state continuation coverage; you must not be eligible for Medicare or Medicaid; you must not have other health insurance; and you must apply for individual health insurance within 63 days of losing your prior creditable coverage. No matter where you live in the U.S., if you are federally eligible you must be offered at least some type of individual health plan with no pre-existing condition periods. In Indiana, you must be offered coverage through ICHIA See also ICHIA, COBRA, Continuous Coverage, Creditable Coverage.

Fully Insured Group Health Plan. Health insurance purchased by an employer from an insurance company. Fully insured health plans are regulated by Indiana. See also Self-Insured Group Health Plans.

Genetic Information. Includes information about family history or genetic test results indicating your risk of developing a health condition. A group health plan cannot consider pre-existing (and therefore exclude coverage for) a condition about which you have genetic information, unless that health condition has been diagnosed by a health professional.

Group Health Plan. Health insurance (usually sponsored by an employer, union or professional association) that covers at least 2 employees. See also Fully Insured Group Health Plan, Self-Insured Group Health Plan.

Guaranteed Issue. A requirement that health plans must permit you to enroll regardless of your health status, age, gender, or other factors that might predict your use of health services. All health plans sold to small employers with 2 to 50 employees in Indiana are guaranteed issue. Plans that are guaranteed issue can turn you away for other reasons.

Guaranteed Renewability. A feature in health plans that means your coverage cannot be canceled because you get sick. HIPAA requires all health plans to be guaranteed renewable. Your coverage can be canceled for other reasons unrelated to your health status.

Health Insurance or ***Health Plan***. In this guide, the term means benefits consisting of medical care (provided directly or through insurance or reimbursement) under any hospital or medical service policy, plan contract, or HMO contract offered by a health insurance company or a group health plan. It does not mean coverage that is limited to accident or disability insurance, workers' compensation insurance, liability insurance (including automobile insurance) for medical expenses, or coverage for on-site medical clinics. Health insurance also does not mean coverage for limited dental or vision benefits to the extent these are provided under a separate policy.

Health Plan Year. That calendar period during which your health plan coverage is in effect. Many group health plan years begin on January 1, while others begin in a different month.

Health Status. When used in this guide, refers to your medical condition (both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), and disability. See also Genetic Information.

HIPAA. The Health Insurance Portability and Accountability Act, sometimes known as Kassebaum-Kennedy, after the two senators who spearheaded the bill. Passed in 1996 to help people buy and keep health insurance, even when they have serious health conditions, the law sets a national floor for health insurance reforms. Since states can and have modified and expanded upon these provisions, consumers' protections vary from state to state.

Hoosier Healthwise. Indiana's Medicaid program that provides managed care coverage for some low-income children, families, and pregnant women who have limited or no health insurance.

ICHIA. Indiana Comprehensive Health Insurance Association, the state-run insurance program for federally eligible persons and for people with high health risks (called a high risk pool).

Individual Health Plan. Policies for people not connected to an employer group. This term also refers to coverage purchased by self-employed persons who have no other employees. Individual health plans are regulated by Indiana.

Kassebaum-Kennedy. See HIPAA.

Large Group Health Plan. A health plan covering employees and their dependents in which the employer employs more than 50 employees.

Late Enrollment. Enrollment in a health plan at a time other than the regular or a special enrollment period. If you are a late enrollee, you may be subject to a longer pre-existing condition exclusion period. See also Special Enrollment Period.

Look Back. The maximum length of time, immediately prior to enrolling in a health plan, that can be examined for evidence of pre-existing conditions. See also Pre-existing Condition.

Medicaid. A program providing comprehensive health insurance coverage and other assistance to certain low-income Indiana residents. The Medicaid program offered to pregnant women, children, and families with children is called Hoosier Healthwise. All other states have Medicaid programs, too, though eligibility levels and covered benefits will vary.

Nondiscrimination. A requirement that group health plans not discriminate against you based on your health status. Your coverage under a group health plan cannot be denied or restricted, nor can you be charged a higher premium, because of your health status. Group health plans can restrict your coverage based on other factors (such as part time employment) that are unrelated to health status. See also Group Health Plan, Health Status.

***Pre-existing Condition* (Group Health Insurance).** Any condition (either physical or mental) for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period immediately preceding enrollment in a health plan. Pregnancy cannot be counted as a pre-existing condition. Genetic information about your likelihood of developing a disease or condition, without a diagnosis of that disease or condition, cannot be considered a pre-existing condition. Newborns, newly adopted children, and children placed for adoption covered within 30 days cannot be subject to pre-existing condition exclusions.

***Pre-existing Condition* (ICHIA).** Any condition for which medical advice, diagnosis, care or treatment was recommended or received within the 3-month period immediately preceding enrollment in a health plan Pregnancy can be counted as a pre-existing condition by ICHIA. See also Prudent Person Rule.

***Pre-existing Condition* (Individual Health Insurance).** Any condition for which medical advice, diagnosis, care or treatment was recommended or received within the 12 month period preceding enrollment in a health plan, or for which an ordinarily prudent person would have sought medical advice, care or treatment. In Indiana, under individual health insurance policies, pregnancy can be counted as a pre-existing condition. Genetic information can not trigger a pre-existing condition exclusion in individual health plans. See also Prudent Person Rule.

Pre-existing Condition Exclusion Period. The time during which a health plan will not pay for covered care relating to a pre-existing condition. See also Pre-existing Condition.

Prudent Person Rule. In individual health plans only, a rule that permits insurers to exclude as pre-existing any condition for which – in the insurer's judgment – most people would have sought care or treatment prior to enrolling in an individual health plan.

Self-Insured Group Health Plans. Plans set up by employers who set aside funds to pay their employees' health claims. Because employers often hire insurance companies to run these plans, they may look to you just like fully insured plans. Employers must disclose in your benefits information whether an insurer is responsible for funding, or for only administering the plan. If the insurer is only administering the plan, it is self-insured. Self-insured plans are regulated by the U.S. Department of Labor, not by Indiana.

Small Group Health Plan. A health plan covering employees and their dependents in which the employer employ at least 2 employers but not more than 50 employees.

Special Enrollment Period. A time, triggered by certain specific events, during which you and your dependents must be permitted to sign up for coverage under a group health plan. Employers and group health insurers must make such a period available to employees and their dependents when their family status changes or when their health insurance status changes. Special enrollment periods must last at least 30 days. Enrollment in a health plan during a special enrollment period is not considered late enrollment. See also Late Enrollment.

State Continuation Coverage. A program similar to COBRA for small employers with fewer than 20 employees. Indiana does not require state continuation coverage, but some other states do. See also COBRA.

Supplemental Security Income (SSI). A program providing cash benefits to certain very low income disabled and elderly individuals. When you qualify for SSI, you generally also qualify for Medicaid. In addition, Medicaid coverage often continues for a limited time if your income increases so that you no longer qualify for SSI.

Temporary Assistance for Needy Families (TANF). A program that provides cash benefits to low income families with children. When you qualify for TANF, you generally also qualify for Medicaid. In addition, Medicaid coverage often continues for a limited time if you no longer qualify for TANF. See also Medicaid.

U.S. Department of Labor. A department of the federal government that regulates employer provided health benefit plans. You may need to contact the Department of Labor if you are in a self-insured group health plan, or if you have questions about COBRA or the Family and Medical Leave Act. See also COBRA, Family and Medical Leave Act.

Waiting Period. The time you may be required to work for an employer before you are eligible for health benefits. Not all employers require waiting periods. Waiting periods do not count as gaps in health insurance for purposes of determining whether coverage is continuous. If your employer requires a waiting period, your pre-existing condition exclusion period begins on the first day of the waiting period. See also Pre-existing Condition Exclusion Period.