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

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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 TENNESSEE

In Tennessee, you have rights under federal and state law that help 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. Chapter 1 gives an overview of your protections. Chapters 2 and 3 explain your protections under group and individual health plans. Chapter 4 highlights your protections as a small employer 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 Tennessee, 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 37. A list of helpful terms and their definitions begins on page 38. 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 Tennessee. 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 Tennessee resident.

HOW AM I PROTECTED?

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

- *Coverage under your **group health plan** (if your employer offers one) cannot be denied or limited, nor can you be required to pay more, because of your health status.* This is called **nondiscrimination** (see page 6).

- *All group health plans in Tennessee 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 plan your old coverage will be credited toward the **pre-existing condition exclusion period**, provided you did not have a long break in coverage (see pages 8 and 15).

- *Your health insurance cannot be canceled because you get sick.* Most health insurance is **guaranteed renewable** (see page 16).

- *If you leave your job, you may be able to remain in your old group health plan for a period 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 page 16).

- *If you lose your fully insured group health insurance, you may be eligible to purchase a **conversion** policy.* This is an individual policy from the company that insured your former group policy. You will not face a new pre-existing condition exclusion period. However, there are no limits on what you can be charged for a conversion policy (see page 22).

- *If you lose your group health coverage, you may be **HIPAA eligible**.* If so, you can buy individual insurance from any insurance company that sells individual health insurance policies in Tennessee (see page 13).

- *If you cannot buy individual health insurance from a private insurer because of a health condition you can buy health insurance from the Tennessee high risk pool, **AccessTN*** (see page 23).

- *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.** All health plans for small employers must be sold on a guaranteed issue basis (see page 25).

- *If you are a small employer with a group consisting of 3-25 employees, there are limits on what you can be charged based on health status* (see page 26).

- *If you are a small business buying a group health plan, you may be eligible for coverage through **CoverTN**.* CoverTN is a state sponsored program that provides small employers access to health insurance at a reduced premium (see page 26).

- *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.* **TennCare,** part of the **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 children are 18 years old or younger, do not have health insurance and meet other qualifications, you may be able to buy insurance for them through a program **CoverKids*** (see page 30).

- *If you believe that you may be at risk for breast or cervical cancer, you may be eligible for free screening and treatment.* The **Tennessee Breast and Cervical Cancer Early Detection Program** provides qualified women with free breast and cervical cancer screening. Some women diagnosed with breast or cervical cancer through this program may be eligible for medical care through Medicaid (see page 31).

- *If you have 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 pay for new health coverage.* This credit is called the **Health Coverage Tax Credit** (HCTC), and it is equal to 65% of the cost of qualified health coverage, including COBRA and a policy offered through BlueCross BlueShield of Tennessee (see page 32).

- *If you are a retiree aged 55-65 and receiving benefits from **Pension Benefit Guarantee Corporation** (PBGC), then you may be eligible for the HCTC* (see page 32).

WHAT ARE THE LIMITS ON MY PROTECTIONS?

As important as they are, the federal and state health insurance reforms are limited. Therefore, you also should understand how the laws do *not* protect you.

- *If you change jobs, you usually cannot take your old health benefits with you.* Except when you exercise your federal COBRA rights, you are not entitled to take your actual group health plan with you when you leave a job. Your new health plan may not cover all of the benefits or the same doctors that your old plan did.

- *If you change jobs, your new employer may not offer you health coverage*. Employers are required only to make sure that their decision is based on factors unrelated to your health status (see page 6).

- *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. **HMO**s can required **affiliation periods** (see page 7).

- *If you have a break in coverage of 63 days or more, you may have to satisfy a new pre-existing condition exclusion period when you join a new group plan* (see page 9).

- *Even if your coverage is **continuous**, there may be a pre-existing condition exclusion period for some benefits if you join a group health plan that covers benefits your old plan did not.* For example, say you move from a group plan that does not cover prescription drugs to one that does. You may have to wait up to one year before your new health plan will pay for drugs prescribed to treat a pre-existing condition (see page 11).

- *If you work for a non-federal public employer in Tennessee, not all of the group health plan protections may apply to you* (see page 11).

- *If you are not HIPAA eligible, your access to individual health insurance depends on your health status.* Private insurers are not prohibited from turning you down, charging you more, or limiting coverage due to your health status (see page 13).

- *If you are HIPAA eligible, the law does not limit what you can be charged for individual health insurance*. You can be charged substantially higher premiums because of your health status, age, gender, and other characteristics (see page 16).

- *If you move away from Tennessee, you may not be able to buy individual health insurance in another state unless you are HIPAA eligible.*

- *If you have a break in coverage for 63 days or more you may have to satisfy a new pre-existing condition exclusion period when you join AccessTN* (see page 24).

- *If you are a small employer buying group health insurance, you will be charged more if somebody in your group is sick.* There are limits on how much more you can be charged if you have 3 to 25 employees, although surcharges can still be substantial. If you have fewer than 3 or more than 25 employees, there are no limits (see page 25).

CHAPTER 2
YOUR PROTECTIONS UNDER GROUP HEALTH PLANS

This chapter describes the protections that you have in group health plans, such as those offered by employers or labor unions. Your protections will vary somewhat, depending on whether your plan is a fully insured group health plan or a **self-insured group health plan**. The plan's benefits information must indicate whether the plan is self-insured.

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

- *In general, you have to be eligible for the group health plan.* For example, your employer may not give health benefits to all employees. Or, your employer may offer an HMO plan that you cannot join because you live outside of the plan's service area.

- *You cannot be turned away or charged more because of your health status.* Health status means your medical condition or history, **genetic information** or disability. This protection is called nondiscrimination. Employers may refuse or restrict coverage for other reasons (such as part-time employment), as long as these are unrelated to health status and applied consistently.

Discrimination due to health status is not permitted

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

- *You must be given a special opportunity to sign up for your group health plan if certain changes happen to your family*. In addition to any regular **enrollment period** your employer or group health plan offers, you must be offered a special, 30-day opportunity to enroll in your group health plan after certain events. You can elect coverage at this time. If your group plan offers family coverage, your dependents can elect coverage as well. Enrollment during a **special enrollment period** is not considered **late enrollment.**

Certain changes can trigger a special enrollment opportunity

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

- *In Tennessee, newborns and newly adopted children are automatically covered under the parents' fully insured group health plan for the first 31 days, if the plan covers dependents.* The insurer may require that the parent enroll the dependent and pay a premium within 31 days of birth or adoption in order to continue coverage beyond the 31 days.

- *If you have a disabled child, that child may remain covered under your fully insured group health plan after he or she reaches the age at which dependent coverage is usually terminated.* To qualify, your adult son or daughter must be incapable of self-support because of mental retardation or physical disability and must be chiefly dependent on the policy holder for support. Proof of incapacity must be furnished within 31 days of reaching the time limit and may be required periodically thereafter, but no more frequently than once a year following the first two years.

- *When you begin a new job, your employer may require a waiting period before you can sign up for health coverage.* This waiting period, however, must be applied consistently and cannot vary due to your health status. You will not have health insurance coverage during this time.

- *When you begin a new job with health insurance through an HMO, the HMO may require a waiting period before coverage begins.* During this affiliation period, you will not have health insurance coverage. The HMO also cannot impose any pre-existing condition exclusions if it imposes an affiliation period. An HMO affiliation period cannot exceed 2 months (3 months for late enrollees)

- *If you have to take leave from your job due to illness, the birth or adoption of a child, or to care for a seriously ill family member, you may be able to keep your group health coverage for a limited time.* A federal law known as the **Family and Medical Leave Act (FMLA)** guarantees you up to 12 weeks of job-protected leave in these circumstances.

  The FMLA applies to you if you work at a company with 50 or more employees.

If you qualify for leave under the FMLA, your employer must continue your health benefits. You will have to continue paying your share of the premium.

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

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

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

When you first enroll in a group health plan, the employer or insurance company may ask if you have any pre-existing conditions. Or, if you make a claim during the first year of coverage, the plan may **look back** to see whether it was for such a condition. If so, it may 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 is called the look back period.

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

- *Group health 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 are hired and not during a regular or special enrollment period), you may have an 18-month pre-existing condition exclusion period. In Tennessee, fully insured group health plans can refuse to enroll late enrollees for up to 18 months, apply an 18-month pre-existing condition exclusion period, or apply some combination of both, which together lasts no more than 18 months. A plan must treat all its late members the same, whichever method it chooses to apply.

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

What is creditable coverage?

Most health insurance counts as creditable coverage, including:

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 between plans 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. He began working for Charter Company the day after he left Beta. 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 towards the 12-month exclusion period.

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 only credit coverage 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 in coverage 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 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 Tennessee 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 coverage, you may be able to remain covered under the group health plan for a limited time.* In addition, you may have special protections when buying certain kinds of individual health coverage. See Chapter 3 for more information about COBRA continuation coverage, state continuation coverage, conversion coverage, individual health insurance for 'HIPAA eligible individuals," and AccessTN.

- *If you have lost your group health insurance and are receiving benefits from the Trade Adjustment Assistance (TAA) program, you may be eligible for a federal income tax credit to help you pay for new health coverage.* This credit is called the Health Coverage Tax Credit (HCTC), and is equal to 65% of the cost of qualified health coverage, including COBRA and a policy offered through BlueCross BlueShield of Tennessee (see page 32).

- *If you are a retiree aged 55-65 and receiving benefits from the Pension Benefit Guaranty Corporation (PBGC), you may also be eligible for the HCTC* (see page 32).

CHAPTER 3
YOUR PROTECTIONS WHEN BUYING INDIVIDUAL HEALTH INSURANCE

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

INDIVIDUAL HEALTH INSURANCE SOLD BY PRIVATE INSURERS

WHEN DO INDIVIDUAL HEALTH INSURERS HAVE TO SELL ME COVERAGE?

In Tennessee, your ability to buy individual health coverage depends on your health status. There are certain circumstances, however, when you must be allowed to buy an individual health insurance policy.

- *In general, insurers that sell individual health insurance in Tennessee 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.

- *If you are HIPAA eligible, however, individual insurers cannot turn you down.* All insurers that sell individual insurance must offer you coverage. Insurers can offer you all of their individual health plans, their two most popular individual health policies, or two policies specially designed for HIPAA eligible individuals – a "high" and a "low" option policy, 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.

To be HIPAA eligible, you must meet certain criteria

If you are HIPAA eligible in Tennessee you are guaranteed the right to buy an individual health plan 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.

- *Even if you are HIPAA eligible, insurance companies in Tennessee are not required to offer you family coverage when you buy individual health insurance.* They must, hover, offer separate individual policies to each person in your family who is HIPAA eligible. Nonetheless, most insurance companies will voluntarily offer you family coverage if you request it.

- *Under Tennessee law, newborns and newly adopted children must be covered under your individual health plan for the first 31 days, if the plan covers dependents.* The insurer may require that the parent enroll the child within the 31 days in order to continue coverage beyond the 31 days.

- *If you have a disabled child, that child may remain covered under your fully insured group health plan after he or she reaches the age at which dependent coverage is usually terminated.* To qualify, your adult son or daughter must be incapable of self-support because of mental retardation or physical disability and must be chiefly dependent on the policy holder for support. Proof of incapacity must be furnished within 31 days of reaching the time limit and may be required periodically thereafter, but not more frequently than once every year.

WHAT WILL MY INDIVIDUAL HEALTH PLAN COVER?

- *It depends on what you buy.* Tennessee 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, Tennessee does require all health plans to cover certain benefits – such as mammograms and prostate cancer screening. Check with the Tennessee Department of Commerce and Insurance for more information about mandated benefits.

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *No pre-existing condition exclusion periods or elimination riders can be imposed on your individual health insurance policy if you are HIPAA eligible.*

- *For people who are not HIPAA eligible, individual health insurance policies 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 of system. Elimination riders can be applied even if you have prior creditable coverage.

- *For people who are not HIPAA eligible, individual health insurance policies can also impose pre-existing condition exclusion periods.* Pre-existing condition exclusion periods cannot exceed 2 years.

  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, or - in your insurer's judgment, for which you should have sought – a diagnosis or medical advice or treatment prior to obtaining the individual health policy This is called the prudent person standard. There is no limit on how far back a health plan can look to see if you had any pre-existing conditions.

- *If you make a claim during the first 2 years of coverage, the insurer can look back to see if the claim is for a condition that would have been considered a pre-existing condition.* If the insurer determines, using the prudent person standard, that the condition is a pre-existing condition, it can refuse to pay for expenses for that condition.

- *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.

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

WHAT CAN I BE CHARGED FOR INDIVIDUAL HEALTH COVERAGE?

- *If you have an expensive health condition, your individual health insurance premiums may be very high.* The law does not prohibit Tennessee health insurers from charging you more because of your health status.

- *When you renew your individual health insurance policy, your premiums can also increase.* Age and other factors will increase your premiums at renewal. In addition, if you have a health condition and the rates for your individual policy have increased, you may not be able to switch to a cheaper policy.

CAN MY INDIVIDUAL HEALTH INSURANCE POLICY BE CANCELLED?

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

- *Some insurance companies sell temporary health insurance policies.* Temporary policies are not renewable. They will only cover you for a limited time, such as 6 months. If you want coverage under a temporary policy after it expires, you will have to apply for a new contract 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 (see page 19).

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

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

COBRA QUALIFYING EVENTS

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

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

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

- *Each person who is eligible for COBRA continuation can make his or her own decision*. If your dependents were covered under your employer plan, they may independently elect COBRA coverage as well.

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

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

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

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

SPECIAL SECOND CHANCE TO ELECT COBRA FOR TRADE-DISLOCATED WORKERS

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

WHAT WILL COBRA COVER?

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

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

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

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

WHAT CAN I BE CHARGED FOR COBRA COVERAGE?

- *You must pay the entire premium (employer and employee share, plus a 2% administrative fee) for COBRA continuation coverage.*

- *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 insurance and are receiving benefits from the Trade Adjustment Assistance (TAA) Program, you may be eligible for a federal income tax credit to help you pay for new health coverage.* This credit is called the Health Coverage Tax Credit (HCTC), and it is equal to 65% of the cost of qualified health coverage, including COBRA (see page 32).

- *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 credit is called the Health Coverage Tax Credit (HCTC) (see page 32).

HOW LONG DOES COBRA COVERAGE LAST?

- *COBRA coverage generally lasts up to 18 months and cannot be renewed.* However, certain disabled people can opt for coverage up to 29 months, and dependents are sometimes eligible for up to 36 months of COBRA continuation coverage, depending on their qualifying event. 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). You must obtain a disability determination letter from the Social Security Administration, and you must notify your group health plan within 60 days of this disability determination.

HOW LONG CAN COBRA COVERAGE LAST?

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. 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 TENNESSEE CONTINUATION COVERAGE?

- *If you were covered under a fully insured group health plan for 3 months or more and lost that coverage, you may be eligible for up to 3 months of continuation coverage under the same group plan.* In addition, if you are a spouse or a dependent who lost coverage because of the death or divorce, you may be eligible for up to 15 months of continuation coverage. Ask your former employer or the

Tennessee Department of Commerce and Insurance about state continuation coverage, if you think this applies to you.

CONVERSION

When you leave group coverage, you may be able to buy a conversion policy. This is an individual health policy from the insurance company that covered your former group.

WHEN DO I HAVE TO BE OFFERED CONVERSION POLICY?

- *If you were covered under a fully insured group health plan for 3 months, you may be able to buy a conversion policy.* You can buy a conversion policy if you lost your group coverage because you left your job or because the group coverage was terminated. However, before being eligible for a conversion policy, you must exhaust and COBRA or state condition coverage that was available to you. If the group coverage was terminated, you will immediately have the right to buy a conversion policy. If you had family coverage under your prior group plan, your dependents can elect conversion coverage as well.

- *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 WILL A CONVERSION POLICY COVER?

- *The benefits under a conversion policy will probably not be the same as those under your former plan.* The conversion policy's benefits may be less generous than those you used to have.

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *Conversion policies cannot impose a new pre-existing condition exclusion period.* However, you might have to satisfy the unexpired portion of any pre-existing condition exclusion period from your former health plan.

HOW MUCH CAN I BE CHARGED FOR A CONVERSION POLICY?

- *Conversion policies may cost much more than your previous group plan.* There is no limit on what you can be charged for a conversion policy. You may be charged higher rates based on your health, age, gender, and other factors. Contact the

Tennessee Department of Insurance if you have questions about conversion policy premiums.

CAN MY CONVERSION POLICY BE CANCELLED?

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

ACCESSTN

Tennessee has a high risk pool, called AccessTN, to provide coverage for people who are unable to buy private health insurance because of their health status.

WHEN CAN I GET COVERAGE FROM ACCESSTN?

- *You can buy coverage from AccessTN if you meet certain qualifications.* You must have lived in Tennessee for at least 6 months, been uninsured for the past 6 months, and have exhausted COBRA or state continuation coverage. In addition, you must be able to demonstrate proof of medical eligibility. There are 3 ways you can show eligibility:
    - You have been turned down for coverage by 2 insurance companies;
    - You have been diagnosed with one of 55 specified health conditions, including cancer and AIDS.
    - You have gone though AccessTN underwriting and have been found to be medically eligible.
- *If you were offered COBRA or state continuation coverage within the past year and you did not elect it, you will not be eligible for AccessTN for 12 months.*
- *AccessTN only offers individual coverage.* If you need to purchase family coverage, each member of your family needs to qualify on his or her own for an AccessTN policy.

WHAT WILL ACCESSTN COVER?

- *You can choose from 3 plan options under AccessTN.* Covered benefits are the same under all 3 plans, but the deductible and cost sharing varies. You will have a choice of PPO plans with deductibles of $1,000, $2,500, and $5,000.

- *Most services are covered at 80% for in-network and 60% for out-of-network.*

  Covered benefits include hospital and physician care, prescription drugs, chemotherapy and radiation treatment, and mental health and substance abuse services. There is a $1 million lifetime limit on covered benefits.

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *You may have a 3 month pre-existing condition exclusion period when you first enroll in AccessTN.* When you enroll, AccessTN will look back 6 months to see if you had a condition for which you actually receive – or for which most people would have sought – a diagnosis, medical advice, or treatment. This is called the prudent person rule. Pregnancy can be considered a pre-existing.

WHAT CAN I BE CHARGED FROM ACCESSTN COVERAGE?

- *Premiums will vary based on your age, weight, smoking, and what plan you choose.* For example the monthly premium for a 24-year-old range from $273 to $494, depending on the coverage option selected. The monthly premium for a 64-year-old range from $539 to $979.

HOW LONG DOES ACCESSTN COVERAGE LAST?

- *AccessTN policies are renewable as long as you pay your premiums, 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. Tennessee 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. Please note that the definitions of small employer and employee are somewhat different under federal and state law. Check with the Tennessee Department of Commerce and Insurance to be sure that you know which protections apply to your group.

DO INSURANCE COMPANIES HAVE TO SELL ME HEALTH INSURANCE?

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

- *Your insurance cannot be canceled because someone in your group becomes sick.* This is called guaranteed renewability and it applies to group plans of all sizes. Insurers can impose other conditions, however. They 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. If insurers discontinue an insurance product that you bought, they must give you a chance to buy other plans they sell to groups of your size.

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

- *For small groups of 3 to 25, Tennessee limits how much premiums can vary based on the health status of your group members.* Even within these limits, 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.

- *For groups of 2 and groups larger than 25, there are no limits on how much employers can be charged if someone in the group is sick.* Also, there are no limits on how much premiums can increase at renewal.

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 may be eligible to deduct 100% of the cost of your premiums from your federal income tax.*

COVERTN

CoverTN is a state sponsored plan designed to provide health insurance to uninsured workers and their families. The program offers streamlined health insurance coverage to employees of small employers by cost sharing with small employers and employees.

- *In order to enroll in CoverTN, small employers must meet certain eligibility requirements.* The business must be in Tennessee, have 25 or fewer full time employees, including self-employed individuals, with 50% of employees earning $41,000 or less annually. In addition, the employer has not offered insurance in the last 6 months (or, if offered coverage, has paid less than 50% of premiums).

- *Individual employees also must meet certain eligibility requirements.* If you enroll in CoverTN, your employees can receive coverage if they have maintained residency in Tennessee for 6 months, work at least 20 hours per week, and have not voluntarily terminated health insurance in the last 6 months.

- *Premiums are shared between the employer, employees and CoverTN.* As the employer, you will be responsible for1/3 of the premium. Employers have the option to pay the employees share of the premium.

- *Premiums are based on age, tobacco use, and weight.* In 2007, the share for each contributing party (employer, employee and CoverTN) share ranges from $34 to $99 per month. In addition to the premiums, employees are responsible for co-payments.

- *CoverTN offers limited health insurance coverage.* Benefits include doctor visits, hospital, prescription drugs, and mental health services. All services are subject to a $25,000 annual limit. In addition, you may have a 12 month pre-existing condition exclusion period.

- *For more information on CoverTN, please contact Cover Tennessee at (866) COVERTN or visit them on the web at http://www.covertn.gov/cover_tn.html.*

A WORD ABOUT ASSOCIATION PLANS

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

CHAPTER 5
FINANCIAL ASSISTANCE

Help is available to certain low-income residents of Tennessee who cannot afford to buy health insurance. TennCare, part of the Medicaid program, and the Breast and Cervical Cancer Early Detection Program offer free or subsidized health insurance coverage, direct medical services, or other assistance at little or no cost to you. In addition, the federal government, under the Trade Adjustment Assistance (TAA) Program, provides tax credits to come 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.

TENNCARE

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

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

  You may be eligible for TennCare Medicaid if you are an infant, a child, pregnant, the parent of a dependent, elderly, or disabled and your family meets the Medicaid income standards.

  Income eligibility levels for these categories are described below. Your assets and some expenses also make be taken into account, so you should contact the Tennessee

Low income persons eligible for Medicaid in Tennessee

Category	Income eligibility (as percent of federal poverty level)
Infant	185%
Child 1-5	133%
Child 6-19	100%
Pregnant woman	185%
Parents	
Working	80%
Non-Working	70%

* 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 2007:

Size of Family Unit	Poverty Guideline (annual income)
1	$10,210
2	$13,690
3	$17,170

For larger families add $3,480 for each additional person

So, for example, using this guideline, 185% of the federal poverty level for a family of 3 would be an annual income of $31,765, or a monthly income of $2,647.

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

In addition, your children may qualify for TennCare Medicaid if your family's income meets certain income standards.

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

- *People who have high medical expenses may also qualify for TennCare*. You may qualify as medically needy if you have high medical expenses that, when subtracted from your income, would make you eligible for TennCare coverage. For example, people who have to pay a lot for prescription drugs, nursing home care, or other long term care services sometimes qualify as medically needy if they don't have health insurance that covers these services.

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

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

  Contact the Bureau of TennCare for more information about other eligibility requirements.

- *There may be other ways that TennCare can help.* To find out if you or other members of your family qualify for Medicaid, please contact the Tennessee Department of Finance and Administration.

- *If you are not eligible for TennCare Medicaid, you may be eligible for TennCare Standard, a state program which provides benefits to children under the age of 19 who meet the eligibility requirements.* For more information about TennCare Standard, contact TennCare at (866) 311-4287.

COVERKIDS

CoverKids is a health insurance program for low-income families living in Tennessee. It is part of a part of a national initiative, the Children's Health Insurance Program (CHIP), to ensure that all children have health insurance.

- *If you are a resident of Tennessee and have children under the age of 19 or are a pregnant woman, you and your children may be eligible for free health insurance through CoverKids.*

- *To be eligible, your child must meet requirements for income and prior health insurance coverage. meet requirements for income and prior health insurance coverage.* Your child must have been uninsured for 3 months (this requirement is waived for children 4 months old or younger and for children transitioning from TennCare or other SCHIP programs), you must have a household income at or below 250% of the federal poverty level (FPL). In 2007, for a family of 3, this works out to an annual income of up to $42,925, or a monthly income of up to $3,577. In addition, if your income is over 250% of the FPL, you may be able to buy coverage through CoverKids.

- *You will have to help pay for your child's CoverKids coverage.* You will be responsible for co-payments, depending on your family's income. Co-payments range from $5 to $15 for most services.

- *Healthy Families covers most medical expenses.* Coverage includes doctor visits, hospital care, prescriptions, mental health services, immunizations, and maternity care for qualified pregnant women.

- *For more information, contact CoverTN at (866) COVERTN.*

TENNESSEE BREAST & CERVICAL CANCER EARLY DETECTION PROGRAM (TBCCEDP)

- *The Tennessee Breast and Cervical Cancer Early Detection Program provides eligible women with breast and cervical cancer screening at no cost.* Women who are screened though this program and diagnosed with breast and/or cervical cancer may be eligible for treatment through TennCare, the state Medicaid program..

- *To be eligible for screening, you must certain age, income and insurance status requirements.* Generally, you must be at least 40 and no more than 64 years of age, have no or limited health insurance, and a family income at or below 250% of the federal poverty level (FPL). However, women ages 18-39, may be eligible under certain circumstance, if they otherwise meet the income and insurance

guidelines. For a family of three, this is an annual income of no more than $42,925.

- *Women screened through this program and diagnosed with breast or cervical cancer may be eligible for medical care through TennCare, the state Medicaid program.* Medicaid coverage will last throughout the duration of cancer treatment. In addition, Tenncare will cover all of your medical needs including treatment for non-cancer related medical services.

- *For more information, please call the Tennessee Breast and Cervical Cancer Early Detection Program.* Their toll free number is (877) 96 – WOMEN *(877-969-6636)* or visit http://www2.state.tn.us/health/BCC/index.htm.

OTHER STATE PROGRAMS

There may be other financial assistance programs available. Please call the Tennessee Department of Commerce and Insurance at (800) 342-4029.

THE FEDERAL HEALTH COVERAGE TAX CREDIT (HCTC)

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

WHEN AM I ELIGIBLE FOR HCTC?

- *To be eligible for the tax credit, you must be receiving Trade Adjustment Assistance (TAA) benefits or retirement benefits from the PBGC.* If you are receiving PBGC benefits, you also must be at least 55 years old.

- *In addition, you must meet other requirements.* Specifically, you are not eligible for the HCTC if any of the following apply to you:

    - You have a health plan maintained by an employer or former employer that pays at least 50% of the cost of your coverage. Any share of your premium that is paid by you or your spouse on a pre-tax basis is considered to have been paid

by your employer and must be included as such when determining the percentage of employer coverage.

- You are enrolled in Medicare (Part A or B).

- You are enrolled in the Federal Employees Health Benefits Program (FEHBP), Medicaid, or State Children's Health Insurance Program (SCHIP).

- You are entitled to health coverage through the U.S. military health system (Tricare/CHAMPUS).

- You can be claimed as a dependent on someone else's federal tax return.

- You received a lump sum payment of your entire PBGC benefit before August 6, 2002.

- As of the first day of the current month in which you are otherwise eligible, you are imprisoned under a federal, state or local authority.

- *HCTC may apply to your family, too.* If you are eligible, you can use the credit to help purchase qualified health coverage for your qualified family members. Qualified family members are your spouse and dependents that you can claim on your federal tax return. Family members are not eligible if they are enrolled in another group health plan where the employer pays at least 50% of the cost of coverage, or in Medicaid, SCHIP, FEHBP, Tricare/CHAMPUS.

- *Eligibility for HCTC is not based on income.* In addition, the HCTC is refundable. This means you can claim the credit even if you do not earn enough income to owe federal income tax.

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

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

WHAT HEALTH COVERAGE IS ELIGIBLE FOR THE TAX CREDIT?

- *The HCTC can only be used to help pay for "qualified" health coverage. Qualified health coverage includes:*

  - COBRA continuation coverage, as long as your employer or former employer contributes less than 50% of the total health plan premium (see Chapter 3 for COBRA and state continuation coverage).

  - Individual heath insurance in which you were enrolled for at least the last 30 days before you were separated from the job that makes you eligible for TAA benefits or for payments from the PBGC.

  - Your spouse's insurance from work, as long as the employer contributes less than 50% of the total health plan premium. (At this time, you can only claim the credit with this type of coverage when you file your federal tax return and not in advance.)

  - State-qualified health plans. In Tennessee, a policy offered by BlueCross BlueShield of Tennessee is the state-qualified health plan.

HOW DO I CLAIM THE HCTC?

- *You can claim the HCTC on your tax return and be reimbursed for 65% of the premium you paid for qualified coverage while you were eligible for the HCTC.* Currently, this is the only way to claim the HCTC if your qualified health plan is provided through a spouse's employer.

- *Alternatively, you can choose to have your credit sent directly to your qualified health plan each month*. To do this, you must register with the HCTC customer service center by calling 1-866-628-HCTC (1-866-628-4282), Monday through Friday between the hours of 7 am and 7 pm, Central time. TDD/TYY callers, please call 1-866-626-HCTC (1-866-626-4282).

- *You will have to fill out a registration form verifying your eligibility for the HCTC and your enrollment in qualified coverage*. You will also fill out a payment invoice. Each month, you will send the HCTC program your 35% share of the premium for qualified coverage. The HCTC program will combine this payment with the tax credit covering the other 65% of the premium and forward the entire payment to your qualified health plan.

- *You must register in advance to have the HCTC paid directly to your health plan each month*. Usually, the direct payments won't begin until at least a month after you register with the HCTC program. Call the HCTC customer service center for more information

WHERE CAN I GET MORE INFORMATION?

- *For more information about the HCTC, contact the HCTC customer service center at 1-866-628-HCTC, or see the IRS website at http://www.irs.gov/individuals/index.html (click on HCTC).*

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

- *For more information about PBGC, contact, http://www.pbgc.gov or call 1-202-326-4000 with general inquiries.*

FOR MORE INFORMATION…

As a summary, this guide will not answer every question for every person in every circumstance. In addition, it is not a substitute for legal advice. If you have more questions, contact the agencies listed below or consult an attorney.

For questions about:	Contact:
Individual health insurance State continuation coverage Conversion coverage Fully insured group health insurance	*Tennessee Department of Commerce and Insurance* (800) 342-4029 (615) 741-2218 http://www.state.tn.us/commerce
Self-insured group health plans COBRA continuation coverage Family and Medical Leave Act	*U.S. Department of Labor* Employee Benefits Administrator Employee & Employer Assistance Hotline and Publications (866) 444-EBSA (3272) http://www.dol.gov/ebsa
CoverTN	*Cover Tennessee, Tennessee Department of Finance and Administration* (866) COVERTN http://www.covertn.gov/cover_tn.html
AccessTN	*Cover Tennessee, Tennessee Department of Finance and Administration* (866) COVERTN http://www.covertn.gov/access_tn.html
Medicaid (TennCare)	*Tennessee Department of Finance and Administration, Bureau of TennCare* (866) 311-4287 http://tennessee.gov/tenncare/
CoverKids	*Cover Tennessee, Tennessee Department of Finance and Administration* (866) COVERTN http://www.covertn.gov/cover_kids.html
Tennessee Breast & Cervical Cancer Early Detection Program	*Tennessee Department of Health* (877) 96 - WOMEN http://www2.state.tn.us/health/BCC/index.htm

Federal Health Coverage Tax Credit (HCTC)	*Internal Revenue Service* 1-866-628-HCTC http://www.irs.gov/individuals/index.html

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

HELPFUL TERMS

AccessTN. AccessTN, the state-run insurance program for people with high health risks (called a high risk pool).

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 form 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 group health plan, or if you want to be federally 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, Federally Eligible, Fully Insured Group Health Plan, Individual Health Plan, Self-Insured Group Health Plan.

Conversion. Your right, when leaving a fully insured group health plan in Tennessee, to convert your policy to an individual health plan. You must use up any COBRA or state continuation coverage before you can buy a conversion policy. While conversion policies must offer coverage similar to your former group plan, they can be significantly more expensive. See also Fully Insured Group Health Plan.

CoverKids. CoverKids provides subsidized insurance to children under the age of 19, and pregnant women, who are not eligible for Medicare and who have no health insurance.

CoverTN. CoverTN is a state sponsored arrangement that provides insurance to small groups employees. The arrangement is intended to provide access to health insurance to working individuals who otherwise would not have access.

Creditable Coverage. Health insurance coverage under any of the following: a group health plan; an individual health plan; Medicare; Medicaid; State Children's Health Insurance Program; CHAMPUS and TRICARE (health coverage for military personnel, retirees, and dependents); the Federal Employees Health Benefits Program; Indian Health Service; the Peace Corps; Public Health Plan (any plan established or maintained by a State, the U.S. government, a foreign country); or a state health insurance high risk pool. See also Continuous Coverage, Group Health Plan, Individual Health Plan.

Creditable Coverage (AccessTN). Health insurance coverage that was involuntarily terminated. See also Continuous Coverage, AccessTN.

Elimination Rider. An amendment permitted in individual health plan contracts that excludes your coverage for a health condition, body part, or body system. Elimination riders can last indefinitely. Elimination riders cannot be imposed if you are HIPAA eligible. You can apply to have an elimination rider modified or removed, but the health plan is not obligated to do so.

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 the FMLA, you can continue coverage under your group health plan.

Fully Insured Group Health Plan. Health insurance purchased by an employer from an insurance company. Fully insured health plans are regulated by Tennessee. See also Self-Insured Group Health Plans.

Genetic Information. Includes information about family history or genetic test results indicating your risk of developing a health condition. A health plan cannot consider pre-existing (and therefore exclude coverage for) a condition about which you have genetic information, unless that health condition has been diagnosed by a health professional.

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

Guaranteed Issue. A requirement that health plans must permit you to enroll regardless of your health status, age, gender, or other factors that might predict your use of health services. All health plans sold to small employers in Tennessee are guaranteed issue. If you are HIPAA eligible, insurance companies must offer you the opportunity to buy a policy. 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 coverage, HIPAA eligibility gives you greater protections than you would otherwise have in Tennessee 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. This term also refers to coverage purchased by the self-employed for themselves (or for their family members) but for no other employees. Individual health plans are regulated by Tennessee.

Kassebaum-Kennedy. See HIPAA.

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

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

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

Managed Care 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. Care received from these providers is called in-network care. Often, managed care plans will require you to get a referral from your primary doctor because you get care from an in-network specialist. Some managed care plans will cover your care at a lower rate if you receive care from an out-of-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 Tennessee residents. In Tennessee, the Medicaid program is part of a larger program called TennCare. All other states have Medicaid programs, too, though eligibility levels and covered benefits will vary. See also TennCare.

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

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

Pre-existing Condition (AccessTN). Any condition for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period immediately preceding enrollment in a health plan, or for which an ordinary prudent person would have sought medical advice, care or treatment. Pregnancy can be counted as a pre-existing condition by AccessTN. See also Prudent Person Rule.

Pre-existing Condition (Group Health Plans). Any condition (either physical or mental) for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period immediately preceding enrollment in a health plan. Fully insured small group plans and HMOs may not impose pre-existing condition exclusions in Tennessee. 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, children placed for adoption, and some children placed for guardianship covered within 31 days cannot be subject to pre-existing condition exclusions.

Pre-existing Condition (Individual Health Plans). Any condition for which medical advice, diagnosis, care, or treatment was recommended or received or for which an ordinarily prudent person would have sought medical advice, care, or treatment. Individual health plans can apply pre-existing condition exclusion periods for pregnancy, but not for genetic information. See also Prudent Person Rule.

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 plans and AccessTN, 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 relating to a pre-existing condition. See also Pre-existing Condition (Individual Health Plan).

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 Tennessee.

Small Group Health Plan Policy.. Plans with 2 to 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 days. Enrollment in a health plan during a special enrollment period is not considered late enrollment. See also Late Enrollment.

State Continuation Coverage. A program similar to COBRA. In Tennessee, if you are in a fully insured group health plan sponsored by an employer and meet other requirements, you may rights to continue your health coverage when your job ends. 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 (also called Families First) that provides cash benefits to low income families with children. When you qualify for TANF, you generally also qualify for TennCare. In addition, TennCare coverage often continues for a limited time or longer if you no longer qualify for TANF. See also Medicaid, TennCare.

TennCare. A program run by the state of Tennessee that provides health insurance to some low income individuals and families, dislocated workers, and uninsurable persons. Medicaid is part of TennCare.

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

U.S. Department of Labor. A department of the federal government that regulates employer provided health benefit plans. You may need to contact the Department of Labor if you are in a self-insured group health plan, or if you have questions about COBRA or the Family and Medical Leave Act. See also COBRA, Family and Medical Leave Act.

Waiting Period. The time you may be required to work for an employer before you are eligible for health benefits. Not all employers require waiting periods. Waiting periods do not count as gaps in health insurance for purposes of determining whether coverage is continuous. If your employer requires a waiting period, your pre-existing condition exclusion period begins on the first day of the waiting period. See also Pre-existing Condition Exclusion Period.