

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

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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 ARIZONA

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

This guide describes your protections as an Arizona 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. Chapter 5 summarizes help that may be available to you if you cannot afford health coverage. If you move away from Arizona, 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 32. For information about how to find consumer guides for other states on the Internet, see page 32. A list of helpful terms and their definitions begins on page 33. 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 insurance plans they regulate (**fully insured group health plans** and **individual health insurance policies**), so your protections may vary if you leave Arizona. Neither federal nor state laws protect your access to health insurance in all circumstances. So please read this guide carefully.

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

HOW AM I PROTECTED?

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

- *Coverage under your **group health plan** (if your employer offers one) cannot be denied or limited, nor can you be required to pay more, because of your health status. This is called **nondiscrimination** (see page 8).*
- *All group health plans in Arizona 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 group health plan your old coverage will be credited toward the **pre-existing condition exclusion period**, provided you did not have a long break in coverage (see page 10).*
- *Your health insurance cannot be canceled because you get sick. All health insurance is **guaranteed renewable** (see pages 17 and 22).*
- *If you leave your job, you may be able to remain in your old group health plan for a certain length of time. This is called **COBRA** 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 17).*

- If you lose your fully insured group health plan or individual health insurance and meet other requirements, you may be able to buy a group **conversion** policy. You will not face a new pre-existing condition exclusion period. There are no limits on what you can be charged for a conversion policy and the benefits may not be as generous as your prior coverage (see page 21).
- *If you lose your group health insurance and meet other qualifications, you will be **HIPAA eligible**.* If so, you have the right to buy an individual health insurance from any insurance company that sells individual health insurance in Arizona. Insurance companies must offer you a choice of at least two plans. However, they may charge you significantly higher premiums due to your health status, age, or other factors (see page 15).
- *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 23).
- *If you are a small employer with 50 or fewer employees, including the self-employed, you may be eligible to obtain coverage through the **Healthcare Group of Arizona (HCG)*** (see page 24).
- *If you are an employer buying a HCG plan, you cannot be charged more due to the health status or claims experience of those in your group.* Premiums for HCG plans do vary by age, gender, choice of plan and by county. This is called **modified community rating** (see page 24).
- *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 Arizona **Medicaid** program offers free health coverage for pregnant women, families with children, elderly and disabled individuals with very low incomes (see Chapter 5).
- *If your children are 18 years old or younger, do not have health insurance, and meet other qualifications, you may be able to buy insurance for them through **KidsCare*** (see page 29).
- *If you believe that you may be at risk for breast or cervical cancer, you may be eligible for free screening and treatment.* The **Well Woman HealthCheck Program** provides qualified woman with free breast and cervical cancer screening. In addition, women diagnosed with cancer through this program may be eligible for medical care through the Arizona Medicaid program (see page 29).

- *If you have lost your health insurance and are receiving benefits from the **Trade Adjustment Assistance (TAA) Program** then you may be eligible for a federal income tax credit to help pay for new health coverage. This credit is called the **Health Coverage Tax Credit (HCTC)**, and it is equal to 65% of the cost of qualified health coverage, including COBRA and HCG coverage (see page 30).*
- *If you are a retiree aged 55-65 and receiving pension benefits from **Pension Benefit Guaranty Corporation (PBGC)**, then you may also be eligible for the HCTC (see page 30).*

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 plan 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 8).*
- *If you change jobs, your new employer may not offer you health benefits. If your employer offers health benefits, then the decision on whether to offer your health insurance cannot be based on factors related to your health status (see page 8).*
- *If you get a new job with health benefits, your coverage may not start right away. Employers can require **waiting periods** before your health benefits begin. **HMOs** can require **affiliation periods** (see page 10).*
- *If you are joining a new group health plan, you may have to satisfy a new pre-existing condition exclusion period if you have a break in coverage of 63 days or more (see page 10).*
- *Even if your coverage is continuous, there may be a pre-existing condition exclusion period for some benefits if you join a **self-insured group health plan** that covers certain benefits your old plan did not. For example, say you move from a group plan that does not cover prescription drugs to a self-insured group health plan 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 11).*
- *If you work for certain non-federal public employers in Arizona, not all of the group health plan protections may apply to you (see page 12).*

- *If you are not HIPAA eligible, your access to individual health insurance may depend on your health status.* Private insurers are not prohibited from turning you down, charging more, or limiting coverage because of pre-existing conditions (see page 14).
- *Even if you are HIPAA eligible, you can be turned down for some individual health insurance.* The law permits insurance companies to limit your choices to two plans (see page 14).
- *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 16).
- *If you are a small employer buying a group health plan, you can be charged more, within limits, based on the health status of those in your group.* Even within these limits, however, premiums can be significantly higher if someone in your group has a serious health condition (see page 23).

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?

- *In general, 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 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. For fully insured plans, the **special enrollment period** must be at least 31 days. You can elect coverage at this time. If your group plan offers family coverage, your dependents can elect coverage as well. Enrollment during a special enrollment period is *not* considered **late enrollment**.

Certain changes can trigger a special enrollment opportunity

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

- *Under Arizona 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 dependent within the 31 days in order to continue coverage beyond the 31 days.*
- *Under Arizona law, your disabled children can remain under your fully insured group health insurance plan after he or she reaches the age at which coverage usually terminates. To qualify, your adult son or daughter must be incapable of self-support because of developmental disability or physical handicap and must be chiefly dependent on the policyholder for support and maintenance. Proof of incapacity must be furnished within 31 days of reaching the time limit and may be required periodically thereafter.*
- *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. You will not have health insurance coverage during this time.*
- *When you begin a new job with health insurance through an HMO, the HMO may require a waiting period before coverage begins. During this affiliation period you will not have health insurance coverage. The HMO also cannot impose any pre-existing condition exclusions if it imposes an affiliation period. An HMO affiliation period cannot exceed 2 months (3 months for late enrollees), and you cannot be charged a premium during this time.*
- *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 the 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?

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 exclude coverage for services related to that condition for a certain length of time. However, federal and state laws protect you by placing limits on these pre-existing condition exclusion periods under group health plans. In some cases your protections will vary, depending on the type of group health plan.

- A group health plans can count as pre-existing conditions only those for which you actually received (or were recommended to receive) a diagnosis, treatment or medical advice within the 6 months immediately before you joined that plan. This period is also called the **look back** period.
- *Group health plans cannot apply a pre-existing condition exclusion period for pregnancy, newborns, newly adopted children, children placed for adoption, or genetic information.*
- *Group health plans can exclude coverage for pre-existing conditions only for a limited time.* The maximum period is 12 months. However, if you enroll late in a group health plan (after you were hired and not during a regular or special enrollment period) you may have a pre-existing condition exclusion period of up to 18 months. You will receive credit towards your pre-existing condition exclusion period for any previous continuous coverage.
- *Group plans that impose pre-existing condition exclusion periods must give you credit for any previous continuous **creditable coverage** that you have had.* Most types of insurance 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:

Children's Health Insurance Program	Medicare
Federal Employees Health Benefits (FEHBP)	Military health coverage (CHAMPUS, TRICARE)
Foreign National Coverage	State high-risk pools
Group health insurance (including COBRA)	Student Health Insurance
Indian Health Service	VA Coverage
Individual health insurance	
Medicaid	

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 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 pre-existing 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*.

- *Your protections may differ if you move to a self-insured group health plan that offers more benefits than your old one did.* Self-insured group 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 self-insured group health plan may impose a pre-existing condition exclusion period for that category. Self-insured plans that use this method of crediting prior coverage must use it for everyone and must disclose this to you when you enroll. Fully insured group health plans in Arizona cannot do this.

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 self-insured plan does cover prescription drugs. However, because her prior policy did not, the new self-insured plan refuses to cover her blood pressure medicine for a year.

Question: Is this permitted?

Answer: Yes. However, the self-insured 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 required for other conditions that were not pre-existing.

- *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.

LIMITS TO PROTECTIONS FOR CERTAIN GOVERNMENT WORKERS

Federal law permits state, county, and local governments to exempt their employees in self-insured group health 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' group health plan.

In the past, few public employers in Arizona have decided that certain health insurance protections will not apply to their employees. The Center for Medicare and Medicaid Services (CMS) used to post a list of employers that had elected to exempt, however it has removed this information from its web site.

If you are not sure about your protections under your public employee health plan, you should contact your employer. In addition, you can contact CMS directly at (877) 267-2323 ext. 61565 or at (410) 786-1565 to see if your employer has elected to be exempt from certain protection.

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 and individual health insurance for “HIPAA eligible individuals.”*
- *If you have lost your group 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 it is equal to 65% of the cost of qualified health coverage, including COBRA and HCG coverage (see page 30).*
- *If you are a retiree aged 55-65 and receiving pension benefits from the Pension Benefit Guaranty Corporation (PBGC), you may also be eligible for the HCTC (see page 30).*

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 insurance policy from a private health insurance company. However, in Arizona – as in most other states – you have limited guaranteed access to individual health insurance. Whether you can buy an individual health insurance may depend on your health status, the kind of coverage you want to buy, and other circumstances. There are some alternatives to individual health insurance coverage – such as COBRA or conversion policies. This chapter summarizes your protections under different kinds of health plan coverage.

INDIVIDUAL HEALTH INSURANCE SOLD BY PRIVATE INSURERS

WHEN DO INSURERS HAVE TO SELL ME AN INDIVIDUAL INSURANCE POLICY?

In Arizona, 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 insurance.

- *In general, insurers that sell individual health insurance in Arizona are free to turn you down because of your health status and other factors. When applying for individual health insurance, 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.*
- *If you are HIPAA eligible, all insurance companies that sell individual health insurance must offer you a choice of at least two plans. Insurers must offer you at least two policies, whose benefits must be similar to those sold to everyone else buying individual health insurance. Companies that do not designate two policies must offer you a choice of all of their individual insurance products.*

To be HIPAA eligible, you must meet certain criteria

No matter where you live in the U.S., if you are HIPAA eligible you are guaranteed the right to buy individual coverage of some kind with no 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 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 individual health insurance, 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.

- *Under Arizona law, newborns, adopted children and children placed for adoption are automatically covered under the parents' health plan for the first 31 days, if the plan covers dependents. The insurer may require that the parent enroll the dependent within the 31 days in order to continue coverage beyond the 31 days.*
- *If you have a disabled child, that child may remain covered under your individual health insurance policy 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 developmental disability or physical handicap and must be chiefly dependent on the policyholder for support. Proof of incapacity must be furnished within 31 days of reaching the time limit and may be required periodically thereafter.*

WHAT WILL MY INDIVIDUAL HEALTH INSURANCE COVER?

- *It depends on what you buy. Arizona 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, Arizona does require all health insurers to cover certain benefits – for example, diabetes treatment and mammograms. Check with the Arizona Department of Insurance for more information about mandated benefits.*

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *If you are HIPAA eligible and purchasing a guaranteed issue individual health insurance policy, a pre-existing condition exclusion period cannot be applied.*
- *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. Elimination riders cannot be applied to HIPAA eligible individuals.*
- *Arizona insurers can also impose pre-existing condition exclusion periods. In Arizona, there are no limits on how long an individual health insurer can exclude a preexisting condition. This means that individual health insurers can decide themselves how long to exclude your pre-existing condition.*

In addition, in Arizona, individual health insurers have broad discretion to define what constitutes a pre-existing condition, even including an undiagnosed condition you may unknowingly have had when you applied for the policy. If you make a claim for a health condition after you buy a policy, it may be denied if the insurer decides the condition was pre-existing. In Arizona, individual health insurers can consider pregnancy a pre-existing condition. Genetic information cannot be considered a pre-existing condition.

- *If you make a claim during the first two years of coverage, the insurer can look back to see if the claim is for a condition that would have been considered a pre-existing condition. If the insurer determines that the condition is a pre-existing condition, it can refuse to pay for expenses for that condition.*
- *Individual health insurers do not have to give credit for your prior coverage, unlike group health plans in Arizona.*

WHAT CAN I BE CHARGED FOR MY INDIVIDUAL HEALTH INSURANCE?

- *In Arizona, there are no limits on 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 factors. So if you have an expensive health condition, your individual health insurance premiums may be very high.*

If you have questions about your premiums, contact the Arizona Department of Insurance.

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.
- *Your health insurance policy may be canceled if the insurer discontinues your health policy or withdraws from the individual market.*

Call the Arizona Department of Insurance if you have questions about an insurance company or the renewability of individual health insurance.

- *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 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 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.

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

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

COBRA QUALIFYING EVENTS

For employees

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

For spouses

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

For dependent children

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

- *Each person who is eligible for COBRA continuation can make his or her own decision.* If your dependents were covered under your employer plan, they may independently 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 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 have lost your group 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 it is equal to 65% of the cost of qualified health coverage, including COBRA and HCG (see page 30).
- If you are a retiree aged 55-65 and receiving pension benefits from Pension Benefit Guaranty Corporation (PBGC), and receiving benefits from the Trade Adjustment Assistance (TAA) Program, then you may be eligible for a federal income tax credit to help pay for new health coverage. This is called the Health Coverage Tax Credit (HCTC) (see page 30).

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.

HOW LONG CAN COBRA COVERAGE LAST?

<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 old 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.*

CONVERSION POLICIES

When you lose coverage under a fully insured group health plan in Arizona, in limited cases you are guaranteed the right to buy a conversion policy. This is an individual policy sold by the insurance company that covered your former group.

WHEN AM I ELIGIBLE FOR CONVERSION COVERAGE?

- *In Arizona, if you lose coverage under an employer's fully insured group health plan, you may be eligible to buy a conversion policy.* This is an individual policy you get from the company that issued your employer sponsored health insurance.
- *Conversion rights are available to certain individuals.* People who may be eligible for a conversion policy include a surviving spouse and children upon the death of the insured, a young adult who reaches the age at which dependent coverage is terminated, and a former spouse and children at divorce. In addition, if you are covered as a spouse or dependent under an individual policy in Arizona, you also have conversion rights. You are eligible to buy a conversion policy upon the death or divorce of the insured policyholder or when you reach the age at which your dependent coverage terminates.
- *If you had coverage through an employer's fully insured HMO plan and you lose that coverage, you may be eligible to buy a conversion policy.* Conversion rights are available to you and your dependents if you lose your job, in the case of the death of the insured, divorce from the insured, or if you age off the policy.

WHAT DOES A CONVERSION POLICY COVER?

- *Coverage under a conversion policy may be less generous than under your previous policy.*

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

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

HOW MUCH CAN I BE CHARGED FOR CONVERSION COVERAGE?

- *Conversion policy premiums may be much more expensive than your former plan premiums.* There are no limits on what you can be charged for a conversion policy.
Contact the Arizona Department of Insurance if you have questions about conversion policy premiums.

CAN MY POLICY BE CANCELLED?

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

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. Arizona has enacted reforms to expand some of these protections. Generally, small employers are those that employ 2-50 employees. Please note, however, that the definitions of small employer and employee are somewhat different under federal and state law. Check with the Arizona 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 policy** they sell to other small employers. However, they can require that a minimum percentage of your eligible workers participate in your group health plan. If you are buying a **large group health plan** for 51 or more eligible employees, your group can be turned down.
- *Your insurance cannot be canceled because someone in your group becomes sick.* This is called guaranteed renewability and it applies to group plans of all sizes. Insurers can impose other conditions, however. They require you to continue meeting 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 health plan or withdrawing from the small employer market. In the latter case, they must give you a chance to buy other plans they sell to groups of your size.

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

- *Arizona law limits how much small employers can be charged for health insurance.* Within limits, premiums for small group health insurance policies can vary based on health status, family composition, geographic location, and other characteristics of those in your group. Even within these limits, however, premiums can be significantly higher if someone in your group has a serious health condition. If you have 51 or more eligible employees, there are no limits on premium variations. Contact the Arizona Department of Insurance if you have questions about your group health insurance premiums.

- *For small employers, Arizona places some limits on annual increases that can be charged.*

WHAT IF I AM SELF-EMPLOYED?

- *Usually, if you are self-employed with no other workers, you are not eligible to buy a group health plan on your own outside of the Healthcare Group of Arizona (HCG). Therefore, the laws that protect employers' access to group health plans do not apply to you. Your access to health insurance is protected by the laws that apply to individuals. (See Chapter 3.)*
- *If you are self-employed, your only guaranteed access to health insurance coverage is through the HCG plan (see below).*
- *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.*

HEALTHCARE GROUP OF ARIZONA (HCG)

The Healthcare Group of Arizona (HCG) is a state-run program that provides insurance to individuals who work for participating small employers.

WHEN CAN I GET COVERAGE FROM HCG?

- *Small employers and the self-employed can buy health insurance through HCG. To be eligible, you must have 50 or fewer employees who work at least 20 hours per week. In addition, you must have conducted business in Arizona for at least 60 consecutive days.*
- *You also must meet minimum participation requirements. If you have 5 or fewer employees, 100% of eligible employees must participate for your business to be eligible to purchase insurance through HCG. If you have 6-50 employees, at least 80% of eligible employees must enroll in HCG. Employees can be waived from participation if they have other group health insurance or coverage through a public program.*
- *You cannot have offered health insurance coverage in the past 6 months. If you lost coverage due to an insurance company discontinuing your health plan, you are not subject to this requirement. You employees are not required to be uninsured to be eligible for coverage through HCG.*

- *HCG has implemented an enrollment freeze.* As of March 2008, HCG is not accepting new employer groups; however there is a waiting list. HCG expects to begin accepting new employer groups in August, 2008.

WHAT WILL HCG COVER?

- *HCG offers an HMO series of “Healthstyle Plans” and two PPO plans.* Covered services include office visits, hospital outpatient care, emergency care, and prescription drugs. All plans offer a choice of deductibles and have a lifetime benefit maximum of \$2 million (HMO plans) or \$3 million (PPO plans). Family coverage is available.
- *For more information about HCG, contact the Healthcare Group Arizona at 602-417-6755, or 1-800-247-2289 or visit them on the web at <http://www.healthcaregroupaz.com/Default.aspx>.*

WHAT ABOUT PRE-EXISTING CONDITIONS?

- *Insurers offering coverage through HCG can apply a pre-existing condition exclusion period.* The exclusion applies only on those conditions 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.
- *Insurers participating in HCG can exclude coverage for pre-existing conditions only for a limited time.* The maximum period is 12 months. However, if you enroll late in a group health plan (after you were hired and not during a regular or special enrollment period) you may have a pre-existing condition exclusion period of up to 18 months.
- *You will receive credit towards your pre-existing condition exclusion period for any previous continuous creditable coverage.*

WHAT CAN I BE CHARGED FOR COVERAGE THROUGH HCG?

- *You cannot be charged more due to the health status or claims experience of those in your group.* Premiums for HCG plans do vary by age, gender, choice of plan and by county. This is called modified community rating.

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 Arizona Department of Insurance about your protections in association health plans.

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CHAPTER 5

FINANCIAL ASSISTANCE

Help is available to certain low-income residents of Arizona who cannot afford to buy health insurance. Medicaid—which in Arizona is known as the Arizona Health Care Cost Containment System (AHCCCS)—and KidsCare 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 eligible low-income Arizona residents. Medicaid covers families with children and pregnant women, 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, however questions concerning immigration status and eligibility should be directed to the Arizona Department of Social Services.

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

In Arizona you may be eligible for Medicaid if you are an infant, a child, pregnant, or a parent of a dependent 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. For more information, you should contact the Arizona Health Care Cost Containment System (AHCCCS) at (800) 654-8713 or visit them online at: <http://www.ahcccs.state.az.us/site/>.

Low income persons eligible for Medicaid in Arizona*

<u>Category</u>	<u>Income eligibility</u> (as percent of federal poverty level)
Infant 0-1	140% (monthly income of about \$2,053 for family of 3)
Child 1-5	133%
Child 6-19	100%
Parent	200%
Pregnant woman	150%

* 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 2008:

<u>Size of Family Unit</u>	<u>Poverty Guideline (annual income)</u>
1	\$ 10,400
2	\$ 14,000
3	\$ 17,600

For larger families add \$3,600 for each additional person.

So, for example, using this guideline, 140% of the federal poverty level for a family of 3 would be an annual income of \$24,640, or a monthly income of \$2,053.

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 **Temporary Assistance for Needy Families (TANF)** (also known as **EMPOWER**) should also know that when you get a job and .your **TAND** benefits end, you generally can stay on Medicaid for a 24-month transitional period. In addition, your children may continue to qualify for Medicaid if your family's income meets certain income standards.*
- *Poor elderly or disabled people who get **Supplemental Security Income (SSI)** benefits automatically eligible for Medicaid.*

Disabled individuals should know that if your income earned from a job increases so that you no longer qualify for SSI, you may be able to continue your Medicaid coverage for a limited time.

- *People who have medical expenses may also qualify for Medicaid under the Medical Expense Deduction (MED) option.* You may qualify if your income is 40% of the federal poverty level after deducting allowable medical expenses and if your resources are within the allowable limits. For example, people who have catastrophic illnesses requiring an inpatient hospital stay may qualify if they do not have health insurance that covers these inpatient services. Call (800) 352-8401 or go to <http://www.ahcccs.state.az.us/Services/Programs/MED.asp> for more information about MED.
- *People who are either elderly, physically or developmentally disabled and who have need for long term care services may qualify for Medicaid under the Arizona Long Term Care Program (ALTCS).* To qualify individuals must have income, which is below 300% of the federal SSI maximum benefit rate (i.e., monthly income of \$1,911 for a one person household) and be determined to be at immediate risk of institutionalization in either a nursing facility or an intermediate care facility. For all eligible persons, ALTCS offers a complete array of acute medical care services, institutional services, behavioral health services, home-and-community based services and case management services.
- *People who are age 65 or over and 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 at or below 100% of the federal 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 between 100 – 120% of the federal poverty level, Medicaid will pay for your monthly Medicare Part B premiums only. This is called the Specified Low-Income Medicare Beneficiary (SLMB) program.

If your household income is between 121% – 175% of the federal poverty level, Medicaid may pay for all or part of your Medicare Part B premium. These are called the Qualified Individual 1 (QI-1) and Qualified Individual 2 (QI-2) programs.

- *There may be other ways that Medicaid can help.* To find out if you or other members of your family qualify for AHCCCS programs, contact AHCCCS. To apply, Arizona residents can use one simple form provided by AHCCCS. You can download the application form from the AHCCCS website at www.ahcccs.state.az.us or you can get an application by mail by calling (602) 417-5010 then press 11 or call toll free (800) 528-0142.

KIDSCARE

KidsCare is a state-designed program that provides health care coverage to low-income Arizona children under the age of 19 who are not eligible for Medicaid and who have no health insurance.

- *To be eligible, your child must meet certain financial qualifications.* A child whose family has a household income at or below 200% of the federal poverty level is eligible for KidsCare. For a family of three, this works out to an annual income of about \$35,200 or a monthly income of about \$2,933. KidsCare is free for families at or below 100% FPL. Families between 101% and 200% FPL are responsible for premiums, ranging from \$10 to \$35 per month.
- *Monthly fees and cost sharing is minimal.* Monthly premiums range from \$10 to \$25 a month for one child or \$15 to \$35 a month for two or more children.
- *KidsCare is considered comprehensive coverage.* Services include doctors visits, hospital and emergency services, prescription drugs, vision, hearing and mental health. In addition, KidsCare does not impose pre-existing condition exclusion periods.
- *For more information, contact KidsCare (602) 417-5437 or (877) 764-5437 or visiting their web site <http://www.kidscare.state.az.us/>.*

WELL WOMAN HEALTHCHECK PROGRAM

- *The Well Woman HealthCheck Program provides qualified women with breast and cervical cancer screening at no cost.* Women who are screened and diagnosed through this program and diagnosed with breast and/or cervical cancer may be eligible for treatment through Medicaid.

In order to be eligible for free screening through the Well Woman HealthCheck Program, you must be an Arizona resident, be uninsured or underinsured, be at or below 250% FPL and meet other eligibility requirements.

- *For more information about eligibility, contact the Well Woman HealthCheck Program at (888) 257-8502 or visit them online at <http://www.wellwomanhealthcheck.org/>.*

OTHER STATE PROGRAMS

There may be other financial assistance programs available to Arizona residents. For more information please contact AHCCCS at (602) 417-4000 in the Phoenix area or statewide at (800) 654-8713

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 not be enrolled in Medicare, Medicaid, or in other employer-sponsored coverage for which the employer contributes at least half of the premium.*
- *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 PREMIUM 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. COBRA continuation coverage is considered qualified health coverage. (See Chapter 3 for more information about COBRA.) In addition, Arizona has designated HCG coverage as a state qualified health plan. (See Chapter 4 for more information about the HCG program.)*

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).*

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/>.*
- *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 Conversion coverage	<i>Arizona Department of Insurance</i> (800) 325-2548 (Arizona calls only) (602) 364-2499 (Phoenix) (520) 628-6370 (Tucson) http://www.id.state.az.us/index.html
Self-insured group health plans COBRA continuation coverage Family and Medical Leave Act	<i>U.S. Department of Labor, Employee Benefits Administrator</i> <i>Employee & Employer Assistance Hotline and Publications:</i> (866) 444-EBSA (3272) http://www.dol.gov/ebsa/
Healthcare Group of Arizona (HCG)	<i>Healthcare Group of Arizona (HCG)</i> (602) 417-6755 (800) 247-2289 http://www.healthcaregroupaz.com/
Arizona Health Care Cost Containment System (AHCCCS)	<i>AHCCCS</i> (602) 417-4000 (800) 654-8713 (In-state only) (800) 523-0231 (Out-of-state calls) http://www.ahcccs.state.az.us/Site/
KidsCare	<i>AHCCCS</i> (877) 764-5437 (Statewide) (602) 417-5437 (Phoenix) http://www.ahcccs.state.az.us/Services/CoverageGroups/AdultNoChildren.asp
Breast and Cervical Cancer Treatment Program (BCCTP)	<i>AHCCCS</i> (800) 528-0142 (Statewide) (602) 417-5010 (Phoenix) http://azahcccs.gov/Services/Programs/BCCT.asp
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 workers 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. Generally, health insurance coverage that is not interrupted by a break of 63 or more consecutive days. However, when you are joining a fully insured small group health plan in Arizona, coverage counts as continuous if it is not interrupted by a break of 90 days or more. 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 Affiliation Period, Creditable Coverage, Fully Insured Group Health Plan, HMO, Small Group Health Plan, Waiting Period.

Conversion. Your right, when leaving a fully insured group health plan in Arizona, to convert your policy to individual health insurance. There are rules about what conversion policies must cover and what premiums can be charged. See also COBRA, Fully Insured Group Health Plan, and HMO.

Creditable Coverage. Health insurance coverage under any of the following: a group health plan; an individual health plan; Medicare; Medicaid; State Children's Health Insurance Program,

CHAMPUS and TRICARE (health coverage for military personnel, retirees, and dependents); the Federal Employees Health Benefits Program; Indian Health Service; the Peace Corps; Public Health Plan (any plan established or maintained by a State, the U.S. government, a foreign country), or a state health insurance risk pool. See also Continuous Coverage, Group Health Plan, Individual Health Insurance.

Elimination Rider. A feature permitted in individual health insurance policies that permanently exclude coverage for a health condition, body part, or body system.

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 Arizona. 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 in Arizona are guaranteed issue. If you are HIPAA eligible, insurance companies must offer you a choice of basic and standard individual health plans that are guaranteed issue. Plans that are guaranteed issue can turn you away for other reasons.

Guaranteed Renewability. A feature in most 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.

Healthcare Group of Arizona (HCG). A state-run program that offers group health coverage to small businesses with 50 or fewer employees, including the self-employed, and political subdivisions (state, counties, cities, towns, school districts and agricultural districts) as long as employers and employees meet specified requirements. The HCG plan is a managed care plan.

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.

HIPAA. The Health Insurance Portability and Accountability Act, better 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 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. You are also HIPAA eligible if your health plan was not renewed by an insurer who discontinued offering and renewing individual health benefit plans in Arizona. When you are buying individual health coverage, federal eligibility confers greater protections on you than you would otherwise have in Arizona 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. Policies for people not connected to an employer group. Individual health insurance is regulated by Arizona.

Kassebaum-Kennedy. See HIPAA.

KidsCare. A state-designed program that provides comprehensive health care coverage to low-income Arizona children under the age of 19 who are not eligible for Medicaid and who have no health insurance.

Large Group Health Plan. One with more than 50 eligible 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 Arizona residents. All other states have Medicaid programs, too, though eligibility levels and covered benefits will vary. In Arizona, Medicaid is referred to as the Arizona Health Care Cost Containment System (AHCCCS).

Modified Community Rating. A requirement applicable to HCG plans that requires that the rate for each policy not vary due to the health status of those who buy that health insurance. Premiums can vary based on age, gender, income, and by county, as well as by health plan option and family status.

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, based on 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 (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, and children placed for adoption covered within 30 days cannot be subject to pre-existing condition exclusions.

Pre-existing Condition (Individual Health Insurance). Any condition for which you received a diagnosis, medical advice, or treatment prior to obtaining the individual policy. In Arizona, individual health insurers has broad discretion to define what constitutes a pre-existing condition, even including an undiagnosed condition you may unknowingly have had when you applied for the policy. Pregnancy can be subject to a pre-existing condition exclusion in Arizona; however, complications of pregnancy arising after coverage begins cannot be considered a pre-existing condition. Genetic information cannot trigger a pre-existing condition exclusion period in individual health insurance in Arizona.

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 Arizona.

Small Group Health Insurance Policies. Policies with at least 2 but not more than 50 eligible employees, or, under HCG, plans with at least one (self-employed) individual but not more than 50 employees. See also Healthcare Group of Arizona.

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.

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. See also Medicaid.

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.