

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

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December 2004

ACKNOWLEDGMENTS AND DISCLAIMER

The authors wish to express appreciation to Elizabeth Hadley, Robert Imes, Stephanie Lewis, Lauren Polite, Jalena Specht, and Nicole Tapay for their work developing earlier editions of these guides.

The authors also wish to express appreciation to the staff of the North Carolina Department of Insurance for their review of this document. Their help was invaluable in our research and understanding of applicable law and policy. Without them, this guide would not have been possible. However, any mistakes that may appear are our own.

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.

December 2004

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A CONSUMER’S GUIDE TO GETTING AND KEEPING HEALTH INSURANCE IN NORTH CAROLINA

As a North Carolina 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 North Carolina resident. Chapter 1 gives an overview of your protections. Chapters 2 and 3 explain your protections under group health plans and individual health insurance. Chapter 4 highlights your protections as a small employer or self-employed person. Chapter 5 summarizes help that may be available to you if you cannot afford health coverage. If you move away from North Carolina, 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 30. For information about how to find consumer guides for other states on the Internet, see page 30. A list of helpful terms and their definitions begins on page 31. 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 insurance**), so your protections may vary if you leave North Carolina. North Carolina 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 North Carolina resident.

HOW AM I PROTECTED?

In North Carolina, 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 than other members of the group, because of your health status. This is called **nondiscrimination**. (See page 6.)*
- *All health plans in North Carolina 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 health plan will begin to pay for care for that condition. Generally, if you join a new 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 pages 8 and 14.)*
- *Your health insurance cannot be canceled because you get sick. Most health insurance is **guaranteed renewable**. (See pages 5 and 21.)*
- *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 or **state 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 15.)*

- *If you have had at least 3 months of coverage under a fully insured group health plan and then lose it, you may be able to buy an individual health policy from the company that provided your group coverage. This is called a **conversion policy**. There are rules about what conversion policies must cover and limits on the premium you can be charged. You will not face a new pre-existing condition exclusion period under a conversion policy. (See page 20.)*
- *All North Carolina residents are guaranteed the right to buy individual health insurance from Blue Cross and Blue Shield of North Carolina. However, rates vary and you may be charged substantially higher premiums due to your health status or other factors. (See page 12.)*
- *If you are **HIPAA eligible**, you are also guaranteed the right to buy individual health insurance from any insurance company that sells such plans in North Carolina. Insurance companies must offer you a choice of at least two plans. (See page 12.)*
- *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 21.)*
- *If you are a small employer buying a group health plan, there are limits on what you can be charged because of health status, age, or other characteristics of those in your group. (See page 21.)*
- *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 North Carolina **Medicaid** program offers free health coverage for pregnant women, families with children, elderly and disabled individuals with very low incomes. In addition, some women who are diagnosed with breast and/or cervical cancer may be eligible for medical care through Medicaid. (See Chapter 5.)*
- *If your children are 18 years old or younger, do not have health insurance and meet other qualifications, they may be eligible to buy health insurance through **North Carolina Health Choice for Children**. (See page 25.)*
- *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 and health insurance offered through the Blue Cross and Blue Shield of North Carolina. (See page 27.)*

- *If you are a retiree aged 55-65 and are receiving benefits from **Pension Benefit Guarantee Corporation (PBGC)**, then you may be eligible for the HCTC (See page 27.)*

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 or state continuation 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 15.)*
- *If you change jobs, your new employer may not offer you health benefits. Employers are required only to make sure that any health benefits they do offer do not discriminate based on health status. (See page 6.)*
- *If you get a new job with health benefits, your coverage may not start right away. Employers can impose **waiting periods** before your health benefits begin. **HMOs** can impose **affiliation periods**. (See page 7.)*
- *If you have a break in coverage of 63 days or more, you may have to satisfy a new pre-existing condition exclusion period when you join a new plan. (See page 8.)*
- *Even if your coverage is **continuous**, 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 10.)*
- *If you work for certain non-federal public employers in North Carolina, not all of the group health plan protections may apply to you. (See page 10.)*
- *If you are not HIPAA eligible, insurers providing individual health insurance in North Carolina (other than Blue Cross and Blue Shield of North Carolina) are free to turn you down for that coverage because of your health status and other factors. (See page 12.)*
- *Even if you are HIPAA eligible, you can be turned down for some individual health insurance policies. The law permits insurance companies to limit your choices to*

two plans, which are supposed to be comparable to others they sell in the individual market in North Carolina. (See page 12.)

- *The law does not limit what you can be charged for individual health insurance. You can be charged substantially higher premiums because of your health status, age, gender, and other characteristics. (See page 14.)*
- *Except when you are HIPAA eligible, individual health policies can permanently exclude coverage for your pre-existing condition. (See page 14.)*

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. Or, your employer may offer an HMO plan that you cannot join because you live outside of the plan's service area.
- *You cannot be turned away or charged more than other group members 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 has 200 employees and 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)

- *If your fully insured employer coverage covers minor children, coverage must begin from the moment of birth, or upon placement for foster and adopted children. The health plan may require that the parent enroll the child within the 30 days in order to continue coverage beyond the 30 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 31 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. Unlike employers, insurance companies cannot require waiting periods.*
- *When you begin a new job with health insurance through an HMO, the HMO may require an affiliation period before coverage begins. During this affiliation period, you will not have health insurance coverage. An HMO affiliation period cannot exceed 2 months (3 months for late enrollees), and you cannot be charged a premium during it.*
- *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 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.

- *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 or 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 period is 12 months. You will receive credit toward your pre-existing condition exclusion period for any previous creditable coverage. If you enroll late in your group health plan (after you are hired and not during a regular or special enrollment period), coverage for your pre-existing condition can be excluded for as long as 18 months.*
- *Group health plans that impose pre-existing condition exclusion periods must give credit for any previous **continuous creditable coverage**. Most types of private and government sponsored health coverage are considered to be creditable coverage. Coverage counts as continuous if it has not been interrupted by a break of 63 or more days in a row.*

What is creditable coverage?

Most health insurance counts as creditable coverage, including:

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

In determining continuous coverage, employer-imposed waiting periods and HMO affiliation 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 continuous 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. HMOs that require an affiliation period cannot exclude coverage for pre-existing conditions.

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 pre-existing 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 health 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 health plan may impose a pre-existing condition exclusion period for that category.

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, the counties of Alamance, Craven, and Rowan 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 North Carolina 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.

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 continuation coverage, state continuation coverage, conversion coverage, individual health insurance, and coverage for “HIPAA eligible individuals.”*
- *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 and health insurance offered through the Blue Cross and Blue Shield of North Carolina. (See page 27.)*
- *If you are a retiree aged 55-65 and are receiving benefits from Pension Benefit Guarantee Corporation (PBGC), then you may be eligible for the HCTC (See page 27.)*

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 individual health insurance from a private insurer. However, in North Carolina – as in most other states – you have limited guaranteed access to individual health insurance. There are some alternatives to individual health insurance coverage – such as COBRA, state continuation coverage, and conversion 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 North Carolina, your ability to buy individual health coverage 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 North Carolina, except for Blue Cross and Blue Shield, 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 offer to sell you a policy that has special limitations on what it covers.*
- *All residents are guaranteed access to individual health insurance through Blue Cross and Blue Shield of North Carolina, although rates may vary.*
- *If you are HIPAA eligible, all private insurance companies that sell individual health insurance must offer you a choice of at least two plans, whose benefits must be similar to those sold to everyone else. Companies that do not designate two policies must offer you a choice of all their individual insurance policies. Policies sold to HIPAA eligible individuals cannot impose pre-existing condition exclusion periods. However, there is no limit on what you can be charged for this coverage.*

To be HIPAA eligible, you must meet certain criteria:

If you are HIPAA eligible you are guaranteed the right to buy individual health insurance 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 HIPAA eligible.)
- You must apply for health insurance for which you are HIPAA 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 HIPAA eligible again by maintaining continuous coverage and rejoining a group health plan.

- *All plans that provide benefits for any minor child must provide benefits from the moment of birth, as well as upon placement for foster and adopted children.* The health plan may require that the parent enroll the child within the 30 days in order to continue coverage beyond the 30 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 31 days of reaching the limiting age and may be required subsequently in the future.

WHAT WILL MY INDIVIDUAL HEALTH INSURANCE COVER?

- *It depends on what you buy.* North Carolina 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. However, North Carolina does require all health plans to cover certain benefits – such as mammograms, pap smears, and diabetes treatment and services. Check with the North Carolina Department of Insurance for more information about mandated benefits.

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *Individual health insurers can impose **elimination riders**.* This is an amendment to your health insurance policy that permanently excludes coverage for a health condition or even an entire body part or system.
- *North Carolina insurers can also impose **pre-existing condition exclusion period**.* Pre-existing condition exclusion periods cannot exceed 12 months. If a 12-month exclusion period is applied, you can get credit for any prior continuous creditable coverage you have had as long as you have not had a gap of 63 days or more between your old and new coverage. No pre-existing condition exclusion periods can be applied if you are HIPAA eligible

The definition of pre-existing condition is different under individual health insurance than under group health plans. Individual health insurance can count as pre-existing conditions only those for which you actually received (or were recommended to receive) a diagnosis, medical advice, or treatment in the 12 months prior to obtaining the individual health policy. Individual health policies can count pregnancy as a pre-existing condition, but not genetic information.

- *After you purchase your individual health insurance policy, insurers can still exclude coverage for pre-existing condition even if it was not specifically excluded in the terms of the policy.* If you make a claim during the first two years of coverage, the insurer can look back 12 months from the time of your application to see if the claim is for a condition that would have been considered a pre-existing condition. If the insurer determines, using the objective standard, that the condition is a pre-existing condition, it can refuse to pay for expenses for that condition.

WHAT CAN I BE CHARGED FOR INDIVIDUAL HEALTH COVERAGE?

- *If you have an expensive health condition, your individual health insurance premiums may be very high.* The law does not prohibit North Carolina health insurers from charging you more because of your health status.
- *Your premiums also will vary depending on your family size and the type of policy you want.*
- *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. Coverage may be canceled should the carrier leave the market after appropriate notice or membership ceases in certain kinds of association groups. Contact the North Carolina Department Insurance for more information about your protections in association health plans.
- *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 six 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. Short Term Major Medical coverage does not constitute a break in coverage for the purpose of creditable coverage if the coverage does not last longer than twelve months.

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 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.

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 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.
- *To qualify as HIPAA eligible, you must choose and use up any COBRA or state continuation coverage available to you.*
- *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 the 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. COBRA does not cover life insurance.*

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 27.)*

HOW LONG DOES COBRA COVERAGE LAST?

- *COBRA coverage generally lasts up to 18 months and cannot be renewed. However, 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 be determined to have become disabled 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 within 60 days of this disability determination.*

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

*Special rules may extend coverage an additional 11 months for certain disabled individuals and their eligible family members

- *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.*

WHAT ABOUT NORTH CAROLINA CONTINUATION COVERAGE?

- *If your employer offers health benefits and has fewer than 20 workers, you may be eligible for up to 18 months of continuation coverage under a North Carolina law that is similar to COBRA. Ask your former employer or the North Carolina Department of Insurance about state continuation coverage if you think it applies to you.*

CONVERSION POLICIES

WHEN AM I ELIGIBLE FOR CONVERSION COVERAGE?

- *In North Carolina, if you have coverage through an 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. You must apply for conversion coverage and pay your first premium within 31 days after receiving notice of your conversion rights. To qualify for a conversion policy, you first must have used up any COBRA or state continuation coverage and cannot be eligible for Medicare or any other federal or state insurance program.*
- *Conversion rights are also available to dependents covered under the employer's group plan.*

WHAT DOES A CONVERSION POLICY COVER?

- *You must be given a choice of conversion policies. Also, if your employer's group plan covered basic hospital and surgical expense and/or major medical expense, then the conversion policy must meet minimum standards for coverage for these expenses as well.*

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *Conversion policies cannot impose a pre-existing exclusion for conditions covered under the prior group plan.*

HOW MUCH CAN I BE CHARGED FOR CONVERSION COVERAGE?

- *Conversion policies may cost more than your previous group plan. There is no limit on what you can be charged for conversion policies. Contact the North Carolina Department of Insurance if you have questions about the cost of conversion coverage.*

CAN MY CONVERSION COVERAGE BE CANCELLED?

- *Your coverage cannot be cancelled because you get sick. This is called guaranteed renewability. You have this protection provided you pay premiums, do not defraud the company, and are not eligible for substantially similar coverage under Medicare or other federal or state law or have other insurance which together with the conversion policy would be considered over-insurance.*

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. North Carolina has enacted reforms to expand some of these protections. Some of these reforms apply to groups of different sizes. Generally, small employers are those that employ 2-50 employees. Self-employed persons with no other employees count as small employers in North Carolina, but have somewhat different protections. Please note, however, that the definitions of small employer and employee are somewhat different under federal and state law. Check with the North Carolina 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 but not more than 50 people eligible for health benefits, 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 workers participate in your group health plan. They can also require you to contribute a minimum percentage of your workers' premiums. If you are buying a **large group health plan** for 51 or more employees, your group can be turned down.
- *Your insurance cannot be canceled because someone in your group becomes seriously ill.* 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, or if they are withdrawing from the small employer market. In case of discontinuance, 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?

- *You can be charged higher premiums, within limits, based on the health, risk, and demographic characteristics of your group.* For small employers, North Carolina limits the difference in premiums and the annual increase that can be charged. For groups with 51 or more eligible employees, North Carolina does not apply these same limits on premium variation or increases. If you have questions about your group health insurance premiums, contact the North Carolina Insurance Department.

WHAT PLAN CHOICES DO I HAVE?

- *Insurance companies must offer small employers standardized health plans. In North Carolina, insurers must offer small employers 2 plans whose benefits are defined in law: a standard plan and a basic plan. Standardization helps you compare differences in cost and coverage. Carriers can also offer non-standardized plans.*

WHAT IF I AM SELF-EMPLOYED?

- *If you are self-employed with no other workers, you are treated similarly to other small employers. Insurers cannot refuse to sell you the standard plan or basic plan. They can refuse to sell you other plans, however.*
- *If you are buying health insurance for a full-time household employee and meet other requirements, you are considered a business group of one. In this case, insurers must offer to sell you standard and basic coverage for your household employee, but can refuse to sell you other small group health plans.*
- *In order to show that you qualify as a self-employed person or a business group of one, insurance companies are allowed to require that you provide them with your tax forms or a certification from your attorney or accountant.*
- *If you are self-employed and buy your own health insurance, you are eligible to deduct 100% 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 North Carolina Department of Insurance about your protections in association health plans.*

CHAPTER 5

FINANCIAL ASSISTANCE

Help is available to certain low-income residents of North Carolina who cannot afford to buy health insurance. Medicaid and the North Carolina Health Choice for Children offer free or subsidized health insurance coverage, direct medical services or other help. In addition, the federal government, under the Trade Adjustment Assistance (TAA) Program, provides tax credits to 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 provides health coverage to some low-income North Carolina residents. Medicaid covers families with children and pregnant women, the elderly, people with disabilities, and medically needy individuals 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.

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

In North Carolina you may be eligible for Medicaid if you are an infant, a child, pregnant, 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 North Carolina Division of Medical Assistance at the Department of Health and Human Services for more information.

Low income persons eligible for Medicaid in North Carolina*

<u>Category</u>	<u>Income eligibility</u> (as percent of federal poverty level)
Infant	185% (monthly income of about \$2,416 for family of 3)
Child 1-5	133%
Child 6-19	100%
Non-working parents	42%
Working parents	57%
Pregnant woman	185%
Medically Needy	
Individual	34%
Couple	33%

* Eligibility information was compiled *State Health Facts Online*, the Henry J. 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 (annual income)</u>
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, 185% of the federal poverty level for a family of 3 would be an annual income of \$28,990, or a monthly income of \$2,416.

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

- *Parents who receive benefits under **TANF (also known as Work First)** 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.*

In addition, your children may qualify for transitional Medicaid coverage for 12 months. Or, you may qualify for Medicaid yourself if your family's income meets the Medicaid income standards.

- *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 of 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 do not 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, 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 premiums only. This is called the Specified Low-Income Medicare Beneficiary (SLMB) program.

Contact your County Office of Public Assistance 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 Division of Medical Assistance at the Department of Health and Human Services.

To obtain the locations and telephone numbers of sites near you call the Division of Medical Assistance of North Carolina at the Department of Health and Human Services.

To apply for Medicaid, call your local department of social services (DSS). You can also ask to have an application mailed to you.

NORTH CAROLINA HEALTH CHOICE FOR CHILDREN

North Carolina Health Choice for Children is a state-designed program that provides health coverage to low-income children under the age of 19 who are not eligible for Medicaid and who have limited or no health insurance.

- *A child whose family has a household income below 200% of the federal poverty level is eligible. For a family of 3, this works out to an annual income of about \$31,340, or a monthly income of about \$2,612.*
- *If your household income is between 151% and 200% of the federal poverty level, there is an enrollment fee of \$50 for one child or \$100 for two or more children. You are also required to make copayments.*
- *If your household income is at or below 150% of the federal poverty level, you are only required to make copayments for prescription drugs. Those copayments are \$1 for a generic drug or for a brand-name drug for which no generic is available and \$10 for brand-name drug for which there is a generic available.*
- *Some of the benefits include hospitalization, physician services, prescription drugs, mental health services, substance abuse treatment, and vision and dental care.*
- *To apply for the program, contact your county social services department or local health department. An application can be found on the program's web site (<http://www.dhhs.state.nc.us/dma/cpcont.htm>).*

<p>NORTH CAROLINA BREAST AND CERVICAL CANCER CONTROL PROGRAM (NCBCCCP)</p>

North Carolina's Breast and Cervical Cancer Control Program (BCCCP) provides free screening services for breast and cervical cancer for the eligible women of North Carolina. Eligible women diagnosed with breast or cervical cancer may be eligible for free health coverage through Medicaid for treatment of their condition.

- *The Breast and Cervical Cancer Program (BCCCP) 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 Breast and Cervical Cancer Control Program, you must meet age and income guidelines and insurance requirements. You must be between the ages of 18 and 64 and you must have an income at or below 200% of the federal poverty level (FPL). Additionally, you must be uninsured or underinsured and must not have Medicare Part B or Medicaid.*
- *For more information, please contact the Chronic Disease and Injury Section at (919) 715-0111 or visit their website at <http://www.communityhealth.dhhs.state.nc.us/cancer/bcccp.htm>.*

OTHER STATE PROGRAMS

There may be other financial assistance programs available. Please contact the North Carolina Department of Health and Human Services at 1-800-662-7030 or <http://www.dhhs.state.nc.us/>

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 (SCHIP).
 - 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. (See Chapter 3 for COBRA and state continuation coverage.)
 - 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.)
 - State qualified plan: In North Carolina, Blue Cross Blue Shield of North Carolina offers “qualified health coverage.”

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 Fully insured group health insurance State continuation coverage Conversion coverage	<i>North Carolina Department of Insurance</i> (800) 546-5664 (in-state only) (919) 733-7349 http://www.ncdoi.com/default.asp
Self-insured group health plans COBRA continuation coverage Family and Medical Leave Act	<i>U.S. Department of Labor</i> (404) 562-2156 Atlanta Regional Office (954) 424-4022 Miami District Office <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	<i>Department of Social Services, CARE-LINE</i> (800) 662-7030 Information/Referral Service (919) 733-4261 Triangle area (919) 733-4851 (TTY), or email care.line@ncmail.net
North Carolina Health Choice for Children	<i>North Carolina Family Health Resource Line</i> (800) 367-2229 http://www.dhhs.state.nc.us/dma/cpcont.htm#app
Breast and Cervical Cancer Control Program	<i>Department of Health and Human Services, Chronic Disease and Injury Section</i> (919) 715-3125 http://www.communityhealth.dhhs.state.nc.us/index.htm
The Federal Health Coverage Tax Credit (HCTC)	<i>Internal Revenue Service (IRS)</i> (866) 628-HCTC http://www.irs.gov/individuals/index.html (Click on HCTC); or call HCTC customer service center

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

HELPFUL TERMS

Affiliation Period. The time an HMO may require you to wait after you enroll and before your coverage begins. HMOs that require an affiliation period cannot exclude coverage of pre-existing conditions. Premiums cannot be charged during HMO affiliation periods. See also HMO.

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. See also State Continuation Coverage.

Continuous Coverage. If you are joining a self-insured group health plan or if you want to be HIPAA eligible, health insurance coverage is continuous if it is not interrupted by a break of 63 or more consecutive days. Employer waiting periods and HMO affiliation periods do not count as gaps in health insurance coverage for the purpose of determining if coverage is continuous. See also Creditable Coverage, HIPAA eligible, Fully Insured Group Health Plan, Individual Health Insurance, Self-Insured Group Health Plan. Coverage provided under a short-term limited duration health insurance plan shall not be treated as a break in coverage if the coverage did not last more than twelve months.

Conversion Policy. Your right, when leaving a group health plan in North Carolina, to convert your policy to an individual policy. You must use up any COBRA or state continuation coverage for which you are eligible before you can buy a conversion policy. Insurers must offer you a choice of coverage plans. Conversion policies may be significantly more expensive. See also Group Health Plan.

Creditable Coverage. Health insurance coverage under any of the following: a group health plan; individual health insurance; 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; the Children's Health Insurance Program, or a state health insurance high risk pool. See also Continuous Coverage, Group Health Plan, Individual Health Insurance.

Elimination Rider. An amendment permitted in individual health insurance contracts that permanently excludes your coverage for a health condition, body part, or body system. Elimination riders are permitted in North Carolina.

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.

Fully Insured Group Health Plan. Health insurance purchased by an employer from an insurance company. Fully insured health plans are regulated by North Carolina. 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 2 employees, or the self-employed. 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 are guaranteed issue. If you are self-employed or a household employer buying coverage for one full-time employee, basic and standard small group health plans are guaranteed issue. If you are HIPAA eligible, insurance companies must offer you at least two individual health plans that 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 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 health coverage tax credit, you must be 1) receiving Trade Readjustment Allowance benefits (TRA), 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 Plan Year. The 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.

HIPAA Eligible. Status you attain once you have had 18 months of continuous creditable health coverage. To be HIPAA 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 North Carolina and in other states. See also COBRA, Continuous Coverage, Creditable Coverage, State Continuation 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. Policies for people not connected to an employer group. Individual health insurance are regulated by North Carolina.

Kassebaum-Kennedy. See HIPAA.

Large Group Health Plan. One with 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.

Managed Care Plans. A kind of health insurance plan. Like an HMO, managed care plans can limit coverage to health care provided by doctors or hospitals who work for or contract with them—also called "network" providers—and therefore may limit enrollment to those people who live within a particular coverage area. Managed care plan may require you to get permission (a "referral") from your family doctor before you get care from a specialist in their network. Some managed care plans will cover your care at a lower rate if you go to a non-network provider or if you get specialty care without a referral. See also HMO.

Medicaid. A program providing comprehensive health insurance coverage and other assistance to certain low-income North Carolinans. 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.

North Carolina Health Choice for Children. A state-designed program that provides health coverage to low-income children under the age of 19 who are not eligible for Medicaid and who have limited or no health insurance.

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 (Group Health Plans). 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, foster children and children placed for adoption covered within 30 days cannot be subject to pre-existing condition exclusions.

Pre-existing Condition (Individual Health Insurance). Same definition as for group plans except the insurer may look back *12 months* prior to enrollment for diagnosis, care, or treatment of a condition.

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 are regulated by the U.S. Department of Labor, not by North Carolina.

Small Group Health Plan. Plans with no more than 50 employees, including the self-employed.

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. In North Carolina, if you are in a fully insured group health plan sponsored by an employer with 2 to 19 employees and meet other requirements, you also have rights to continue your health coverage when your job ends.

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 (also known as North Carolina Works) 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.