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

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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 NORTH CAROLINA

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

This guide describes your protections as a North Carolina resident. Chapter 1 gives an overview of your protections. Chapters 2 and 3 explain your protections under group health plans and individual health insurance. Chapter 4 highlights your protections as a small employer or self-employed person. Chapter 5 summarizes help that may be available to you if you cannot afford health coverage. If you move away from North Carolina, your protections may change. Since this guide is a summary, it may not answer all of your questions. For places to contact for more information see page 33. For information about how to find consumer guides for other states on the Internet, see page 33. A list of helpful terms and their definitions begins on page 34. These terms are in **boldface type** the first time they appear.

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CHAPTER 1
A SUMMARY OF YOUR PROTECTIONS

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

The following information summarizes how federal and state laws do – or do not – protect you as a North Carolina resident.

HOW AM I PROTECTED?

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

- *Coverage under your* ***group health plan*** *(if your employer offers one) cannot be denied or limited, nor can you be required to pay more than other members of the group, because of your health status.* This is called **nondiscrimination.** (see Chapter 2)

- *All health plans in North Carolina must limit exclusion of pre-existing conditions.* There are rules about what counts as a pre-existing condition and how long you must wait before a new health plan will begin to pay for care for that condition. Generally, if you join a new plan your old coverage will be credited toward the **pre-existing condition exclusion period**, provided you did not have a long break in coverage. (see Chapter 2 for Group Coverage, and Chapter 3 for Individual Coverage)

- *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)

- *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 you leave your job, you may be able to remain in your old group health plan for a certain length of time.* This is called **COBRA** continuation coverage or **state continuation coverage**. It can help when you are between jobs or waiting for a new health plan to cover your pre-existing condition. There are limits on what you can be charged for this coverage. (see 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 have had at least 3 months of coverage under a fully insured group health plan and then lose it, you may be able to buy an individual health policy from the company that provided your group coverage.* This is called a **conversion policy**. There are rules about what conversion policies must cover and limits on the premium you can be charged. You will not face a new pre-existing condition exclusion period under a conversion policy. (see Chapter 3)

- *If you lose your group health insurance and meet other qualifications, you will be* ***HIPAA eligible****. If you so, you are guaranteed the right to buy individual health insurance from any insurance company that sells such plans in North Carolina.* Insurance companies must offer you a choice of at least two plans. You will not face a new pre-existing condition exclusion period. (see Chapter 3)

- *If you are HIPAA eligible, you also can buy an individual health insurance policy from the* ***North Carolina Health Insurance Risk Pool (NCHIRP)****.* You will not face a new pre-existing condition exclusion period. (see Chapter 3)

- *You may also be able to buy insurance from NCHIRP if you have difficulty obtaining affordable health insurance from private companies because of your health condition*. In this case you may face a new pre-existing condition exclusion period. There are limits on what you can be charged for a NCHIRP policy. (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*. This is called **guaranteed issue.** (see Chapter 4)

- *If you are a small employer buying a group health plan, there are limits on what you can be charged because of health status, age, or other characteristics of those in your group.* (see 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 are self-employed, you may qualify to buy a fully insured small group health plan.* (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 North Carolina **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, they may be able to buy insurance through the* ***North Carolina Health Choice for Children*** *program.* (see Chapter 5)

- If you believe you may be at risk for cancer but are uninsured or underinsured, you may be eligible for screening and treatment. *The* ***North Carolina Breast and Cervical Cancer Control Program*** *provides free cancer screening for qualified residents. Some women diagnosed with breast or cervical cancer through this program may be eligible for medical care through Medicaid.* (see Chapter 5)

- *If you lost your health insurance and are receiving benefits from the* ***Trade Adjustment Assistance (TAA) Program****, you may be eligible for a federal income tax credit to help you pay for new health coverage.* This credit is called the Health Coverage Tax Credit (HCTC), and is equal to 80% of the cost of qualified coverage, including COBRA and health insurance offered through NCHIRP. (see Chapter 5)

- *If you are a retiree aged 55-65 and are receiving benefits from* ***Pension Benefit Guarantee Corporation (PBGC)****, then you may be eligible for the HCTC.* (see 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, your new employer may not offer you health benefits.* If your employer offers health benefits, then the decision on weather to offer you health insurance cannot be based on factors related to your health status. (see Chapter 2)

- *If you get a new job with health benefits, your coverage may not start right away.* Employers can impose **waiting periods** before your health benefits begin. **HMO**s can impose **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 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 North Carolina, not all of the group health plan protections may apply to you.* (see Chapter 2)

- *If you are not HIPAA eligible, insurers providing individual health insurance in North Carolina are free to turn you down for that coverage because of your health status and other factors.* (see Chapter 3)

- *Even if you are HIPAA eligible, you can be turned down for individual health insurance policies.* The law permits insurance companies to limit your choices to two plans, which are supposed to be comparable to others they sell in the individual market in North Carolina. In addition, you are guaranteed the right to purchase coverage from NCHIRP. (see Chapter 3)

- *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)

- *Except when you are HIPAA eligible, individual health policies can permanently exclude coverage for your pre-existing condition.* (see Chapter 3)

- *If you buy health insurance through NCHIRP and are not HIPAA eligible, you will face a pre-existing condition exclusion period.* (see Chapter 3)

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 than other group members because of your health status.* Health status means your medical condition or history, **genetic information** or disability. This protection is called nondiscrimination. Employers may refuse or restrict coverage for other reasons (such as part time employment), as long as these are unrelated to health status and applied consistently.

> **Discrimination due to health status is not permitted**
>
> The Acme Company has 200 employees and offers two different health plans. Full time employees are offered a high option plan that covers prescription drugs; part time employees are offered a low option plan that does not. This is *permitted* under the law. By contrast, in a cost-cutting move, Acme restricts its high option plan to those employees who can pass a physical examination. This is *not permitted* under the law.

- You must be given a special opportunity to sign up for your group health plan if certain changes happen to your family. *In addition to any regular* ***enrollment period*** *your employer or group health plan offers, you must be offered a special 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 a group plan

- *Under North Carolina law, newborns foster children and adopted children are automatically covered under the parent's fully insured health plan for the first 30 days, if the plan covered dependents.* The insurer may require that the parent notify the plan and pay a premium within the first 30 days in order to continue coverage beyond the first 30 days. .

- *Under North Carolina law, disabled adult children can remain on their parent's fully insured group health plan after reaching the age at which dependent coverage is usually terminated, if they meet certain requirements.* To qualify, your adult son or daughter must be incapable of self-support because of mental retardation or physical disability and must be chiefly dependent on the policyholder for support. Proof of incapacity must be furnished to the insurer within 31 days of reaching the limiting age and may be required subsequently in the future.

- *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. A new federal law allows dependent children who take a medically 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.

  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.* 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 an affiliation period before coverage begins.* During this affiliation period, you will not have health insurance coverage. The HMO 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 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 FMLA, your employer must continue your health benefits. You will have to continue paying your share of the premium.

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

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

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

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

- *A group health plan can count as pre-existing conditions only those for which you actually received (or were recommended to receive) a diagnosis, treatment or*

medical advice within the 6 months immediately before you joined that plan. This period is also called the look back period.

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

- *Group health plan 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.

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

Coverage counts as continuous if it has not been interrupted by a break of 63 or more days in a row.

What is creditable coverage?

Most health insurance counts as creditable coverage, including:

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.

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 group health plan that offers more benefits than your old one did.* Plans can look back to determine whether your previous health plan covered prescription drugs, mental health, substance abuse, dental care, or vision care. If you did not have continuous coverage for one or more of these categories of benefits, your new group health plan may impose a pre-existing condition exclusion period for that category. 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 North Carolina 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. See Chapter 3 for more information about COBRA continuation coverage, state continuation coverage, conversion coverage, individual health insurance, and coverage for "HIPAA eligible individuals."

- *If you lost your health insurance and are receiving benefits from the Trade Adjustment Assistance (TAA) Program, you may be eligible for a federal income tax credit to help you pay for new health coverage.* This credit is called the Health Coverage Tax Credit (HCTC), and is equal to 80% of the cost of qualified coverage, including COBRA and health insurance offered through the North Carolina Health Insurance Risk Pool. (see Chapter 5)

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

CHAPTER 3
YOUR PROTECTIONS WHEN BUYING INDIVIDUAL HEALTH INSURANCE

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

INDIVIDUAL HEALTH INSURANCE SOLD BY PRIVATE INSURERS

WHEN DO INDIVIDUAL HEALTH INSURERS HAVE TO SELL ME A POLICY?

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

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

  However, under no circumstance may you be turned down, charged more or face a pre-existing exclusion period 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, all private insurance companies that sell individual health insurance must offer you a choice of at least two plans, whose benefits must be similar to those sold to everyone else*. Companies that do not designate two policies must offer you a choice of all their individual insurance policies. Policies sold to HIPAA eligible individuals cannot impose pre-existing condition exclusion periods. However, there is no limit on what you can be charged for this coverage.

To be HIPAA eligible, you must meet certain criteria:

If you are HIPAA eligible you are guaranteed the right to buy individual health insurance and are exempted from pre-existing condition exclusion periods. To be HIPAA eligible, you must meet all of the following:

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

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

- *In North Carolina, newborns, adopted children and grandchildren (provided the birth parent is a dependent under the age of 18) are automatically covered under the parents' fully insured health plan for the first 30 days, if the plan covers dependents.* The insurer may require that the parent enroll the child within the 30 days in order to continue coverage beyond the 30 days.

- *If you have a disabled child, he or she may remain covered under your individual health insurance policy after the age at which dependent coverage is usually terminated.* To qualify, your adult son or daughter must be incapable of self-support because of mental retardation or physical disability and must be chiefly dependent on the policyholder for support. Proof of incapacity must be furnished within 31 days of reaching the time limit and may be required periodically thereafter.

WHAT WILL MY INDIVIDUAL HEALTH INSURANCE POLICY COVER?

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

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *Individual health insurers can impose* ***elimination riders***. This is an amendment to your health insurance policy that permanently excludes coverage for a health condition or even an entire body part or system.

- *North Carolina insurers can also impose pre-existing condition exclusion period.* Pre-existing condition exclusion periods cannot exceed 12 months. If a 12-month exclusion period is applied, you can get credit for any prior continuous creditable coverage you have had as long as you have not had a gap of 63 days or more between your old and new coverage. No pre-existing condition exclusion periods can be applied if you are HIPAA eligible.

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

- *Individual health insurers that impose pre-existing condition exclusion periods must give credit for any previous continuous creditable coverage*. Most types of private and government sponsored health coverage are considered to be creditable coverage. Coverage counts as continuous if it has not been interrupted by a break of 63 or more days in a row.

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

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

- *If you have an expensive health condition, your individual health insurance premiums may be very high.* The law does not prohibit North Carolina health insurers from charging you more because of your health status and other factors. However premiums cannot vary based on your genetic information.

- *When you renew your individual coverage, your premiums will increase based on your age.*

CAN MY INDIVIDUAL HEALTH INSURANCE POLICY BE CANCELED?

- *Your coverage cannot be canceled because you get sick.* This is called guaranteed renewability. You have this protection provided that you pay the premiums, do not defraud the company, and, in the case of **managed care plans**, continue to live in the plan service area. Coverage may be canceled should the carrier leave the market after appropriate notice or membership ceases in certain kinds of association groups

- *However, 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 North Carolina Department of Insurance to learn more about your rights.

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

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 or state continuation coverage. The information presented below was taken from publications prepared by the U.S. Department of Labor. You should contact them for more information about your rights under COBRA.

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

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

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

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

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

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 the 60-day period to elect COBRA continuation coverage has expired.* In this circumstance, TAA-eligible people have a second 60-day period, starting on the date of their TAA eligibility, to elect COBRA. (However, in no case can COBRA be elected more than 6-months following the original qualifying event (i.e. layoff) that caused the loss of group health plan coverage.)

- *When COBRA is elected during this special, second election period, coverage starts on the first date of the special election period.* Any time that has elapsed between the original qualifying event and the first date of the special election period is not counted as a lapse in coverage in determining continuous coverage history.

WHAT WILL COBRA COVER?

- *Your covered health benefits under COBRA will be the same as those you had before you qualified for COBRA.* For example, if you had coverage for medical, hospitalization, dental, vision, and prescription drug benefits before COBRA, you can continue coverage for all of these benefits under COBRA. If these benefits were covered under more than one plan (for example, a separate health insurance and dental insurance plan) you can choose to continue coverage under any or all of the plans. 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 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. (see Chapter 5)

- *If you 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 is called the Health Coverage Tax Credit (HCTC). (see Chapter 5)

- *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) 444-3272or 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/.

- *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 in hours) or be determined to have become disabled within 60 days of that qualifying event. You must obtain this disability determination from the Social Security Administration, and you must notify your group health plan within 60 days of this disability determination.

LENGTH OF COBRA COVERAGE

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

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

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

- *COBRA coverage also ends if your employer stops offering health benefits to other employees.*

- *COBRA coverage might end if you are in a managed care plan that is available only to people living in a limited geographic area and you move out of that area.* However, if you are eligible for COBRA and are moving out of your current health plan’s service area, your employer must provide you with the opportunity to switch to a different plan, but only if the employer already offers other plans to its employees. Some examples of the other plans your employer may offer you are a

managed care plan whose service area includes the area you are moving to, or another plan that does not have a limited service area.

WHAT ABOUT NORTH CAROLINA CONTINUATION COVERAGE?

- *If your employer offers health benefits, you may be eligible for up to 18 months of continuation coverage under a North Carolina law that is similar to COBRA*. To qualify, you must apply for state continuation coverage within 60 days of losing your old coverage. Ask your former employer or the North Carolina Department of Insurance about state continuation coverage if you think it applies to you.

- *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/.

CONVERSION COVERAGE

North Carolina law provides individuals with some rights to purchase a conversion policy when certain events occur. A conversion policy is an individual policy sold by the insurer that provided your prior coverage. Conversion policies may be more expensive and not cover the same benefits as your prior policy.

WHEN AM I ELIGIBLE FOR CONVERSION COVERAGE?

- *In North Carolina, if you have three months of coverage through an employer's fully insured group health plan and you leave that job, you may be eligible to buy conversion coverage.* This is an individual policy you get from the company that insured your employer's group plan.

- *You must apply for conversion coverage and pay your first premium within 31 days of losing prior coverage*.

- *Conversion rights are also available to dependents covered under the employer's group plan.*

WHAT DOES A CONVERSION POLICY COVER?

- *You must be given a choice of three conversion policies.* Conversion policies may not provide the same level of coverage as your prior employer sponsored group coverage.

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

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

HOW MUCH CAN I BE CHARGED FOR CONVERSION COVERAGE?

- *Conversion policies may cost more than your previous group plan.* There is no limit on what you can be charged for conversion policies. These policies may cost more than your prior group coverage.

CAN MY CONVERSION POLICY BE CANCELED?

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

NORTH CAROLINA HEALTH INSURANCE RISK POOL (NCHIRP)

North Carolina maintains a high-risk pool, called the North Carolina Health Insurance Risk Pool (NCHIRP), to provide insurance for residents of North Carolina who are unable to buy private health insurance due to their health conditions, and for people who are HIPAA eligible and TAA eligible.

WHEN CAN I BUY HEALTH INSURANCE FROM THE HIGH RISK POOL?

- *If you are HIPAA eligible, you can buy health insurance from NCHIRP.*

- *You can also buy health insurance from NCHIRP if you have lived in North Carolina for at least 30 days and can demonstrate proof of eligibility.* There are several different ways to who eligibility:

- You have been turned down for coverage by one insurance company because of a health condition;
- You have been quoted a premium for an individual policy that is more than the high risk pool premium;
- You have been offered an individual health insurance policy, but it contains an elimination rider on a condition you have;
- You have been diagnosed with a serious condition, such as cancer, AIDS, or Parkinson's disease, that would limit your ability to purchase health insurance.

You only need to show that you are eligible in one of these ways in order to be eligible for health insurance from NCHIRP.

- *You can also buy health insurance from NCHIRP if you have been certified as eligible for federal premium assistance under the HCTC.* (see Chapter 5)
- *NCHIRP does not offer family coverage.* Each member of your family who wants to enroll in NCHIRP will have to qualify on his or her own.

WHAT WILL THE HIGH RISK POOL COVER?

- *Health insurance from NCHIRP includes hospital and physician care, prescription drugs, limited mental health, and other services.* Total coverage is limited to a lifetime maximum of $1,000,000.
- *NCHIRP offers 3 plan options.* Benefits are the same under all options, but the annual deductible and cost sharing varies. Your deductible choices are $1,000, $2,500 or $5,000.
- *NCHIRP plans cover hospital and physician services, preventive care, prescription drugs, and limited mental health and substance abuse treatment.*
    - Under Plan A, the calendar year deductible is $1,000 per person. This plan pays for 80% of in-network or 50% of out-or-network covered services. You pay the remainder, up to a maximum dollar amount, also called your out-of-pocket limit. There is a calendar year out-of-pocket limit maximum of $2,000 on cost sharing for certain services provided by network providers ($4,000 for non-network providers.)

- Under Plan B, the calendar year deductible is $2,500 per person. This plan pays for 80% of in-network or 50% of out-or-network covered services. You pay the remainder, up to a maximum dollar amount, also called your out-of-pocket limit. There is a calendar year out-of-pocket limit maximum of $4,000 on cost sharing for certain services provided by network providers ($5,000 for non-network providers.)

- Under Plan C, the calendar year deductible is $5,000 per person. This plan pays for 100% of covered services after you satisfy the deductible. There is a calendar year out-of-pocket limit maximum of $5,000, on cost sharing for certain covered benefits.

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *If you are HIPAA eligible, NCHIRP will not impose a pre-existing condition exclusion when you enroll.*

- If you are not HIPAA eligible, you may have a 12-months pre-existing condition exclusion period. When you enroll, NCHIRP will look back 12 months to see if you had a condition for which you actually received a diagnosis, medical advice, or treatment. Pregnancy can be considered a pre-existing condition.

- NCHIRP will credit prior continuous coverage toward your pre-existing condition exclusion if you apply within 63 days of losing your prior coverage.

WHAT CAN I BE CHARGED FOR HIGH RISK POOL COVERAGE?

- *NCHIRP premiums are limited to about 175% of the amount that a healthy person would pay if he or she bought a similar plan sold by a private insurer.* Premiums will vary based on your age, gender, smoking status, and deductible you choose.

  For example, the monthly premium for a 24-year old non-smoking man ranges from $145 to $283 depending on the deductible he chooses. By contrast, the monthly premium for a 64-year old non-smoking man ranges from $731 to $1,340, depending on the deductible he chooses.

- *Contact NCHIRP for the most current information about premium and coverage options.*

HOW LONG DOES HIGH RISK POOL COVERAGE LAST?

- *NCHIRP coverage is renewable as long as you pay your premiums, continue to reside in North Carolina, and meet other eligibility requirements.* If your high risk

pool policy is terminated or you cancel it, you will have to wait 12 months before you can reply for Pool coverage, unless you are HIPAA eligible or HCTC eligible.

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

Federal law extends certain protections to employers seeking to buy health insurance for themselves and their workers. North Carolina has enacted reforms to expand some of these protections. Some of these reforms apply to groups of different sizes. Generally, small employers are those that employ 2-50 employees. Self-employed persons with no other employees count as small employers in North Carolina, but have somewhat different protections. Please note, however, that the definitions of small employer and employee are somewhat different under federal and state law. Check with the North Carolina Department of Insurance to be sure that you know which protections apply to your group.

DO INSURANCE COMPANIES HAVE TO SELL ME HEALTH INSURANCE?

- *With few exceptions, small employers cannot be turned down.* This is called guaranteed issue. If you employ at least 2 but not more than 50 people eligible for health benefits, health insurance companies must sell you any **small group health plan** they sell to other small employers. However, they can require that a minimum percentage of your workers participate in your group health plan. They can also require you to contribute a minimum percentage of your workers' premiums. If you are buying a **large group health plan** for 51 or more employees, your group can be turned down.

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

- *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.

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

- *Under North Carolina law, small employers can be charged more, within limits, based on the health status, claims history, and demographics of the group.* Even

within these limits, 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 or increases. If you have questions about your group health plan premiums, contact the North Carolina Insurance Department.

WHAT PLAN CHOICES DO I HAVE?

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

WHAT IF I AM SELF-EMPLOYED?

- *If you are self-employed with no other workers, you are treated similarly to other small employers.* Insurers cannot refuse to sell you the standard plan or basic plan. However, insurers can refuse to sell you other plans.

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

A WORD ABOUT ASSOCIATION PLANS

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

CHAPTER 5
FINANCIAL ASSISTANCE

Help is available to certain low-income residents of North Carolina who cannot afford to buy health insurance. Medicaid and the North Carolina Health Choice for Children offer free or subsidized health insurance coverage, direct medical services or other help. In addition, the federal government, under the Trade Adjustment Assistance (TAA) Program, provides tax credits to some workers who lose their jobs or whose work hours and wages are reduced as a result of increased imports. This chapter provides summary information about these programs and contact information for further assistance.

MEDICAID

Medicaid is a program that provides health coverage to some low-income North Carolina residents. Medicaid covers families with children and pregnant women, the elderly, people with disabilities, and medically needy individuals if state and federal guidelines are met. Legal residents who are not U.S. citizens may be eligible for Medicaid. Non-citizens who do not have immigration documents cannot enroll in Medicaid.

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

  In North Carolina you may be eligible for Medicaid if you are an infant, a child, pregnant, a parent of a child, or medically needy and your family income meets the Medicaid income standards.

  Income eligibility levels for these categories are described below. Your assets and some expenses also may be taken into account, so you should contact the North Carolina Division of Medical Assistance at the Department of Health and Human Services for more information.

Low income persons eligible for Medicaid in North Carolina*

Category	Income eligibility (as percent of federal poverty level)
Infant	200% (monthly income of about $3,052 for family of 3)
Child 1-5	200%
Child 6-19	100%
Non-working parents	37%
Working parents	51%
Pregnant woman	185%
Medically Needy	
Individual	34%
Couple	33%

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

To get an idea of how your income compares to the federal poverty level,* use the federal poverty guideline issued by the U.S. Department of Health and Human Services for the year 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 local department of social services for the most up to date information and for other eligibility requirements that may apply.

- *Parents who receive benefits under* ***TANF (also known as Work First)*** *should know that when you get a job and your TANF benefits end, you generally can stay on Medicaid for a 12-month transitional period.*

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

- *Very poor elderly or disabled people who get* ***Supplemental Security Income (SSI)*** *benefits can also qualify for Medicaid.*

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

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

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

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

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

  Contact your County Office of Public Assistance for more information about other eligibility requirements.

- *There may be other ways that Medicaid can help.* To find out if you or other members of your family qualify for Medicaid, contact the Division of Medical Assistance at the Department of Health and Human Services.

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

  To apply for Medicaid, call your local Division of Social Services (DSS). You can also ask to have an application mailed to you. More information is available at http://www.dhhs.state.nc.us/dss/contact/index.htm or by calling (800) 662-7030 or (919)733-3055.

NORTH CAROLINA HEALTH CHOICE FOR CHILDREN

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

- *A child whose family has a household income below 200% of the federal poverty level is eligible.* For a family of 3, this works out to an annual income of about $36,620, or a monthly income of about $3,052.

- *If your household income is between 151% and 200% of the federal poverty level, there is an enrollment fee of $50 for one child or $100 for two or more children.* You are also required to make copayments.

- *If your household income is at or below 150% of the federal poverty level, you are only required to make copayments for prescriptions drugs.* Those copayments are $1 for a generic drug or for a brand-name drug for which no generic is available and $3 for a brand-name drug for which there is a generic available.

- *Some of the benefits include hospitalization, physician services, prescription drugs, mental health services, and vision and dental care.*

- *To apply for the program, contact your county social services department or local health department.* An application can be found on the program's web site (http://www.dhhs.state.nc.us/dma/cpcont.htm).

NORTH CAROLINA BREAST AND CERVICAL CANCER CONTROL PROGRAM (NCBCCCP)

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

- *The Breast and Cervical Cancer Program (BCCCP) provides qualified woman with free screenings for breast and cervical cancer.* Women screened through this program and diagnosed with breast or cervical cancer may be eligible for free health coverage through Medicaid which extends throughout the duration of treatment.

- *In order to be eligible for screening through the Breast and Cervical Cancer Control* Program*, you must meet age and income guidelines and insurance requirements.* You must be between the ages of 18 and 64 for cervical cancer screening and, 40 and 64 for mammograms, and you must have an income at or below 200% of the federal

poverty level (FPL). Additionally, you must be uninsured or underinsured and must not have Medicare Part B or Medicaid.

- *For more information, please contact the Chronic Disease and Injury Section at (919) 707-5200 or visit their website at* http://www.ncpublichealth.com/chronicdiseaseandinjury/index.htm.

OTHER STATE PROGRAMS

There may be other financial assistance programs available. Please contact the North Carolina Department of Health and Human Services at (919) 707-5200 or http://www.dhhs.state.nc.us/dma/cpcont.htm#app.

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 income 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, North Carolina has designated the North Carolina Health Insurance Risk Pool as a state qualified health plan. (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 State continuation coverage Conversion coverage	*North Carolina Department of Insurance* (800) 546-5664 (in-state only) (919) 807-6750 (out-of-state) http://www.ncdoi.com/default.asp
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
Blue Cross and Blue Shield	*BlueCross BlueShield of North Carolina* (800) 250-3630 http://www.bcbsnc.com/
Medicaid	*Department of Social Services, CARE-LINE* (800) 662-7030 Information/Referral Service (919)733-3055 (919) 855-4400 (in-state) (919) 733-4851 (TTY), or email care.line@ncmail.net http://www.dhhs.state.nc.us/dss
North Carolina Health Choice for Children	*North Carolina Family Health Resource Line* (800) 367-2229 http://www.dhhs.state.nc.us/dma/cpcont.htm#app
Breast and Cervical Cancer Control Program	*Department of Health and Human Services, Chronic Disease and Injury Section* (919) 707-5200 http://www.ncpublichealth.com/chronicdiseaseandinjury/index.htm
The Federal Health Coverage Tax Credit (HCTC)	*Internal Revenue Service (IRS)* (866)-628-HCTC http://www.irs.gov/individuals/article/0,,id=187948,00.html

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

HELPFUL TERMS

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. See also State Continuation Coverage.

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

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

Creditable Coverage. Health insurance coverage under any of the following: a group health plan; individual health insurance; student health insurance; Medicare; Medicaid; CHAMPUS and TRICARE (health coverage for military personnel, retirees, and dependents); the Federal Employees Health Benefits Program; Indian Health Service; the Peace Corps; 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. A health plan purchased by an employer from an insurance company. Fully insured health plans are regulated by North Carolina. See also Self-Insured Group Health Plans.

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

Guaranteed Issue. A requirement that health plans must permit you to enroll regardless of your health status, age, gender, or other factors that might predict your use of health services. All health plans sold to small employers are guaranteed issue. If you are self-employed or a household employer buying coverage for one full-time employee, basic and standard small group health plans are guaranteed issue. If you are HIPAA eligible, insurance companies must offer you at least two individual health insurance policies that are guaranteed issue. Plans that are guaranteed issue can turn you away for other reasons.

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

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

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

Health 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 a national floor for health insurance reforms. Since states can and have modified and expanded upon these provisions, consumers' protections vary from state to state.

HIPAA Eligible. Status you attain once you have had 18 months of continuous creditable health coverage. To be HIPAA eligible, you also must have used up any COBRA or state continuation coverage; you must not be eligible for Medicare or Medicaid; you must not have other health insurance; and you must apply for individual health insurance within 63 days of losing your prior creditable coverage. When you are buying individual health insurance, HIPAA eligibility confers greater protections on you than you would otherwise have in North Carolina and in other states. See also COBRA, Continuous Coverage, Creditable Coverage, State Continuation Coverage.

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

Individual Health Insurance. Policies for people not connected to an employer group. Individual health insurance is regulated by North Carolina.

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

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

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

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

Medicaid. A program providing comprehensive health insurance coverage and other assistance to certain low-income North Carolinans. All other states have Medicaid programs, too, though eligibility levels and covered benefits will vary.

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

North Carolina Breast and Cervical Cancer Control Program. The North Carolina Breast and Cervical Cancer Control Program provides preventative screenings to women with limited or no health insurance coverage. This program pays for mammograms, Pap tests and certain other health screenings.

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

North Carolina Health Insurance Risk Pool (NCHIRP). North Carolina Health Insurance Risk Pool, the state-run insurance program for HIPAA eligible persons and for people with high health risks (called a high risk pool).

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

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

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

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

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

Special Enrollment Period. A time, triggered by certain specific events, during which you and your dependents must be permitted to sign up for coverage under a group health plan. Employers and group health insurers must make such a period available to employees and their dependents when their family status changes or when their health insurance status changes. Special enrollment periods must last at least 30 or 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. In North Carolina, if you are in a fully insured group health plan sponsored by an employer with 2 to 19 employees and meet other requirements, you also have rights to continue your health coverage when your job ends.

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

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

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