

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

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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 Health Policy Institute 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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A CONSUMER'S GUIDE TO GETTING AND KEEPING HEALTH INSURANCE IN HAWAII

As a Hawaii 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 a Hawaii 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 Hawaii, 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 24. For information about how to find consumer guides for other states on the Internet, see page 24. A list of helpful terms and their definitions begins on page 25. 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 and self insured group health plans** and **individual health insurance**), so your protections may vary if you leave Hawaii. Hawaii has expanded protections for certain kinds of health insurance beyond what federal law requires. 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 a Hawaii resident.

HOW AM I PROTECTED?

In Hawaii, 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.

- *All employers in Hawaii are required to offer health coverage to employees who work at least 20 hours per week. Coverage must meet standards set by state law. Employers must pay at least half of the premium. (See page 5.)*
- *Group health plans in Hawaii cannot impose **pre-existing condition exclusion periods**. (See pages 7.)*
- *If you are **HIPAA eligible**, you are guaranteed the right to buy any individual health policy from any individual health insurer that sells in Hawaii. (See page 8.)*
- *Your health insurance cannot be canceled because you get sick. Most health insurance is **guaranteed renewable**. (See page 10.)*
- *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 11.)*

- *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. This is called guaranteed issue. (See page 15.)*
- *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 Hawaii **Medicaid** program, which includes the **Medicaid Fee-for-Service Program** and **Hawaii QUEST**, offers free health coverage for pregnant women, families with children, and elderly and disabled individuals with very low incomes. The Hawaii Quest also offers free or subsidized health insurance for some low-income Hawaii residents who are not eligible for Medicaid. (See page 17.)*
- *If you believe you may be at risk for cancer but are uninsured or underinsured, you may be eligible for screening and treatment. The **Hawaii Breast and Cervical Cancer Control Program** provides free cancer screening for qualified residents. Some women diagnosed with breast or cervical cancer through this program may be eligible for medical care through Medicaid. (See page 20.)*
- *If you lost your health insurance and are receiving benefits from the **Trade Adjustment Assistance (TAA) Program**, you may be eligible for a federal income tax credit to help you pay for new health coverage. This credit is called the Health Coverage Tax Credit (HCTC), and is equal to 65% of the cost of qualified coverage, including COBRA. (See page 21.)*
- *If you are a retiree aged 55-65 and receiving benefits from **Pension Benefit Guarantee Corporation (PBGC)**, then you may be eligible for the HCTC. (See page 21.)*

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. (See page 7.)*
- *If you are buying individual health insurance as a HIPAA eligible individual, the law does not limit what you can be charged for that individual health policy. You can be charged substantially higher premiums because of your health status, age, gender, and other characteristics. (See page 10.)*

- *If you are not HIPAA eligible, individual health insurers in Hawaii are free to turn you down because of your health status and other factors. If you are offered an individual health insurance policy, you may have to satisfy a new pre-existing condition exclusion period. In addition, the law does not limit what you can be charged for individual health policy. You can be charged substantially higher premiums because of your health status, age, gender, and other characteristics. (See page 8.)*
- *If you are a small employer buying a group health plan, there are no limits on how much your premiums can vary. (See page 15.)*

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. Since 1974, Hawaii has required all employers to provide employees with health insurance coverage under qualified prepaid group health plans. As a result, a greater proportion of residents in Hawaii have health insurance coverage than in any other state in the U.S. If you move away from Hawaii, your protections under group health plans in other states will be different.

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

- *Hawaii requires all employers to provide health insurance coverage to employees who meet certain requirements.* You are not required to accept coverage offered by your employer. For example, you may prefer to accept coverage offered by your spouse's employer.
- *You must work for your employer at least 20 hours per week for 4 consecutive weeks.* If you have more than one job, the employer for whom you work at least 20 hours per week will provide health coverage. If you work more than 20 hours per week for more than one employer, you can choose which employer health plan to join. However, if one of your employers is a government entity and you elect coverage, you must elect the government employer plan.
- *Employers are not required to provide health benefits to seasonal workers.*
- *Employer sponsored health coverage must be through an approved "prepaid group health care plan."* A prepaid group health care plan must cover benefits required by state law, including at least 120 days of hospital care per year, physician services, diagnostic lab tests and x-rays, substance abuse treatment and maternity care (if enrolled in the plan at least 9 months before delivery).
- *Your employer must pay at least one-half of your health plan premium.* If your group coverage is under one of the "prevalent" group health plans (those sold by Kaiser or Hawaii Medical Services Association — also know as HMSA), your employer is not required to contribute to the cost of dependent coverage. However, if your group coverage is under a plan other than one of the prevalent plans, your employer is required to pay half of the premium for you and your dependents.

- *In Hawaii, an employer who is otherwise exempt from offering an employee coverage, because that employee has other coverage through another employer, spouse or government program, is required to offer coverage to that employee if the employee loses their other coverage.*
- *Under Hawaii 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.*
- *In Hawaii, adult dependents who are physically disabled or mentally retarded are able to stay on their parents' fully insured group health plan after they have reached the age at which the health plan usually cancels dependent coverage. In order to be eligible, the adult dependent must be incapable of self-support and must be dependent on the policyholder for support. Proof of incapacity must be provided to the health plan within 31 days of reaching the limiting age.*
- *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 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?

- *A group health plan cannot impose pre-existing condition exclusion periods.* When you join a group health plan in Hawaii that plan must immediately pay for all covered services, even those relating to a condition (such as asthma or diabetes) you may have had prior to joining the plan.

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 and individual health insurance for “HIPAA 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 policy from a private health insurance company. However, in Hawaii – as in most other states – you have limited guaranteed access to individual health insurance. There are some alternatives to individual health insurance – such as COBRA. 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 AN INDIVIDUAL HEALTH INSURANCE POLICY?

In Hawaii, your ability to buy individual health insurance may depend on your health status. There are certain circumstances, however, when you must be allowed to buy individual health coverage.

- *In general, companies that sell individual health insurance in Hawaii are free to turn you down because of your health status and other factors.*
- *If you are HIPAA eligible, private insurers cannot turn you down. Companies that sell individual insurance must offer you a choice of at least 2 plans that they sell.*

To be HIPAA eligible, you must meet certain criteria

If you are HIPAA eligible you are guaranteed the right to buy an individual health policy and are exempted from pre-existing condition exclusion periods. To be HIPAA 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.

HIPAA eligibility ends when you enroll in 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.

- *In Hawaii, newborns, adopted children, and children placed for adoption are automatically covered under the parents' individual health insurance policy for the first 31 days, if the policy 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.
- *In Hawaii, adult dependents who are physically disabled or mentally retarded are able to stay on their parent's individual health insurance policy after they have reached the age at which the health plan usually cancels dependent coverage.* In order to be eligible, the adult dependent must be incapable of self-support and must be dependent on the policyholder for support. Proof of incapacity must be provided to the insurer within 31 days of reaching the limiting age.

WHAT WILL MY INDIVIDUAL HEALTH INSURANCE POLICY COVER?

- *It depends on what you buy.* Hawaii does not require health insurers in the individual market to sell standardized policies. Health insurers can design different policies and you will have to read and compare them carefully. However, Hawaii does require all health plans to cover certain benefits – such as mammograms. Check with the Hawaii Insurance Division for more information about mandated benefits.

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *If you are purchasing individual health insurance as a HIPAA eligible individual, no pre-existing condition exclusion periods or elimination riders can be imposed on your individual health insurance policy.*
- *If you are not HIPAA eligible, there are different ways an individual health insurer can exclude a pre-existing condition. The insurer can impose an **elimination rider**. An elimination rider is an amendment to your health insurance contract that temporarily or permanently excludes coverage for a health condition, body part, or body system.*

Also, an individual health insurer may impose a pre-existing condition exclusion period. There is no standard definition of pre-existing condition for the individual market under Hawaii law; however, insurers offering individual health insurance are generally limited to a three-year period for pre-existing condition exclusions. Further, individual health insurers are not required to credit prior health coverage toward pre-existing condition exclusion periods.

In Hawaii, pregnancy can be considered a pre-existing condition by individual health insurers, but genetic information cannot be considered a pre-existing condition in the absence of a diagnosis.

WHAT CAN I BE CHARGED FOR MY INDIVIDUAL HEALTH INSURANCE POLICY?

- *If you have an expensive health condition, your individual health insurance premiums may be very high. The law does not prohibit Hawaii health insurers from charging you more because of your health status. In addition, when you renew your individual coverage, your premiums can increase substantially as you age or if your health declines.*

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 short-term health insurance policies. Short-term 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 short-term 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

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 or state continuation 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 their own decision. If your dependents were covered under your employer plan, they may independently elect COBRA coverage as well.*

- *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.
- *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.

SPECIAL SECOND CHANCE TO ELECT COBRA FOR TRADE-DISLOCATED WORKERS

- *A second COBRA election period may be available for TAA eligible people who did not elect cobra when it was first offered.* The second election period can be exercised 60 days from the 1st day of TAA eligibility, but in no case later than 6 months following loss of coverage. Coverage elected during this second election begins retroactive to the beginning of the special election period – not back to qualifying event.
- *Certain people who lost their job-based health coverage because of the impact of imports on their employers have a limited second chance to elect COBRA.* People who are receiving benefits from the Trade Adjustment Assistance (TAA) Program are eligible for a federal income tax credit (the Health Coverage Tax Credit, or HCTC) that will pay 65% of their premiums.
- *For some laid off workers, TAA benefits begin after their 60-day period to elect COBRA continuation coverage has expired.* In this circumstance, TAA-eligible people have a second 60-day period, starting on the date of their TAA eligibility, to elect COBRA. (However, in no case can COBRA be elected more than 6-months following the original qualifying event (i.e. layoff) that caused the loss of group health plan coverage.)
- *When COBRA is elected during this special, second election period, coverage starts on the first date of the special election period.* Any time that has elapsed between the original qualifying event and the first date of the special election period is not counted as a lapse in coverage in determining continuous coverage history.

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 be faced with 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.
- *If you are eligible for the Health Coverage Tax Credit (HCTC), the federal government will pay 65% of your COBRA premium.* (See page 21.)

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. (See box)

LENGTH OF COBRA COVERAGE

| <u>Qualifying event(s)</u> | <u>Eligible person(s)</u> | <u>Coverage</u> |
|------------------------------------------------------------------------------------------|---------------------------------------|-----------------|
| 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 employer stops offering health benefits to 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. Some 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.*

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. These reforms complement Hawaii's requirements that employers provide health benefits. Generally, small employers are those that employ 1-50 employees. Please note that the definitions of small employer and employee are somewhat different under federal and state law. Check with the Hawaii Insurance Division 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 fewer than 50 people, health insurance companies must sell you any **small group health plan** they sell to other small employers. The prevalent prepaid group health plans sold by Kaiser and HMSA must be sold on a guaranteed issue basis to employers of any size.
- *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. Additionally, they can refuse to renew your coverage for nonpayment of premiums or if you commit fraud. If insurers discontinue an insurance product that you bought, 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?

- *In general, you can be charged higher premiums based on the health, risk, and demographic characteristics of your group.* Premiums for the prevalent prepaid group health plans sold by Kaiser and HMSA are based on a community rate. This means that they will not vary based on the health status or any other characteristic of the people in your group.

WHAT PLAN CHOICES DO I HAVE?

- *In Hawaii, insurers must offer small employers prepaid group health plan which must include certain benefits.* These benefits include hospitalization, outpatient care, surgical care, physicians' services, laboratory and x-ray services, substance abuse

treatment and maternity care if the employee was enrolled in the plan for 9 months prior to delivery. Standardization helps you compare differences in cost and coverage. Carriers can also offer to sell you non-standardized plans. Most small employers choose to purchase a non-standardized plan.

WHAT IF I AM SELF-EMPLOYED?

- *If you are self-employed with no other workers, you cannot buy a group health plan. Therefore, the laws that protect small employers' access to group health plans do not apply to you. However, you may be able to join a group health plan through a family member or a professional association that sells group health coverage to other small employers. If not, 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 100% percentage of the cost of your premium from your federal income tax.*

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 Hawaii Insurance Division about your protections in association health plans.*

CHAPTER 5

FINANCIAL ASSISTANCE

Help is available to certain low-income residents of Hawaii who cannot afford to buy health insurance. Medicaid, Hawaii QUEST, the Breast and Cervical Cancer Control Program and other programs either offer free or subsidized health insurance coverage, direct medical services or other help.

In addition, the Federal Health Coverage Tax Credit (HCTC) Program provides tax credits to early retirees and some workers who lose their jobs or whose work hours and wages are reduced as a result of increased imports.

This chapter provides summary information about these programs and contact information for further assistance.

MEDICAID

Medicaid is a program that includes the Medicaid Fee-for-Service Program and Hawaii QUEST. It provides health coverage to some low-income Hawaii residents and covers families with children and pregnant women, medically needy individuals, the elderly, and people with disabilities, 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.

The Medicaid Fee-for-Service program provides coverage for residents who are over the age of 65 or are blind or disabled. Hawaii QUEST is a managed care program that provides coverage for all other eligible persons.

- *In Hawaii you may be eligible for Medicaid if you are an infant, a child, a pregnant woman, or a parent of a child and your family income meets the Medicaid income standards.*

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 Hawaii Department of Human Services for more information.

- *Families who get cash benefits from TANF can get Medicaid.*

Parents should know that when you get a job and your TANF benefits end, you generally can stay on Medicaid for a 12-month transitional period.

Parents should know that when your family's TANF benefits end, your children may also qualify for transitional Medicaid coverage for 12 months. Or, they may qualify for Medicaid themselves if your family's income meets the Medicaid income standards. (See below.)

Low income persons eligible for Medicaid in Hawaii*

| <u>Category</u> | <u>Income eligibility</u> (as percent of federal poverty level) |
|----------------------|-----------------------------------------------------------------|
| Child 1-18 | 200% (monthly income of about \$2,612 for a family of 3) |
| Parent (non-working) | 100% |
| Parent (working) | 100% |
| Pregnant woman | 185% |
| Medically Needy | |
| -Individual | 51% |
| -Couple | 51% |

* Eligibility information was compiled from *State Health Facts Online*, the Kaiser Family Foundation, 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 2004:

| <u>Size of Family Unit</u> | <u>Poverty Guideline</u> (annual income) |
|----------------------------|------------------------------------------|
| 1 | \$ 9,310 |
| 2 | \$ 12,490 |
| 3 | \$ 15,670 |

For larger families add \$3,180 for each additional person

So, for example, using this guideline, 200% of the federal poverty level for a family of 3 would be an annual income of \$31,340, or a monthly income of \$2,612.

- *Very poor elderly or disabled people who get **Supplemental Security Income (SSI)** benefits can also qualify 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 at least for a limited time.

- *People who have high medical expenses may also qualify for Medicaid.* You may qualify as medically needy if you are a child, parent or a dependent child, pregnant, elderly, or disabled and have high medical expenses that, when subtracted from your income, would make you eligible for Medicaid coverage. For example, people who have to pay a lot for prescription drugs, nursing home care, or other long term care services sometimes qualify as medically needy if they don't have health insurance that covers these services.
- *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, there may be other ways Medicaid can help you.

If your household income is below the poverty level and your assets are within the established limits, 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 and your assets are within established limits, Medicaid will pay for your monthly Medicare premiums only. This is called the Specified Low-Income Medicare Beneficiary (SLMB) program.

Contact the Hawaii Department of Human Services 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 Hawaii Department of Human Services.

HAWAII QUEST

Hawaii QUEST also subsidizes health coverage to low-income Hawaiians who are not eligible for Medicaid and who have no health insurance.

- *To be eligible for Hawaii Quest coverage, you must meet eligibility requirements.* You must be a Hawaii resident and a U.S. citizen or qualified alien. In addition, you must have a social security number. You must be under age 65 and you must not be blind, disabled, or living in a public institution. Your income must be below 100% of the federal poverty level, although the income limits are higher for pregnant women (185%) and those under the age of 19 (200%). In addition, you must have limited assets. Finally, you must not be eligible for health insurance from your employer unless you are receiving welfare or general assistance benefits.

- *Hawaii Quest has an enrollment cap.* If enrollment in the program is full, no new applications will be taken. However, certain residents are eligible for Hawaii Quest without regard to the enrollment cap. These people include foster children, pregnant women and children with household incomes up to 185% of the federal poverty level, people who lose employer-sponsored coverage when they lose their jobs, and certain others. Contact Hawaii Quest for more information about eligibility and enrollment.
- *Six medical plans participate in Hawaii Quest.* A choice of all six plans is available on Oahu and a choice of at least two of the participating plans is offered on each of the Neighbor Islands. Some plans limit the number of enrollees. If your first choice plan is full, you may be asked to select a different plan. Enrollees who don't select a Hawaii Quest plan will be assigned to one.
- *Hawaii Quest coverage includes hospital and physician care, prescription drugs, preventive care, vision care, and other services.* Comprehensive dental benefits are available for children. All benefits are offered through managed care plans. Cost sharing is limited, but no copayments will be charged for enrollees with very low incomes.
- *Premiums for Hawaii Quest coverage depend on your income and employment status.* Contact Hawaii Quest for more information about premiums.

HAWAII BREAST AND CERVICAL CANCER CONTROL PROGRAM

- *The Hawaii Breast and Cervical Cancer Control Program provides qualified woman with free screenings for breast and cervical cancer.* Women screened through this program and diagnosed with breast or cervical cancer may be eligible for free health coverage through Medicaid which extends throughout the duration of treatment.
- *In order to be eligible for screening through the program, you must be a resident of Hawaii.* To be eligible for the program, you must be between the ages of 40 and 64, while you must be between the ages of 40 and 64. You must also have no or limited health coverage, be ineligible for Medicaid or Medicare, and have an income at or below 250% of the federal poverty level.
- *For more information, please call Hawaii Breast and Cervical Cancer Control at (808) 692-7481 or visit them on the web at <http://www.hawaii.gov/health/family-child-health/chronic-disease/cancer/about.html>*

OTHER PROGRAMS

There may be other financial assistance programs available. Please contact your local Department of Health Services Health or visit <http://www.hawaii.gov/dhs/>

THE FEDERAL HEALTH COVERAGE TAX CREDIT (HCTC)

A federal income tax credit is available to help certain trade dislocated workers and early retirees, and their dependents, buy qualified health insurance coverage. The Health Coverage Tax Credit (HCTC) covers 65% of the insurance premium for qualified coverage. Under this program, you can either claim the tax credit at the end of the year on your tax return or you can elect to have the money paid directly to your qualified health plan each month by the Internal Revenue Service.

WHEN AM I ELIGIBLE FOR THE HCTC?

- *To be eligible for the tax credit, you must be receiving Trade Adjustment Assistance (TAA) benefits or retirement benefits from the PBGC.* If you are receiving PBGC benefits, you also must be at least 55 years old.
- *In addition, you must meet other requirements.* Specifically, you are not eligible for the HCTC if any of the following apply to you:
 - You have a health plan maintained by an employer or former employer that pays at least 50% of the cost of your coverage. Any share of your premium that is paid by you or your spouse on a pre-tax basis is considered to have been paid by your employer and must be included as such when determining the percentage of employer coverage.
 - You are enrolled in Medicare (Part A or B).
 - You are enrolled in the Federal Employees Health Benefits Program (FEHBP), Medicaid, or State Children's Health Insurance Program (CHIP).
 - You are entitled to health coverage through the U.S. military health system (Tricare/CHAMPUS).
 - You can be claimed as a dependent on someone else's federal tax return.
 - You received a lump sum payment of your entire PBGC benefit before August 6, 2002.

- As of the first day of the current month in which you are otherwise eligible, you are imprisoned under a federal, state or local authority.
- *HCTC may apply to your family, too.* If you are eligible, you can use the credit to help purchase qualified health coverage for your qualified family members. Qualified family members are your spouse and dependents that you can claim on your federal tax return. Family members are not eligible if they are enrolled in another group health plan where the employer pays at least 50% of the cost of coverage, or in Medicaid, SCHIP, FEHBP, Tricare/CHAMPUS.
- *Eligibility for HCTC is not based on income.* In addition, the HCTC is refundable. This means you can claim the credit even if you do not earn enough income to owe federal income tax.

HOW MUCH OF MY HEALTH COVERAGE COST WILL THE TAX CREDIT COVER?

- *The HCTC is equal to 65% of health insurance premiums for qualified health insurance coverage.*

WHAT HEALTH COVERAGE IS ELIGIBLE FOR THE TAX CREDIT?

- *The HCTC can only be used to help pay for “qualified” health coverage.* Qualified health coverage includes:
 - COBRA continuation coverage, as long as your employer or former employer contributes less than 50% of the total health plan premium.
 - State qualified plans: Currently, there are no state qualified plans offered in Hawaii.
 - Individual health insurance in which you were enrolled for at least the last 30 days before you were separated from the job that makes you eligible for TAA benefits or for payments from the PBGC.
 - Your husband’s or wife’s insurance from work, as long as the employer contributes less than 50% of the total health plan premium. (At this time, you can only claim the credit with this type of coverage when you file your federal tax return and not in advance.)

HOW DO I CLAIM THE HCTC?

- *You can claim the HCTC on your tax return and be reimbursed for 65% of the premium you paid for qualified coverage while you were eligible for the HCTC. Currently, this is the only way to claim the HCTC if your qualified health plan is provided through a spouse's employer.*
- *Alternatively, you can choose to have your credit sent directly to your qualified health plan each month. To do this, you must register with the HCTC customer service center by calling 1-866-628-HCTC (1-866-628-4282), Monday through Friday between the hours of 7 am and 7 pm, Central time. TDD/TYY callers, please call 1-866-626-HCTC (1-866-626-4282).*
- *You will have to fill out a registration form verifying your eligibility for the HCTC and your enrollment in qualified coverage. You will also fill out a payment invoice. Each month, you will send the HCTC program your 35% share of the premium for qualified coverage. The HCTC program will combine this payment with the tax credit covering the other 65% of the premium and forward the entire payment to your qualified health plan.*
- *You must register in advance to have the HCTC paid directly to your health plan each month. Usually, the direct payments won't begin until at least a month after you register with the HCTC program. Call the HCTC customer service center for more information*

WHERE CAN I GET MORE INFORMATION?

- *For more information about the HCTC, contact the HCTC customer service center at 1-866-628-HCTC, or see the IRS website at <http://www.irs.gov/individuals/index.html> (click on HCTC)*
- *For more information about TAA benefits contact, http://www.doleta.gov/tradeact/2002act_summary.asp.*
- *For more information about PBGC, contact, <http://www.pbgc.gov> or call 1-202-326-4000 with general inquiries.*

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 | <i>Hawaii Insurance Division</i> (808) 586-2790 http://www.state.hi.us/dcca/ins |
| Prepaid group health plans | <i>Department of Labor & Industrial Relations</i> (808) 586-8865 http://www.dlir.state.hi.us |
| COBRA continuation coverage Family and Medical Leave Act | <i>U.S. Department of Labor, San Francisco Regional Office</i> (626) 229-1000, or contact <i>U.S. Department of Labor, Division of Technical Assistance and Inquiries, Washington, D.C.</i> (202) 219-8776 <i>For Department of Labor publications:</i> (800) 998-7542 http://www.dol.gov/dol/pwba |
| Medicaid Hawaii QUEST | <i>Hawaii Department of Human Services</i> (808) 586-5390 http://www.state.hi.us/dhs |
| Hawaii Breast and Cervical Cancer Control Program | <i>Hawaii State Department of Health</i> (808) 692-748 http://www.hawaii.gov/health/family-child-health/chronic-disease/cancer/about.html |
| Other Programs | <i>Hawaii Department of Human Services</i> http://www.state.hi.us/dhs |
| Federal Health Coverage Tax Credit (HCTC) | <i>Internal Revenue Service</i> (866)-628-HCTC http://www.irs.gov/individuals/index.html |

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

HELPFUL TERMS

Alternative Trade Adjustment Assistance (ATAA). ATAA is a benefit for workers at least 50 years old who have obtained different, full-time employment within 26 weeks of the termination of adversely-affected employment. These worker may receive 50% of the wage differential (up to \$10,000) during their 2 year eligibility period. To be eligible for the ATAA program, workers may not earn more than \$50,000 per year in their new employment. Also, the firm where the workers worked must meet certain eligibility criteria.

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 (Individual Health Insurance). If you are buying an individual health insurance policy and you are not federally eligible, health insurance coverage is continuous if it is not interrupted by a break of more than 63 consecutive days. See also Federally Eligible, Individual Health Insurance.

Creditable Coverage (Individual Health Insurance). Health insurance coverage under any of the following: a group health plan; and individual health insurance policy; Medicare; Medicaid; CHAMPUS (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 Insurance.

Enrollment Period. The period during which all employees and their dependents can sign up for coverage under an employer group health plan. See also Group Health Plan, Special Enrollment Period.

Elimination Rider. An amendment permitted in individual health insurance contract that excludes coverage for a health condition, body part, or body system. Elimination riders can last indefinitely. Elimination riders cannot be imposed if you are federally eligible or if the insurer had you fill out a simplified application form when you applied for coverage.

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.

Fully Insured Group Health Plan. Health insurance purchased by an employer from an insurance company. Fully insured health plans are regulated by Hawaii. 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 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 1 employee. 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 Hawaii small employers with 1 to 50 employees are guaranteed issue. If you are federally eligible, insurance companies must offer you a choice of at least 2 plans that they sell.

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.

Hawaii Breast and Cervical Cancer Control Program. Program which provides free screening for breast and cervical cancer to eligible residents of Hawaii. Eligible women diagnosed with breast or cervical cancer may be eligible for free health coverage through Medicaid for treatment of their condition

Hawaii QUEST. A state program providing health coverage for low-income residents who meet certain qualifications.

Health Coverage Tax Credit (HCTC). The Health Coverage Tax Credit (HCTC) is a program that can help pay for nearly two-thirds of eligible individuals' health plan premiums. In general, in order to be eligible for the tax credit, you must be 1) receiving Trade Readjustment Allowance (TRA) benefits or 2) will receive TRA benefits once your unemployment benefits are exhausted or 3) receiving benefits under the **Alternative Trade Adjustment Assistance (ATAA)** program or 4) aged 55 or older and receiving benefits from the Pension Benefit Guaranty Corporation (PBGC).

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 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.

HIPAA Eligible. Status you attain once you have had 18 months of continuous creditable health coverage. 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. When you are buying individual health coverage, federal eligibility confers greater protections on you than you would otherwise have in Hawaii and in other states. See also COBRA, Continuous Coverage, Creditable Coverage.

HMO. Health maintenance organization. A kind of health insurance plan. HMOs usually limit coverage to care from doctors who work for or contract with the HMO. They generally do not require deductibles, but often do charge a small fee, called a copayment, for services like doctor visits or prescriptions. If you are covered under an HMO, the HMO might require an affiliation period before coverage begins. See also Affiliation Period.

Individual Health Insurance Policy. Policies for people not connected to an employer group. Individual health plans are regulated by Hawaii.

Kassebaum-Kennedy. See HIPAA.

Large Group Health Plan. One with more than 50 employees.

Medicaid. A program providing comprehensive health insurance coverage and other assistance to certain low-income Hawaii residents. In Hawaii, residents who are over the age of 65 or blind or disabled may be eligible for the Medicaid Fee-for-Service Program. Other eligible residents receive managed care services through Hawaii QUEST. All other states have Medicaid programs, too, though eligibility levels and covered benefits will vary.

Medicaid Fee-for-Service Program. A program providing comprehensive health insurance coverage and assistance to certain low-income residents who are over the age of 65, disabled or blind. See also Medicaid, Hawaii QUEST.

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.

Pension Benefit Guaranty Corporation (PBGC). PBGC is a federal government corporation established by Title IV of the Employee Retirement Income Security Act of 1974 (ERISA) to encourage the continuation and maintenance of defined benefit pension plans, provide timely and uninterrupted payment of pension benefits to participants and beneficiaries in plans covered by PBGC. It currently guarantees payment of basic pension benefits earned by American workers and retirees participating in private-sector defined benefit pension plans. The agency receives no funds from general tax revenues. Operations are financed largely by insurance premiums paid by companies that sponsor pension plans and by PBGC's investment returns.

Pre-existing Condition. Any condition (either mental or physical) you may have had prior to purchasing an individual health insurance policy. Individual health insurers cannot exclude coverage for pre-existing conditions if you are federally eligible. If you are not federally eligible, insurers may offer you an individual health insurance policy that temporarily or permanently exclude coverage of pre-existing conditions. Group health plans in Hawaii cannot exclude coverage of pre-existing conditions. Pregnancy can be counted as a pre-existing condition, but genetic information cannot be counted as a pre-existing condition in the absence of a diagnosis. Newborns, newly adopted children, and children placed for adoption covered within 31 days cannot be subject to pre-existing condition exclusions.

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.

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 must follow the same rules as all other group health plans in Hawaii.

Small Group Health Plans. Plans with fewer than 50 employees.

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 or longer if you no longer qualify for TANF. See also Medicaid.

Trade Adjustment Assistance (TAA) Program. A program authorized by the Trade Adjustment Assistance Reform Act of 2002. This program provides aid to workers who lose their job or whose hours of work and wages are reduced as a result of increased imports. The TAA Program offers six benefits and reemployment services to assist unemployed workers prepare for and obtain new suitable employment. In addition, TAA offers a significant tax credit that covers 65% of health insurance premiums for certain plans.

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.