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

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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 ILLINOIS

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

This guide describes your protections as an Illinois 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 Illinois, 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 36. For information about how to find consumer guides for other states on the Internet, see page 36. A list of helpful terms and their definitions begins on page 37. 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 Illinois. 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 Illinois resident.

HOW AM I PROTECTED?

In Illinois, 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 Chapter 2)

- *All group health plans in Illinois must limit exclusion of pre-existing conditions.* There are rules about what counts as a pre-existing condition and how long you must wait before a new group health plan will begin to pay for care for that condition. Generally, if you join a new group health plan, your old coverage will be credited toward the **pre-existing condition exclusion period**, provided you did not have a long break in coverage. (see Chapter 2)

- *Your health insurance cannot be canceled because you get sick.* Most health insurance is **guaranteed renewable**. (see Chapter 3 for Individual Coverage, and Chapter 4 for Small Group Coverage)

- *If your son or daughter is in college and covered as a dependent under your group, but cannot maintain student status due to illness, he or she may still be able to remain covered as your dependent for up to one year.* (see Chapter 2)

- *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** 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 Chapter 3)

- *If you lost your group health plan because of involuntary termination of employment that occurred between September 1, 2008 and December 31, 2009, you may be eligible for a federal tax credit that can help you pay for your COBRA or state continuation coverage premiums for up to nine months*. (see Chapter 3)

- *If you lose your group health plan and meet other qualifications, you will be **HIPAA eligible***. If so, you can buy an individual health insurance policy from the state high-risk pool, **Illinois Comprehensive Health Insurance Plan** (**CHIP**). You will not face a new pre-existing condition exclusion period. There are limits on what you can be charged for a CHIP policy. (see Chapter 3)

- *If you have had difficulty obtaining affordable individual health insurance because of your health condition or if you have one of 31 presumptive medical conditions, you may also be eligible for a CHIP policy.* In this case you may face a new pre-existing condition exclusion period. There are limits on what you can be charged for a CHIP policy. (see Chapter 3)

- *If you lose your fully insured group health plan and meet other qualifications, you may be eligible to buy a **conversion policy***. You will not face a new pre-existing condition exclusion period. (see Chapter 3)

- *When you apply for an individual health insurance policy, insurance companies may not turn you down, charge you more or impose a pre-existing condition exclusion period because of your **genetic information***. In addition, insurance companies are not allowed to even ask about your genetic tests or family history when you apply for coverage. (see Chapter 3)

- *If you are a small employer buying a group health plan, you cannot be turned down because of the health status, age, or any factor that might predict the use of health services of those in your group.* All fully insured health plans for small employers must be sold on a **guaranteed-issue** basis. (see Chapter 4)

- *As a small employer, you may not be turned down or charged more because of the genetic information of a member of your group.* In addition, insurance companies are not allowed to even ask about genetic tests or family history of people in your group when you apply for coverage. (see Chapter 4)

- *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 Illinois **Medicaid** program offers free or subsidized health coverage for pregnant women, families with children, elderly, and disabled individuals with very low incomes. (see Chapter 5)

- *If your child is 18 years old or younger, does not have health insurance and meets other qualifications, you may be able to buy insurance for them or receive assistance paying for private health insurance through the* ***Illinois All Kids Program***. (see Chapter 5)

- *If you believe that you may be at risk for cancer, you may be eligible for free screening and treatment.* The **Illinois Breast and Cervical Cancer Program (IBCCP)** provides qualified women with free breast and cervical cancer screening. In addition, women diagnosed with cancer through this program may be eligible for medical care through the Illinois Medicaid program. (see Chapter 5)

- *If you 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 80% of the cost of qualified health coverage, including COBRA, and a specific policy offered through the Illinois Comprehensive Health Insurance Plan (CHIP). (see Chapter 5)

- *If you are a retiree aged 55*-65 *receiving pension benefits from* ***Pension Benefit Guarantee Corporation (PBGC),*** *then you may also be eligible for the HCTC*. (see Chapter 5)

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 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 Chapter 2)

- *Employers are not required to provide health benefits for their employees, so if you change jobs, you may find that your new employer does not offer you health coverage.* Employers are required only to make sure that any health benefits they do offer do not discriminate based on health status. (see Chapter 2)

- *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 Chapter 2)

- *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 group health plan*. (see Chapter 2)

- *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 Chapter 2)

- *If you work for certain non-federal public employers in Illinois, not all of the group health plan protections may apply to you*. (see Chapter 2)

- *In Illinois, 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 due to your health. (see Chapter 3)

- *If you are HIPAA eligible, the Illinois Comprehensive Health Insurance Plan (CHIP) is your only guaranteed access to individual health insurance coverage.* However, if you are healthy, you may be able to buy an individual health insurance policy from a private insurer. (see Chapter 3)

- *In most cases, 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 Chapter 3)

- *If you enroll in the Illinois Comprehensive Health Insurance Plan (CHIP) and are not HIPAA eligible, you will face a pre-existing condition exclusion period.* (see Chapter 3)

- *If you move away from Illinois, you may not be able to buy individual health insurance in another state unless you are HIPAA eligible*. (see Chapter 3)

- *If you are a small employer, you might be charged more for health insurance if someone in your group is sick.* While there are limits on what you can be charged based on health status, premiums can be significantly higher if someone in your group has a serious health condition. Also, the insurance carrier can turn you down if your small business does not meet the participation or contribution requirements. (see Chapter 4)

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 or not the plan is self-insured.

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

- *You have to be eligible for the group health plan.* For example, your employer may not give health benefits to all employees such as part-time, non-permanent, or seasonal employees. 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 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 opportunity to enroll in your group health plan after certain events. Depending on the event, these **special enrollment periods** can last either 30 or 60 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 30-day special enrollment opportunity

- The birth, adoption, or placement for adoption of a child
- Marriage
- Involuntary 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.)

Certain changes can trigger a 60-day special enrollment opportunity

- Loss of eligibility under Medicaid or SCHIP
- Eligibility for a state Medicaid or SCHIP premium assistance subsidy applicable to premiums for a group plan

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

- *If you have a dependent, 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.* As long as the person remains dependent because of a handicapped condition and cannot sustain employment, the individual can remain on your policy, provided that it remains in force.

- *If your group health plan covers dependents, you may be able to keep your son or daughter covered under the plan after the age of majority.* Most group health plans will allow your son or daughter to remain covered under your family plan past the age of 19 if they are a full time student.

  If your son or daughter is in college and covered as a dependent under your group, but cannot maintain student status due to illness, he or she may still be able to remain covered as your dependent for up to one year. Federal law allows dependent children who take a medical necessary leave of absence due to a serious illness or injury to remain covered as dependents under their parents' group plan for up to one year or until the coverage would otherwise end, whichever comes first. This law will apply to plan years beginning on or after October 9, 2009.

In addition, in Illinois fully insured group health plans (and individual health insurance policies if they provide coverage for dependents) must cover as a dependent your unmarried child up to age 26. If you have a child who lives in Illinois and who once served in the military, he or she is considered your dependent up to age 30 for the purposes of enrolling him or her in your employer-sponsored group health plan (or individual health insurance policy if it provides coverage for dependents). This law does not apply to self-insured group health plans. Check with your employer to find out the kind of group health plan you have.

Read you plan documents carefully to determine when your child will "age off" your group health plan.

- *When you begin a new job, your employer may require a waiting period before you can sign up for health coverage.* These waiting periods, however, must be applied consistently and cannot vary due to your health status. Unlike employers, insurers cannot require waiting periods. If your new job has health insurance through an HMO, the HMO may also require a waiting period called an HMO **affiliation period**, and you will not have health insurance coverage during this time. An affiliation period cannot exceed 2 months (3 months for late enrollees), and you cannot be charged a premium during this period.

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

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

- *Group health plans can only exclude coverage for pre-existing conditions for a limited time.* The maximum period allowed for exclusion 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.

- *Group health plans that impose pre-existing condition exclusion periods must give you credit for any previous continuous **creditable coverage** that you've had.* Most types of private and government-sponsored health insurance are considered creditable coverage.

What is creditable coverage?

Most health insurance counts as creditable coverage, including:

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

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 of prior coverage, such as old health plan ID cards or statements from your doctor showing bills paid by your health insurance plan.

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

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

What is continuous coverage?

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

Take Art, who has diabetes. Ajax Company covered him under its group health plan for 9 months, but he lost his job and health coverage. Then, *45 days later*, Art found a new job at Beta Corporation and had health coverage for 9 more months. Art changed jobs again. His new company, Charter, has a health plan that covers care for diabetes but excludes 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 extension.

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 group health plan that offers more benefits than your old health plan 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. Plans that use this method of crediting prior coverage must use it for everyone and must disclose this to you when you enroll.

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

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

Question: Is this permitted?

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

- *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, a large number of public employers in Illinois 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 which 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 plan, 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 insurance policies. See Chapter 3 for more information about COBRA, state continuation coverage, conversion policy, and Illinois Comprehensive Health Insurance Plan (CHIP) coverage.

- *If you have lost your group health plan 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 80% of the cost of qualified health coverage, including COBRA and a specific policy offered through the Illinois Comprehensive Health Insurance Plan (CHIP). (see Chapter 5)

- *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 Chapter 5)

CHAPTER 3
YOUR PROTECTIONS WHEN BUYING INDIVIDUAL HEALTH INSURANCE

If you do not have access to employer-sponsored group health plan, you may want to buy an individual health insurance policy from a private insurer or you may be eligible for coverage under a program offered by the State of Illinois, the Comprehensive Health Insurance Plan (CHIP). However, in Illinois – as in most other states – you have limited guaranteed access to individual health insurance in the private market. There are some alternatives to private individual health insurance, such as COBRA coverage or conversion policy. 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 A POLICY?

In Illinois, your ability to buy an individual health insurance policy from a private insurance company depends on your health status.

- *In general, companies that sell individual health insurance in Illinois are free to turn you down because of your health status and other factors.* When applying for an individual health insurance policy, you may be asked questions about health conditions you have now or have 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 turned down or offered a policy with reductions or restrictions, you may be eligible for CHIP coverage.

  However, under no circumstance may you be turned down, charged more or face a pre-existing exclusion period by an individual insurers because of your genetic information. Genetic information includes the results of a genetic test and your family history of health conditions.

- *If you are HIPAA eligible, Illinois Comprehensive Health Insurance Plan (CHIP) is your only guaranteed source of individual health insurance.*

- *Under Illinois law, newborns are automatically covered under the parents' individual health insurance policy for the first 31 days, if the policy covers dependents.* The insurer may require that the parent enroll the child within the 31 days in order to continue coverage beyond the 31 days.

- *If you have a dependent, 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.* As long as the person remains dependent because of a handicapped condition and cannot sustain employment, the individual can remain on your policy, provided that it remains in force.

WHAT WILL MY INDIVIDUAL HEALTH INSURANCE POLICY COVER?

- *It depends on what you buy.* Illinois does not require health insurers in the individual market to sell standardized policies. Insurers can design different policies and you will have to read and compare them carefully. However, Illinois does require all policies to cover certain benefits – for example, diabetes care and mammography screening. Check with the Illinois 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, body part, or body system. Also, an insurer can impose an exclusion period for up to 24 months on any pre-existing condition.

  The definition of pre-existing condition is different under individual health insurance than under group health plans. Individual health insurers can count as pre-existing any condition for which you received medical advice, care, treatment, or diagnosis in the 24 months prior to purchasing coverage. In addition, insurers can count as pre-existing any condition that produced symptoms within 12 months prior to the effective of coverage for which the insurer believes most people would have sought care. This is called the **prudent person rule**.

- *Pregnancy can be considered a pre-existing condition by individual health insurers.* However, genetic information, provided that it is not favorable and provided voluntarily by the individual, cannot be used as the basis of a pre-existing condition.

- *If you make a claim during the first two years of coverage, your insurer can look back as far as 24 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 that the condition is a pre-existing condition, it can refuse to pay for expenses for that condition.

- *Unlike group health plans, individual health insurers do not have to give you credit for prior coverage.*

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

- *Generally, in Illinois, there are no limits on how much individual premiums can vary due to age, gender, health status, family size, and other factors.* However premiums cannot vary based on your genetic information.

CAN MY INDIVIDUAL HEALTH INSURANCE POLICY BE CANCELED?

- *Your coverage cannot be canceled because you get sick.* This is called guaranteed renewability. Generally, 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. However, guaranteed renewability does not protect you from having your premiums go up at renewal, and premiums can also increase within limits as you age or your health declines.

  Further, if you make a claim during the first two years of coverage under your policy, the insurer might re-investigate information you provided during the application process to determine whether you made a misstatement. If so, the insurer might try to take back your policy and void coverage altogether.

  If you become involved in one of these "post-claims" investigations, be sure to call the Illinois Department of Insurance to learn more about your rights.

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

COBRA AND STATE 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. 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 plan.

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 as well.

- *You must be notified of your COBRA rights when you join the group health plan, and again if you qualify for COBRA coverage.* The notice rules are somewhat complicated and you should contact the U.S. Department of Labor for more information.

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

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

SPECIAL SECOND CHANCE TO ELECT COBRA FOR TRADE-DISLOCATED WORKERS

- *A second COBRA election period may be available for TAA eligible people who did not elect COBRA when it was first offered*. The second election period can be exercised 60 days from the 1st day of TAA eligibility, but in no case later than 6 months following loss of coverage. Coverage elected during this second election begins retroactive to the beginning of the special election period – not back to qualifying event.
- *Certain people who lost their job-based health coverage because of the impact of imports on their employers have a limited second chance to elect COBRA*. People who are receiving benefits from the Trade Adjustment Assistance (TAA) Program are eligible for a federal income tax credit (the Health Coverage Tax Credit, or HCTC) that will pay 80% 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.

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

WHAT WILL COBRA COVER?

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

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

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

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

WHAT CAN I BE CHARGED FOR COBRA COVERAGE?

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

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

- *If you lost your group health plan because of involuntary termination of employment that occurred between September 1, 2008 and December 31, 2009, you may be eligible for a federal tax credit that can help you pay for your COBRA premiums for up to nine months.* This tax credit was created as part of The American Recovery and Reinvestment Act of 2009 (ARRA) and covers 65% of your COBRA premium. For more information, call the Employee Benefits Security Administration at the United State Department of Labor at (866) 444-3272 or visit the COBRA/AARA information center at http://www.dol.gov/ebsa/cobra.html. Information about the COBRA tax credit is also available from the IRS at http://www.irs.gov/newsroom/article/0,,id=204505,00.html and Department of Health And Human Services at http://www.cms.hhs.gov/COBRAContinuationofCov/.

- *If you lost your group health plan 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.* The credit is called the Health Coverage Tax Credit (HCTC), and it is equal to 80% of the cost of qualified health coverage, including COBRA. (see Chapter 5)

- *If your are a retiree aged 55-65 and receiving pension benefits from 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 credit is called the Health Coverage Tax Credit (HCTC). (see Chapter 5)

- *Call the Department of Labor at (866) 444-3272 to find out if other temporary COBRA subsidies are available to you.*

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 of hours). You must obtain a disability determination letter from the Social Security Administration, and you must notify your group health plan within 60 days of receiving this disability determination letter, and before your original 18 months expires.

HOW LONG CAN COBRA COVERAGE LAST?

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

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

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

- *COBRA coverage also ends if your 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. 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 ILLINOIS CONTINUATION COVERAGE?

- *You may be eligible to continue coverage under state laws that are similar to COBRA.*

  If you are losing fully insured group coverage due to the termination of employment or reduction of hours, you may be eligible to continue that coverage for up to 12 months. To be eligible, you must have been covered under the group plan for at least three months prior to the termination of your employment. However, employees who are terminated from their jobs between September 1, 2008 and December 31, 2009 are eligible for Illinois continuation coverage if they were insured through the group health plan on the day prior to the termination.

  If you under the age of 55 and losing fully insured group coverage because of divorce or death of a spouse, you and your eligible dependents may able to continue that coverage for up to 24 months. To be eligible, you must be covered under a fully insured group plan on the day before the divorce from or the death of the employee.

  If you are 55 years or older and losing fully insured group coverage because of divorce, death, or retirement of your spouse, you and your eligible dependents may be eligible to continue your coverage until you are eligible for Medicare. To be eligible, you must be covered under a fully insured group plan on the day before the divorce from or the death or retirement of the employee.

  If you are losing fully insured group coverage because you are aging off a plan, you may be eligible to continue your coverage for up to 24 months.

- *If you lost your group health plan because of involuntary termination of employment that occurred between September 1, 2008 and December 31, 2009, you may be eligible for a federal tax credit that can help you pay for your state continuation coverage premiums for up to nine months.* This tax credit was enacted in The American Recovery and Reinvestment Act of 2009 (ARRA) and covers 65% of your state continuation coverage premium. For more information, call the Employee Benefits Security Administration at the United State Department of Labor at (866) 444-3272 or visit them online at http://www.dol.gov/ebsa/cobra.html. Also see "Health Information About State Continuation Coverage And ARRA" on the website of the Department of Health And Human Services at http://www.cms.hhs.gov/COBRAContinuationofCov/.

- *Your rights to continue coverage may be lost if you do not properly elect coverage.* The rules regarding the election of state continuation coverage are very specific and must be followed precisely. If you think this applies to you, contact the Illinois Department of Professional and Financial Regulation, Division of Insurance at (877) 527-9431 or (217) 782-4515 and ask about your state continuation rights. In addition, information about state continuation coverage is available on the Division of Insurance's website at http://www.idfpr.com/DOI/Main/Consumer_facts.asp.

CONVERSION

WHEN AM I ELIGIBLE FOR A CONVERSION POLICY?

- *In Illinois, if you have coverage through an employer's fully insured group health plan and you lose that coverage, you are eligible to buy a conversion policy.* A conversion policy is an individual policy you get from the company that insured your previous group plan.

  Conversion rights are also available to a surviving spouse and child upon the death of an insured or in the case that they cease to be qualified family member under a group policy.

- *To qualify for a conversion policy, you must have had at least 3 months of continuous coverage through an employer's fully insured group health plan.* In addition, you must not be covered under, or eligible for coverage under Medicare or another group health plan. Finally, you must apply within 31 days of the termination of the group plan or 15 days after notice of the privilege, whichever is later, but in no case later than 60 days after termination.

- *You do not need to be HIPAA eligible to buy a conversion policy.* However, if you do elect a conversion policy, you will lose your HIPAA eligibility status.

WHAT DOES A CONVERSION POLICY COVER?

- *Conversion policy benefits must meet certain minimum benefit requirements, which may not be the same as those under your former plan.*

WHAT ABOUT COVERAGE FOR MY PRE-EXISITNG CONDITION?

- *A conversion policy may not impose a new pre-existing condition exclusion period.* However, if you were in a pre-existing exclusion period under your old group health plan when it ended, you may have to finish it.

HOW MUCH CAN I BE CHARGED FOR A CONVERSION POLICY?

- *There is no limit on what your insurer can charge for a conversion policy.* Premiums are determined based on the age and classification of risk of each person applying for a converted policy. These policies often are more expensive than your prior group coverage.

CAN MY CONVERSION POLICY BE CANCELED?

- *Conversion policies, like other individual health insurance policies, are guaranteed renewable.* Your coverage cannot be canceled if you get sick. 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. Also, if you become eligible for Medicare or other insurance with similar benefits, you will no longer be eligible for a conversion policy.

ILLINOIS COMPREHENSIVE HEALTH INSURANCE PLAN (CHIP)

Illinois has a high-risk pool program, called Illinois Comprehensive Health Insurance Plan (CHIP) that offers insurance for people with health conditions who are unable to buy private health insurance coverage and for people who are HIPAA eligible. CHIP is also considered a qualified health plan for individuals eligible for the health coverage tax credit (HCTC). (see Chapter 5)

WHEN CAN I GET A POLICY FROM CHIP?

- *If you are HIPAA eligible, you can buy health insurance from CHIP.* This coverage is called HIPAA-CHIP.

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 health insurance of some kind with no pre-existing condition exclusion period. In Illinois, you are only guaranteed the right to buy coverage from CHIP. 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 CHIP within 63 days of losing your prior coverage.

HIPAA eligibility ends when you enroll in CHIP or an individual health insurance policy, 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.

- *If you are eligible for the Health Coverage Tax Credit (HCTC), you can buy insurance from CHIP*. This is called TAA/PBGC CHIP.

- *If you are not HIPAA eligible, you can buy coverage from CHIP if you are a resident of Illinois for at least 6 months and can demonstrate proof of eligibility*. This is called Traditional CHIP. There are several different ways to show eligibility:

  - You have been turned down for substantially similar individual health insurance coverage by at least one insurance company because of a pre-existing health condition;

  - You have a substantially similar individual health insurance policy that is more expensive than the rate you would pay for CHIP coverage;

  - You have one of 31 medical conditions, such as AIDS, Cystic Fibrosis or Parkinson's disease, for which CHIP provides automatic eligibility.

  You only need to show that you are eligible in one of these ways in order to apply for a CHIP policy.

- *CHIP limits the number of people who can enroll in Traditional CHIP*. This limit is based on the availability of state finances used to subsidize this state program. If the limit has been reached when you apply, you may not be able to enroll at that time but your name will be placed on a waiting list. In addition, as enrollment opportunities become available, applicants will be contacted in the order in which their names appear on the waiting list. The enrollment limit does not apply to HIPAA-CHIP or TAA/PBGC CHIP. If you are HIPAA eligible or HCTC eligible, you can always enroll in CHIP.

  As of July 1, 2009, enrollment into Traditional CHIP has been closed. A waiting list is kept for applicants who wish to be considered at a later date.

- *CHIP does offer optional family coverage.* However, each member of your family who wants to enroll in CHIP will have to qualify on his or her own.

WHAT DOES A CHIP POLICY COVER?

- *CHIP offers coverage through a Preferred Provider Organization (PPO) plan.* The PPO has a network of doctors and hospitals in your area. Coverage includes hospital and physician care, diagnostic tests and x-rays, prescription drugs and other services.

- *Both those eligible for HIPPA-CHIP and Traditional-CHIP receive basically the same benefit options.* However, HIPAA-CHIP participants are not subject to a pre-existing condition limitation.

- *CHIP offers you the choice of eight plans, each with a different deductible.* The annual deductible options are $500, $1,000, $1,500, $2,500 and $5,000, and qualified Health Savings Account deductible health plans with $1,200, $2,000 and $5,200 deductible options. In addition, you will be responsible for a coinsurance charge each time you receive care.

  Once you have met your deductible, you will be charged 20% coinsurance for care from a PPO provider and 40% coinsurance for care from a non-PPO provider. After you pay a maximum amount for covered services (also called out-of-pocket limit) CHIP will pay 100% of the cost of your covered care.

  CHIP's out-of pocket limit is different depending on if the care you receive is in-network or out-of-network. For in-network care, the limit is $1,500 above your deductible. The limit is $4,500 above your deductible for out-of-network care.

- *CHIP does not provide routine maternity benefits.* However, at the time of enrollment or marriage, participants may purchase a maternity indemnity rider in $500 increments that will cover limited maternity benefits. The maximum number of increments available is based on your geographical area, but in no case can you buy more than 8 increments.

  No maternity benefits are available for the three Health Savings Account qualified health plans and a maternity rider is not available for purchase.

- *CHIP also offers a separate benefit plan policy for those eligible persons who are enrolled in both Parts A and B of Medicare due to disability or end-stage renal disease.* This plan is secondary to Medicare and the benefits provided by CHIP are reduced by any amounts that are payable under Medicare Parts A and B.

  As of July 1, 2009, enrollment into Medicare CHIP has been closed. A waiting list is kept for applicants who wish to be considered at a later date.

WHAT ABOUT COVERAGE FOR A PRE-EXISTING CONDITION?

- *If you are HIPAA eligible or eligible for the Health Coverage Tax Credit (HCTC), you will not have a pre-existing condition exclusion when you enroll in CHIP.* Elimination riders are not permitted on CHIP plans.

- *If you are not HIPAA eligible, you will have a 6-month pre-existing condition exclusion period when you first enroll in CHIP.* When you enroll, CHIP will look back 6 months to see if you had a condition for which you actually received medical advice, diagnosis, care or treatment.

  CHIP will not credit your prior coverage against this pre-existing exclusion period.

- *Pregnancy is not considered a pre-existing condition, but CHIP does not provide any routine maternity benefits.* However, an optional, limited, maternity rider is available at the time you initially enroll in CHIP or in the case that you are a participant, within 60 days of marriage (see above).

WHAT CAN I BE CHARGED FOR A CHIP POLICY?

- *Premiums will vary based on the plan you choose.* In addition, CHIP charges enrollees different rates based on their age, gender and geographical area.

For example, as of June 2009, the monthly premium for a 24-year-old single man living in Chicago with Traditional CHIP coverage ranges from $247 to $360, depending on the deductible he chooses. By contrast, the monthly premium for a 64-year-old single man living in Chicago with Traditional CHIP coverage ranges from $1,041 to $1,466.

- *Premiums are slightly lower for HIPAA-CHIP participants versus those eligible for Traditional CHIP and TAA/PBGC CHIP.*

- *CHIP premium rate tables are usually updated twice per year on February 1 and August 1 and are subject to changes without notice.*

  For further information about CHIP rates, visit the CHIP website at http://www.chip.state.il.us or call (800) 962-8384.

HOW LONG DOES CHIP COVERAGE LAST?

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

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

Federal law extends certain protections to employers seeking to buy health insurance for themselves and their workers. Illinois 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 Illinois 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, health insurance companies must sell you any **small group health plan** they sell to other small employers if the employer group meets the participation requirements. They can also require you to contribute a minimum percentage of your workers' premiums. They can also require you to pay a share of your workers' premiums. If you are buying a large group health plan for 51 or more employees, your group can be turned down.

- *Under no circumstances may you be turned down or charged more because of the genetic information of someone in your group.* In addition, insurance companies may not even ask about genetic test results or family history of people in your group when you apply for coverage.

- *Your insurance cannot be canceled because someone in your group becomes sick.* This is called guaranteed renewability and it applies to group plans of all sizes. Insurers can impose other conditions, however. They can require you to meet minimum participation and contribution rates in order to renew your coverage. Additionally, they can refuse to renew your coverage for nonpayment of premiums or if you commit fraud, or if they are discontinuing that health plan or if they are withdrawing from the small employer market. In the 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?

- *Illinois limits how much premiums can vary due to a small group's health status.* Even with these limits, however, premiums can be significantly higher if someone in your small group has a serious health condition. In addition, premiums can vary based on age, industry, and other characteristics of those in your group. Insurers cannot charge higher premiums based on the genetic information of those in your group.

- *Illinois also limits how much small group plan premiums can increase at renewal because of claims experience.*

  Check with the Illinois Department of Insurance if you have any questions about your small group plan premiums.

WHAT IF I AM SELF-EMPLOYED?

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

- *If you are self-employed and buy your own health insurance, you are eligible to deduct 100% of the cost of your premium from your federal income tax.*

A WORD ABOUT ASSOCIATION PLANS

- *Some small employers and self-employed people 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 Illinois Department of Insurance about your protections in association health plans.

CHAPTER 5
FINANCIAL ASSISTANCE

Help is available to certain low-income residents of Illinois who cannot afford to buy health insurance. Medicaid, the Illinois Breast and Cervical Cancer Program (IBCCP), and All Kids offer free or subsidized health insurance coverage, direct medical services or other help at little or no cost to you.

In addition, the federal government, under 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 Illinois residents. Medicaid (also called medical assistance) covers families with children and pregnant women, medically needy individuals, the elderly, people with disabilities, and persons with breast or cervical cancer, 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. Questions concerning immigration status and eligibility should be directed to the Illinois Department of Public Aid.

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

  In Illinois you may be eligible for Medicaid if you are 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 Medicaid Program for more information.

Low income persons eligible for Medicaid in Illinois*

Category	Income eligibility (as percent of federal poverty level)
Infant	200%
Child 1-19	133%
Working Parent	185%
Non-Working Parent	185%
Pregnant woman	200%
Medically needy	
Individual	40%
Couple	39%

* Eligibility information was compiled from *State Health Facts Online*, the Kaiser Family Foundation, and may have changed since this guide was published. Contact your state Medicaid program for the most up-to-date information and for other eligibility requirements that may apply.

To get an idea of how your income compares to the federal poverty level, use the federal poverty guideline issued by the U.S. Department of Health and Human Services for the year 2009:

Size of Family Unit	Poverty Guideline (annual income)
1	$10,830
2	$14,570
3	$18,310

For larger families add $3,740 for each additional person.

So, for example, using this guideline, 200% of the federal poverty level for a family of 3 would be an annual income of $36,620, or a monthly income of $3,052.

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

- *Families who get cash benefits from **TANF** (also known as Temporary Assistance for Needy Families) can get Medicaid.* In addition, your children may qualify for Medicaid if your family's income meets certain income standards.

- *Very poor elderly or disabled people who get **Supplemental Security Income (SSI)** benefits can also qualify for Medicaid.* You do not need to submit a separate application 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 if you are elderly or you are still considered disabled and you continue to have medical need.

- *People who have high medical expenses may also qualify for Medicaid.* You may qualify as medically needy if you 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 their health insurance is limited or does not cover 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.

  If your household income is above 100% but below 135% of the poverty level, Medicaid will pay for your monthly Medicare premiums only.

- *Working, disabled persons with higher income levels may be eligible for Medicaid benefits under the Health Benefits for Workers with Disabilities Program (HBWD).* To qualify for HBWD, you must be employed, disabled and between the ages of 16 and 64, with a countable income up to 200% poverty level and less than $10,000 in assets. HBWD enrollees must pay a monthly premium that ranges from $0 to $100 based on income level.

- *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 Illinois Department of Healthcare and Family Services at (217) 782-1200 or visit online at http://www.hfs.illinois.gov/.

ILLINOIS ALL KIDS PROGRAM

The Illinois All Kids Program is a state program that provides health insurance coverage to all children under the age of 19 in Illinois. All Kids can also help in paying premiums of employer-based or private health insurance plans.

- *Your child is eligible for All Kids regardless of your income, insurance status, or immigration status.*

- *If your child has private health insurance, All Kids will help pay for your private health insurance premium through the All Kids Rebate program.* For a family of four, monthly income must be between $2,030 and $3,052 to qualify.

- *If your child does not have insurance, All Kids provides payment of medical expenses at little or no cost.* The price a family pays depends on your family income. For example in 2009, a family of four that has an income of up to $28,000 per year does not have to pay any premiums or copayments. However, a family of four that earns up to $64,000 per year pays a $40 monthly premium per child and pays copayments ranging from $3 to $10 and up to $500 per year for hospitalization per child.

- *All Kids provides comprehensive coverage to enrollees*. This includes doctor and nurse care, immunization and preventative care, health clinic care, prescription drugs, medical equipment, dental care, eye care, hospital care, prescriptions, speech and physical therapy, and preventative well-child visits, as well as other services.

- *For more information about All Kids, visit online at http://www.allkids.com/.*

ILLINOIS BREAST AND CERVICAL CANCER PROGRAM (IBCCP)

- *The Illinois Breast and Cervical Cancer Program (IBCCP) provides a qualified woman with full health care benefits through Medicaid at no cost or for a nominal copayment.* 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 addition, Medicaid will cover all of your medical needs including treatment for non-cancer related medical services.

- *In order to be eligible for screening through the IBCCP, you must live in Illinois.* In addition, to qualify for mammograms you must be between the ages of 40 and 64 and to qualify for pelvic exams and pap tests you must be between 35 and 64. You may not have other health insurance and your income must be under 200% of the federal poverty level. If you are Medicaid-eligible, you are not eligible for IBCCP.

- *For more information or to enroll, call the Illinois Department of Public Health's Health-Line at (888) 522-1282 or visit http://cancerscreening.illinois.gov/aboutIBCCP.cfm*

OTHER PROGRAMS

There may be other financial assistance programs available. Please call the Illinois Department of Healthcare and Family Services at (217) 782-1200 or visit online at http://www.hfs.illinois.gov/.

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 80% 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 to owe federal income tax.

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

- *The HCTC is equal to 80% 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, Illinois has designated the Illinois Comprehensive Health Insurance Plan as qualified health coverage. (see Chapter 3)

HOW DO I CLAIM THE HCTC?

- *You can claim the HCTC on your tax return and be reimbursed for 80% 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 (866) 628-HCTC (866-628-4282), Monday through Friday between the hours of 7 am and 7 pm, Central time. TDD/TYY callers, please call (866) 626-HCTC (866-626-4282).

WHERE CAN I GET MORE INFORMATION?

- *For more information about the HCTC, contact the HCTC customer service center at (866) 628-HCTC, or see the IRS website at* http://www.irs.gov/individuals/article/0,,id=187948,00.html.

- *For more information about TAA benefits, visit http://www.doleta.gov/tradeact.*

- *For more information about PBGC, call (202) 326-4000 or visit online at http://www.pbgc.gov.*

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 plan	*Illinois Department of Insurance* *Office of Consumer Health Insurance* (877) 527-9431 http://www.state.il.us/ins/
Self-insured group health plans COBRA continuation coverage Family and Medical Leave Act	*U.S. Department of Labor, Division of Technical Assistance and Inquiries, Washington, D.C.* (202) 219-8776 *For Department of Labor Employee Benefits Security Administration Employee & Employer Assistance Hotline and Publications:* (866) 444-EBSA (3272) http://dol.gov/ebsa
State High Risk Pool	*Illinois Comprehensive Health Insurance Plan* (800) 962-8384 *(Illinois Residents Only)* (217)-782-6333 http://www.chip.state.il.us
Medicaid	*Illinois Department of Healthcare and Family Services* (800) 226-0768 (217) 782-1200 http://www.hfs.illinois.gov/
Illinois Breast and Cervical Cancer Program (IBCCP)	*Illinois Department of Public Health* (888) 522-1282 (*Illinois Residents Only)* (217)-524-6088 *http://cancerscreening.illinois.gov/aboutIBCCP.cfm*
Illinois All Kids	*Illinois Department of Public Aid* (866) 255-5437 http://www.allkidscovered.com/
Federal Health Coverage Tax Credit (HCTC)	*Internal Revenue Service* (866) 628-HCTC http://www.irs.gov/individuals/content/0,,id=187058,00.html

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

Last Reviewed June 2009

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 under group health plans. 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.

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

Certificate of Creditable Coverage. A document provided by your health plan that lets you prove that 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.

CHIP. Illinois Comprehensive Health Insurance Plan, the state-run program for eligible Illinois residents with high health risks (called a state health benefits risk pool). CHIP provides health insurance for those who are HIPAA eligible, and to others with serious health conditions who have been denied individual health insurance by a private health insurance company or would have to personally pay premiums in excess of the applicable CHIP rate.

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. Under federal rules, health insurance coverage that is not interrupted by a break of 63 or more days in a row. 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. Federal rules apply to you if you are joining a self-insured group health plan. See also Creditable Coverage.

Conversion Policy. Your right, when leaving a fully insured group health plan in Illinois, to convert your policy to an individual health insurance policy, if you were continuously insured under the group plan for at least 3 months. You must apply for coverage within 31 days of termination or 15 days after notice of privilege, whichever is later, but no later than 60 days after termination. While conversion policies must offer coverage that meets certain minimum standards, it may not be similar to your former group plan, and may be significantly more expensive. See also Fully Insured Group Health Plan.

Creditable Coverage. Health insurance coverage under any of the following: a group health plan; individual health insurance; Medicare; Medicaid; CHAMPUS (health coverage for military personnel, retirees, and dependents); Federal Employees Health Benefits Program (FEHBP); Indian Health Service; Peace Corps; Public Health Plan (any plan established or maintained by a State, the U.S. government, a foreign country); State 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. A feature permitted in individual health insurance policies that permanently excludes 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 plan purchased by an employer from an insurance company. Fully insured group health plans are regulated by the state of Illinois. See also Self-Insured Group Health Plans.

Genetic Information. Genetic test results indicating your or a member of your family's risk of developing a health condition. Genetic information includes the existence or history of a disease or disorder in a family member. Genetic services, including genetic counseling and education received by you or a family member, is also considered part of your genetic information.

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

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 small group health plans sold to small employers in Illinois 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 insurance 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 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 was passed in 1996 to help people buy and keep health insurance, even when they have serious health conditions, the law sets basic requirements that all health plans must meet. Since states can and have modified and expanded upon these provisions for state regulated health plans, 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 insurance, HIPAA eligibility gives you greater protections than you would otherwise have in Illinois 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 co-payment, for services like doctor visits or prescriptions. An HMO may require you to live or work in its service area to be eligible for coverage. If you are covered under an HMO, the HMO might require an affiliation period before coverage begins. See also Affiliation Period.

Illinois Comprehensive Health Insurance Plan. See CHIP.

Individual Health Insurance Policy. Policies for people not connected to an employer group. This term also refers to coverage purchased by the self-employed for themselves (or their family members) but for no other employees. Individual health insurance policies are regulated by the state of Illinois.

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 Plan. 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 plans 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 Medicaid residents. 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, due to 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, and 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* (CHIP).** Any condition (either physical or mental) for which a diagnosis, care, or treatment was recommended or received within the 6-month period immediately preceding enrollment in a health plan. Pregnancy is not considered 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.

***Pre-existing Condition* (Group Health Plans).** Any condition (either physical or mental) for which a 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, as long as your group health plan offers maternity benefits. 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 Policies).** Any condition for which a diagnosis, care or treatment was recommended or received within the 2 year prior to coverage. In addition, if you make a claim during the first 2 years of coverage, your plan can look back 12 months, from the date of your application, for any symptoms or signs that would have prompted a prudent person to seek medical care, or advice. If it finds such evidence, it can apply a 2 year pre-existing exclusion period for that 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.

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

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 the state of Illinois. However, self-insured plans that are also state or local government plans are regulated by the state of Illinois and subject to state law.

Small Group Health Plans. Plans with at least 2 but not more than 50 employees.

Special Enrollment Period. A time, triggered by certain specific events, during which you and your dependents must be permitted to sign up for coverage under a group health plan. Employers and group health insurers must make such a period available to employees and their dependents when their family status changes or when their health insurance status changes. Special enrollment periods must last at least 30 to 60 days, depending on the qualifying event. Enrollment in a health plan during a special enrollment period is not considered late enrollment. See also Late Enrollment.

State Continuation Coverage. A program similar to COBRA for small employers in Illinois with fewer than 20 employees. See also COBRA.

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

Temporary Assistance for Needy Families (TANF). A program that provides cash benefits to low income families with children. When you qualify for TANF, you generally also qualify for Medicaid. In addition, Medicaid coverage often continues for a limited time 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 80% 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. Waiting periods reduce pre-existing condition exclusion periods.