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

By

Karen Pollitz
Jennifer Libster
Eliza Bangit
Kevin Lucia
Mila Kofman

GEORGETOWN UNIVERSITY
Health Policy Institute

January 2006

ACKNOWLEDGMENTS AND DISCLAIMER

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

The authors also wish to express appreciation to the staff of the Pennsylvania Insurance Administration and the United States Department of Labor. Their help was invaluable in our research and understanding of applicable law and policy. Without them, this guide would not have been possible. However, any mistakes that may appear are our own.

This guide is intended to help consumers understand their protections under federal and state law. The authors have made every attempt to assure that the information presented in this guide is accurate as of the date of publication. However, the guide is a summary, and should not be used as a substitute for legal, accounting, or other expert professional advice. Readers should consult insurance regulators or other competent professionals for guidance in making health insurance decisions. The authors, Georgetown University, and the Health Policy Institute specifically disclaim any personal liability, loss or risk incurred as a consequence of the use and application, either directly or indirectly, of any information presented herein.

January 2006

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

As a Pennsylvania 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 Pennsylvania resident. Chapter 1 gives an overview of your protections. Chapters 2 and 3 explain your protections under group and individual health insurance. Chapter 4 highlights your protections as a small employer. Chapter 5 summarizes help that may be available to you if you cannot afford health coverage. If you move away from Pennsylvania, 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 34. For information about how to find consumer guides for other states on the Internet, see page 35. A list of helpful terms and their definitions begins on page 36. These terms are in boldface type the first time they appear.

Contents

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 Pennsylvania. 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 Pennsylvania resident.

HOW AM I PROTECTED?

In Pennsylvania, 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 Pennsylvania must limit exclusion of pre-existing conditions.* There are rules about what counts as a pre-existing condition and how long you must wait before a new group health plan will begin to pay for care for that condition. Generally, if you join a new group health plan, your old coverage will be credited toward the **pre-existing condition exclusion period**, provided you did not have a long break in coverage (see page 8).

- *Your coverage cannot be canceled because you get sick.* This is called **guaranteed renewability.** You have this protection provided that you pay the premiums, do not defraud the company, and, in the case of managed care plans, continue to live in the plan service area. Your insurance company also can refuse to renew your individual health insurance if that company decides to stop selling all individual health insurance in Pennsylvania (see pages 16, 18, 24, and 25).

- *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**. It can help when you are between jobs, or when you retire early and are not yet eligible for

Medicare. There are limits on what you can be charged for this coverage (see page 18).

- *If you lose your group health plan and meet other qualifications, you will be **HIPAA eligible***. If so, you can buy an individual health policy from a Blue Cross Blue Shield plan operating in your region of Pennsylvania. You will not face a new pre-existing condition exclusion period. Blue Cross and Blue Shield must offer you a choice of at least two policies, including one with comprehensive benefits (see page 12).

- *If you lose your fully insured group health plan, you can buy individual health insurance under a group **conversion policy.*** You will not face a new pre-existing condition exclusion period. There are limits on what you can be charged for a conversion policy (see page 23).

- *If you are a small employer buying a **small group health plan**, you cannot be turned down because of the health status, age, or any factor that might predict the use of health services of those in your group*. All fully insured health plans for small employers must be sold on a **guaranteed issue** basis (see page 24).

- *If you are not HIPAA eligible, Blue Cross and Blue Shield plans operating in Pennsylvania must offer you at least one individual health insurance policy on a guaranteed issue basis.* You cannot be turned down for this policy because you are sick (see page 12).

- *If you are HIPAA eligible, the Blue Cross and Blue Shield plan operating in your region must offer you a choice of at least two state-approved policies.* If two policies are not designated, you must be offered a choice of all of their individual insurance policies (see page 12).

- *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 Pennsylvania **Medicaid** program offers free health coverage for pregnant women, families with children, elderly and disabled individuals with very low incomes. In addition, some women who are diagnosed with breast or cervical cancer may be eligible for medical care through Medicaid (see Chapter 5).

- *If your children are 18 years old or younger, do not have health insurance and meet other qualifications, they may be able to buy insurance through the **Pennsylvania Children's Health Insurance Program (PaCHIP)*** (see page 29).

- *If you have low or modest household income, you may be eligible for subsidized health coverage through a state run program called **AdultBasi**c* (see page 29).

- *If you have lost your health insurance and are receiving benefits from the **Trade Adjustment Assistance (TAA) Program** then you may be eligible for a federal income tax credit to help pay for new health coverage*. This credit is called the **Health Coverage Tax Credit** (**HCTC**), and it is equal to 65% of the cost of qualified health coverage, including COBRA and a specific policy offered through the Blue Cross and Blue Shield plans operating in your region (see page 31).

- *If you are a retiree aged 55-65 and receiving pension benefits from **Pension Benefit Guarantee Corporation** (**PBGC**), then you may also be eligible for the HCTC* (see Page 31).

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 group health plan with you.* Except when you exercise your federal COBRA, 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 include the same doctors that your old health plan did (see page 6).

- *If you change jobs, your new employer may not offer you health benefits*. 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 impose **waiting periods** before your health benefits begin (See page 6).

- *If you have a break in coverage of 63 days or more, you may have to satisfy a new pre-existing condition exclusion period when you join a new group health plan* (see page 8).

- *Even if your coverage is **continuous**, there may be a pre-existing condition exclusion period for some benefits if you join a group health plan that covers benefits your old group 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 one year before your new health plan will pay for drugs prescribed to treat a pre-existing condition (see page 10).

- *If you work for a non-federal public employer in Pennsylvania, such as a county or municipal government, not all of the group health plan protections may apply to you* (see page 10).

- *Individual health insurers in Pennsylvania, other than the Blue Cross and Blue Shield plans, are free to turn you down because of your health status and other factors*. In addition, Blue Cross and Blue Shield Plans can turn you down if you apply for a non-guaranteed issue plan (see page 16).

- *Even if you are HIPAA eligible, you can be turned down for some Blue Cross and Blue Shield individual health insurance policies.* The law permits Blue Cross and Blue Shield to limit your choices to two plans, which must be comparable to others they sell in the individual market in Pennsylvania (see Page 12).

- *Individual health insurers are not required to credit prior continuous coverage* against pre-existing condition exclusion periods (see pages 15 and 18).

- *Except in regards to individual health insurance policies sold through Blue Cross Blue Shield, 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 pages 15 and 18).

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

CHAPTER 2
YOUR PROTECTIONS UNDER GROUP HEALTH PLANS

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

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

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

- *You cannot be turned away or charged more 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.

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

- *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** that 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 health insurance (for example, that you or your dependents had through yourself or another family member and lost because of death, divorce, legal separation, termination, retirement, or reduction in hours worked)

- *Under Pennsylvania law, newborns are automatically covered for the 31 days after birth.* If the plan covers dependents, the parent must enroll the child within the 31 days of the birth of the newborn to continue coverage beyond the initial 31 days.

  However, if the plan does not provide for coverage of dependents, the parent has the right to convert – within 31 days after the child's birth- to a plan which will provide similar benefits.

- *Under Pennsylvania law, your disabled child can remain covered as a dependent under your group health plan into adulthood.* This applies if your dependent was already disabled and covered under the health plan before he or she reached the limiting age for dependent coverage. You will be required to submit proof of your child's continued incapacity and dependency within 31 days following the date that your child reaches the limiting age and annually thereafter. Subsequently, if you change health plans, you might not be able to cover your disabled son or daughter as a dependent under the new health plan.

- *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 for 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 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 on your rights under the FMLA, contact the **U.S. Department of Labor**.

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

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

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

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

- *Group health plans can only exclude covering for pre-existing conditions for a limited time.* The maximum period allowed for the exclusion is 12 months. However, if you enroll late in one of these types of group health plans (after you are hired and not during a regular or special enrollment period), you may have a longer pre-existing condition exclusion period of up to 18 months.

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

What is creditable coverage?

Most health insurance counts as creditable coverage, including:

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

In most cases, you should get a **certificate of creditable coverage** when you leave a health plan. You also can request certificates at other times. If you cannot get one, you can submit other proof of prior coverage, such as old health plan ID cards or statements from your doctor showing bills paid by your health insurance plan.

- *Coverage counts as continuous if it is not interrupted by a significant break. In the large group market, coverage counts as continuous if it is not interrupted by a break of 63 or more days in a row*

What is continuous coverage?

You are considered to have continuous coverage under one plan, or several plans, as long as you don't have a lapse of 63 or more 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, offers 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 he has more than 12 months of prior continuous coverage 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 – 9 months). Art does not get credit for his coverage at Ajax since he had a break in coverage of 63 or more consecutive days.

- *In determining continuous coverage, employer-imposed waiting periods do not count as a break in coverage*. If your new plan imposes a pre-existing exclusion period, you can credit time under your prior continuous coverage towards it. If your

employer requires a waiting period, the pre-existing condition exclusion period begins on the first day of the waiting period.

- *Your protections may differ if you move to a group health plan that offers more benefits than your old one did.* Plans can look back to determine whether your previous health plan covered prescription drugs, mental health, substance abuse, dental care, or vision care. If you did not have continuous coverage for one or more of these categories of benefits, your new group health plan may impose a pre-existing condition exclusion period for that category.

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

Sue needs prescription medication to control her blood pressure. She had 2 years of continuous coverage under her employer's group health plan, which did not cover prescription drugs. Sue changes jobs, and her new employer's self-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, your plan 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 Pennsylvania 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 (800) 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.

- *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 65% of the cost of qualified health coverage, including COBRA and a specific policy offered through one of the Blue Cross and Blue Shield plans operating in your region (see page 31).

- *If you are a retiree aged 55-65 and receiving pension benefits from the Pension Benefit Guaranty Corporation (PBGC), you may also be eligible for the HCTC* (see page 31).

CHAPTER 3
YOUR PROTECTIONS WHEN BUYING INDIVIDUAL HEALTH INSURANCE

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

BLUE CROSS AND BLUE SHIELD PLANS IN PENNSYLVANIA

Blue Cross and Blue Shield plans operate in every region of Pennsylvania. Western Pennsylvania is covered by HighMark Blue Cross Blue Shield. Northeastern Pennsylvania is covered by Blue Cross of Northeastern Pennsylvania and Blue Shield. Central Pennsylvania is covered by Capital Blue Cross and Blue Shield. The Philadelphia area of Eastern Pennsylvania is covered by Independence Blue Cross and Blue Shield.

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

- *Blue Cross and Blue Shield plans in Pennsylvania will sell at least one individual health insurance policy to any resident on a guaranteed issue basis.* However, Blue Cross and Blue Shield plans are free to turn you down for an individual policy that is not offered on a guaranteed issue basis.

- *If you are HIPAA eligible, the Blue Cross and Blue Shield plan operating in your region must offer you a choice of at least two state-approved policies.* If two policies are not designated, you must be offered a choice of all of their individual insurance policies.

To be HIPAA eligible, you must meet certain criteria

If you are HIPAA eligible in Pennsylvania you are guaranteed the right to buy individual health insurance policies 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 individual coverage, 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 Pennsylvania, newborns are automatically covered under the parents' individual health insurance policy for the first 31 days.* The insurer may require that the parent enroll the baby within the 31 days in order to continue coverage beyond the 31 days.

  However, if the policy does not provide for coverage of dependents, the parent has the right to convert – within 31 days after the child's birth- to a policy which will provide similar benefits.

- *Under Pennsylvania law, your disabled child can remain covered as a dependent under your individual health insurance policy into adulthood.* This applies if your dependent was already disabled and covered under the health policy before he or she reached the limiting age for dependent coverage. You will be required to submit proof of your child's continued incapacity and dependency within 31 days following the date that your child reaches the limiting age and annually thereafter. Subsequently, if you change health insurance plans, you might not be able to cover your disabled son or daughter as a dependent under the new health plan.

WHAT WILL MY INIDIVIDUAL HEALTH INSURANCE POLICY COVER?

- *It depends on what you buy*. Pennsylvania does not require Blue Cross and Blue Shield plans operating in the individual market to sell standardized policies. These plans can design different policies and you will have to read and compare them carefully. However, Pennsylvania does require all policies to cover certain benefits-such as post-delivery hospital stays and breast cancer screening. Check with the Pennsylvania Department of Insurance for more information about mandated benefits.

- *If you are HIPAA eligible, a Blue Cross and Blue Shield plan operating in your region must offer you a choice of at least two state-approved policies, whose benefits must be similar to others they typically sell*. At least one of those policies must offer comprehensive benefits. If two policies are not designated, you must be offered a choice of all of their individual insurance policies.

- *When you buy an individual health insurance policy from a Blue Cross and Blue Shield plan, it may require a probationary period before most of your coverage becomes effective.* This period cannot exceed 30 days for non-accident-related conditions, or 6 months for certain procedures defined as elective. Accidental injuries will be covered immediately.

  You can be charged a premium during this probationary period even though the plan will not pay claims other than for accidental injuries during this time.

  If your insurance company requires a probationary period, the pre-existing condition exclusion period begins on the first day of the probationary period.

  Probationary periods cannot be applied if you are HIPAA eligible.

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *If you are HIPAA eligible, Blue Cross and Blue Shield plans cannot impose a pre-existing condition exclusion period.*

- *If you buy a guaranteed issue policy from a Blue Cross and Blue Shield plan, the policy may impose a pre-existing condition exclusion period.* Pre-existing condition exclusion periods cannot exceed 36 months. If you make a claim during the first 3 years of coverage, Blue Cross and Blue Shield can look back 5 years to see if

treatment for a condition was actually recommended or provided to you. Pregnancy and genetic information can be considered a pre-existing condition.

- *If you buy a non- guaranteed issue policy from a Blue Cross and Blue Shield plan, there are different ways that the plan can exclude a pre-existing condition.*

  The plan can impose an **elimination rider**. An elimination rider is an amendment to your health insurance contract that temporarily or permanently excludes coverage for a health condition, body part, or body system.

  Blue Cross and Blue Shield may also impose a pre-existing condition exclusion period. Pre-existing condition exclusion periods cannot exceed 36 months. If you make a claim during the first 3 years of coverage, your individual health insurer can look back 5 years to see if care or treatment for a condition was actually received or provided to you. Pregnancy and genetic information can be considered a pre-existing condition.

- *Individual health insurers are not required to give you credit for any prior coverage*. However, the Blue Cross and Blue Shield plan operating in your region may give you credit for having been continuously covered under another Blue Cross and Blue Shield plan.

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

- *Premiums will vary depending on your family size and type of policy you want.*

- *If you buy a guaranteed issue individual health insurance policies from a Blue Cross and Blue Shield plan, your premiums will not vary based on your health status, age or other factors.* This is called community rating.

- *If you buy a non-guaranteed issue individual health insurance policy from a Blue Cross and Blue Shield plan operating in Pennsylvania, there are no limits on how much you can be charged.* Premiums can vary due to age, gender, health status, family size, and other factors.

CAN MY INDIVIDUAL HEALTH INSURANCE POLICY BE CANCELED?

- *Your health insurance policy 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 case of **managed care plans**, continue to live in the plan service area.

- *Blue Cross and Blue Shield plans 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.

INDIVIDUAL HEALTH INSURANCE SOLD BY OTHER PRIVATE INSURERS

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

- *Individual health insurers, other than those offered by one of the regional Blue Cross and Blue Shield plans in Pennsylvania, are free to turn you down because of your health status and other factors.*

- *If you are HIPAA eligible, your only option for a guaranteed issue policy is through a Blue Cross and Blue Shield plan operating in your region.* Other individual health insurers are not required to offer you an individual health insurance policy. However, you can still apply for an individual health insurance policy through another company and may be offered coverage if you are healthy.

- *In Pennsylvania, newborns are automatically covered under the parents' individual health insurance policy for the first 31 days.* The insurer may require that the parent enroll the baby within the 31 days in order to continue coverage beyond the 31 days.

  However, if the policy does not provide for coverage of dependents, the parent has the right to convert – within 31 days after the child's birth- to a policy which will provide similar benefits.

- *Under Pennsylvania law, your disabled child can remain covered as a dependent under your individual health insurance policy into adulthood.* This applies if your dependent was already disabled and covered under the health policy before he or she reached the limiting age for dependent coverage. You will be required to submit proof of your child's continued incapacity and dependency within 31 days following the date that your child reaches the limiting age and annually thereafter. Subsequently, if you change health plans, you might not be able to cover your disabled son or daughter as a dependent under the new health plan.

WHAT WILL MY INDIVIDUAL HEALTH INSURANCE COVER?

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

- *When you buy an individual health insurance policy in Pennsylvania, individual health insurers can require a probationary period before most of your coverage becomes effective.* This period cannot exceed 30 days for non-accident-related conditions, or 6 months for certain procedures defined as elective. Accidental injuries will be covered immediately.

  You can be charged a premium during this probationary period even though the insurer will not pay claims other than for accidental injuries during this time.

  If your insurer requires a probationary period, the pre-existing condition exclusion period begins on the first day of the probationary period.

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *There are different ways that an individual health insurer can exclude a pre-existing condition.*

  The insurer can impose an elimination rider. An elimination rider is an amendment to your health insurance policy that temporarily or permanently excludes coverage for a health condition, body part, or body system.

  An individual health insurer may also impose a pre-existing condition exclusion period. Pre-existing condition exclusion periods cannot exceed 36 months. If you make a claim during the first 3 years of coverage, your individual health insurer can look back 5 years to see if care or treatment for a condition was actually recommended or provided to you.

  Pregnancy and genetic information can be considered a pre-existing condition in all individual health insurance policies.

- *Individual health insurers are not required to give you credit toward pre-existing condition exclusion periods for any prior continuous coverage.*

WHAT CAN I BE CHARGED FOR INDIVIDUAL HEALTH INSURANCE?

- *Generally, in Pennsylvania, there are no limits on how much you can be charged for an individual health insurance policy.* Premiums can vary due to age, gender, health status, family size, and other factors.

CAN MY INDIVIDUAL HEALTH INSURANCE POLICY BE CANCELED?

- *Your health insurance policy 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. However, guaranteed renewability does not protect you from having your premiums go up at renewal.

- *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

WHEN DO I HAVE TO BE OFFERED COBRA COVERAGE?

If you are leaving your job and you had group health plan, you may be able to stay in your group health plan for an extended time through COBRA. The information presented below was taken from publications prepared by the U.S. Department of Labor. You should contact it 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 below).

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

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

COBRA QUALIFYING EVENTS

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

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

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

- *Each person who is eligible for COBRA continuation can make their 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 have a new pre-existing condition exclusion period under COBRA*. However, if you were in the middle of a pre-existing condition exclusion period when your qualifying event occurred, you will have to finish it.

WHAT CAN I BE CHARGED FOR COBRA COVERAGE?

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

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

- *If you 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 65% of the cost of qualified health coverage, including COBRA and a specific policy offered through one of the Blue Cross and Blue Shield plans operating in your region (see page 31).

- *If your are a retiree aged 55-65 and receiving pension benefits from PBGC, and receiving benefits from the Trade Adjustment Assistance (TAA) Program, then you may be eligible for a federal income tax credit to help pay for new health coverage* (see page 31).

HOW LONG DOES COBRA COVERAGE LAST?

- *COBRA coverage generally lasts up to 18 months and cannot be renewed.* However, dependents are sometimes eligible for up to 36 months of COBRA continuation coverage, depending on their qualifying event. In addition, special rules for disabled individuals may extend the maximum period of coverage to 29 months. To qualify for the disability extension, you must have been disabled at the time of your COBRA

qualifying event (such as termination of employment or reduction of hours) or be determined to have become disabled within 60 days of that qualifying event. You must obtain a disability determination letter from the Social Security Administration, and you must notify your group health plan within 60 days of receiving this disability determination letter, and before your original 18 months expires.

HOW LONG CAN COBRA COVERAGE LAST?

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

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

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

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

- *COBRA coverage might end if you are in a managed care plan that is available only to people living in a limited geographic area and you move out of that area.* However, if you are eligible for COBRA and are moving out of your current health plan's service area, your employer must provide you with the opportunity to switch to a different plan, but only if the employer already offers other plans to its employees. Examples of the other plans your employer may offer you are a managed care plan whose service area includes the area you are moving to, or another plan that does not have a limited service area.

- *In Pennsylvania, you can buy coverage through Blue Cross Blue Shield regardless of whether you used up your COBRA continuation coverage*. Compare the options to see which is best for you. However, if you are planning to move to another state, you may need to be HIPAA eligible to buy individual coverage. If so, you may want to consider COBRA.

CONVERSION

In Pennsylvania, if you have coverage through an employer's fully insured group health plan and then lose it, you can buy conversion coverage. This is an individual policy you get from the company that insured your employer's group plan.

WHEN AM I ELIGIBLE FOR A CONVERSION POLICY?

- *To qualify for conversion coverage, you must have been covered under your prior group health plan for at least 3 months.* In addition, at the time of your application, you cannot be covered under or eligible for similar benefits through a group health plan, individual health insurance policy or Medicare.
- *You must elect the option for a conversion policy within 31 days of notification of your right to a conversion policy.*

WHAT WILL THE CONVERSION POLICY COVER?

- *Conversion policies are required to meet minimum standards set out in state regulations.* Even so, the benefits may be less generous than what you received under your former group coverage.

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *Your conversion policy 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.

WHAT CAN I BE CHARGED FOR MY CONVERSION POLICY?

- *Conversion policy premiums are limited to 20% above what you would pay under a similar group policy.*

HOW LONG WILL MY CONVERSION POLICY LAST?

- *Your conversion policy 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.

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. Pennsylvania has enacted its own reforms. Some of these reforms apply to groups of different sizes. Check with the Pennsylvania 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 employees, health insurance companies must sell you any small group health plan they sell to other small employers if the employer group meets the participation requirements. They can also require you to contribute a minimum percentage of your workers' premiums If you are buying a **large group health plan** and you employ 51 or more employees, your group can be turned down.

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

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

- *Generally, as a small employer, you can be charged higher premiums because someone in your group is seriously ill.* The law does not prohibit Pennsylvania health insurers from charging you more because of the health status of your group or other factors.

  However, if you buy small group coverage from a Blue Cross and Blue Shield plan, you can not charged more because of the health status of someone in your group but you can be charged more for other demographic factors such as age, gender and industry. This is called modified community rating.

WHAT IF I AM SELF-EMPLOYED?

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

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

A WORD ABOUT ASSOCIATION PLANS

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

CHAPTER 5
FINANCIAL ASSISTANCE

Help is available to certain low-income residents of Pennsylvania who cannot afford to buy health care coverage. Medicaid, Pennsylvania Children's Health Insurance Program and the AdultBasic program offer subsidized health insurance coverage, direct medical services or other help at little or no cost to you.

In addition, the federal government, under Trade Adjustment Assistance (TAA) Program provides tax credits to some workers who lose their jobs or whose work hours and wages are reduced as a result of increased imports. This chapter provides summary information about these programs and contact information for further assistance.

MEDICAID

Medicaid is a program that provides health coverage to some low-income Pennsylvania residents. Medicaid (also called Medical Assistance) 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 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 Pennsylvania you may be eligible for Medicaid if you are an infant, a child, pregnant, or a parent of a child and your family income meets the Medicaid income standards.

  Income eligibility levels for these categories are described below. Your assets and some expenses also may be taken into account, so you should contact the Pennsylvania Department of Public Welfare for more information.

Low income persons eligible for Medicaid in Pennsylvania

Category	Income eligibility (as percent of federal poverty level)
Infant	185% (monthly income of about $2,416 for family of 3)
Child 1-5	133%
Child 6-18	100%
Non-working parents	31%
Working parents	63%
Pregnant woman	185%

* Eligibility information was compiled from *State 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 2006:

Size of Family Unit	Poverty Guideline (annual income)
1	$ 9,800
2	$13,200
3	$16,600

For larger families add $3,400 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 $33,200, or a monthly income of $2,767.

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

- *Families who get cash benefits from TANF (also known as Temporary Assistance for Needy Families) can get Medicaid.*

  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.

  Parents should know that when your family's TANF benefits end, your children may also qualify for transitional Medicaid coverage for 12 months. Or, your children may qualify for Medicaid themselves 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 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 don't 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 135% of the poverty level, Medicaid will pay for your monthly Medicare premiums only. This is called the Specified Low-Income Medicare Beneficiary (SLMB) program.

- *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 Pennsylvania Department of Public Welfare at (800) 692-7462.

THE HEALTHY WOMAN PROJECT: BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT PROGRAM

- *The Healthy Woman Project provides qualified women with comprehensive screening services for breast and cervical cancer.*

- *In order to be eligible for screening through the Healthy Woman Project, you must be between the ages of 50 and 65, a Pennsylvania resident, a U.S. citizen or lawfully admitted immigrant, have no insurance or limited insurance and have an income*

under 250% of the federal poverty level. For a family of three, this is an annual income of no more than $41,500.

- *Women who have been screened through the Healthy Woman Project and diagnosed with breast or cervical cancer may be eligible for treatment through Medicaid*. If eligible, you will continue to be eligible for treatment through the duration of your cancer treatment. In addition, Medicaid will cover all of your medical needs including treatment for non-cancer related medical needs.

- *For more information, please call the Pennsylvania Department of Health at 1-877-PA-HEALTH.*

PENNSYLVANIA'S CHILDREN HEALTH INSURANCE PROGRAM (PACHIP)

- *In Pennsylvania, if your children are 18 years old or younger, are uninsured, and meet certain eligibility requirements, they may be eligible for health insurance through the Pennsylvania Children's Health Insurance Program (PaCHIP).*

- *To be eligible, your child must be a resident of the state for at least 30 days (except for newborns), cannot have any other health insurance coverage, including Medicaid, and must meet certain family income guidelines*. Children living in families with incomes up to 235% of the federal poverty level are eligible for PaCHIP.

- *Premiums for the children's policy are based on family income.* Significant premium assistance is available for lower income families.

- *Benefits include well-child visits, diagnosis and treatment of illness or injury, prescription drugs, mental health benefits, and limited hospitalization.*

- *For more information, please call* 1-800-451-5886 *or (800) 986-KIDS.*

PENNSYLVANIA ADULTBASIC: HEALTH INSURANCE FOR THE UNINSURED

- *AdultBasic is a state run program that offers basic health insurance coverage to a limited number of low income residents of Pennsylvania.*

- *To be eligible, you must meet certain qualifications.* You must be an uninsured, U.S. citizen and Pennsylvania resident between the ages of 19 and 64 with a family income below 200% of the federal poverty level. If the program is enrolled to capacity, you may have to be in a waiting list.

- *The AdultBasic Program offers access to basic medical services.* Coverage includes preventive care, physician services, diagnosis and treatment of illness or injury, in-patient hospitalization, out-patient hospital services and emergency accident and medical care. Prescription drugs are not covered.

- *Eligible enrollees are responsible for some costs.* Enrollees must pay a monthly premium and co-payments for certain services.

- *To find out whether you are eligible for AdultBasic, please call 1-800-GO-BASIC.*

OTHER ASSISTANCE PROGRAMS

- *There may be other financial assistance programs available.* Please call the Office of Medical Assistance Programs at the Department of Public Welfare for more information at (717) 787-1870.

THE FEDERAL HEALTH COVERAGE TAX CREDIT (HCTC)

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

WHEN AM I ELIGIBLE FOR THE HCTC?

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

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

- *You have a health plan maintained by an employer or former employer that pays at least 50% of the cost of your coverage*. Any share of your premium that is paid by you or your spouse on a pre-tax basis is considered to have been paid by your employer and must be included as such when determining the percentage of employer coverage.

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

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

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

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

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

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

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

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

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

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

WHAT HEALTH COVERAGE IS ELIGIBLE FOR THE TAX CREDIT?

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

  - COBRA continuation coverage, as long as your employer or former employer contributes less than 50% of the total health plan premium.

  - State qualified plans: In Pennsylvania, a specific policy offered through the Blue Cross and Blue Shield plan operating in your region is the state qualified health plan.

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

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 Fully insured group health plan	*Pennsylvania Department of Insurance Regional Consumer Office* (877) 881-6388 http://www.insurance.state.pa.us/
Self-insured group health plans COBRA continuation coverage Family and Medical Leave Act	*U.S. Department of Labor* *Employee Benefits Security Administration* *Employee & Employer Assistance Hotline and Publications* (866) 444-EBSA (3272) http://www.dol.gov/ebsa/
Blue Cross and Blue Shield	*Pennsylvania Blue Cross Blue Shield* *Highmark Blue Cross Blue Shield* (800) 544-6679 *Blue Cross of Northeastern Pennsylvania and Blue Shield* (800) 829-8599 *Capital Blue Cross and Blue Shield* (800) 958-5558 *Independence Blue Cross and Blue Shield* (800) 555-7514
Medicaid	*Pennsylvania Department of Public Welfare* (800) 692-7462 http://www.dpw.state.pa.us/ *Pennsylvania Department of Public Welfare, Office of Medical Assistance Programs (OMAP)* (717) 787-1870 http://www.dpw.state.pa.us/omap
Pennsylvania Children's Health Insurance Program (PaCHIP)	*Pennsylvania Department of Insurance* (717) 783-1437 or (800) 986-KIDS http://chipcoverspakids.com/

For questions about:	Contact:
AdultBasic Health Insurance Program	*Pennsylvania Department of Insurance* 1-800-GO-BASIC http://www.ins.state.pa.us/ins/cwp/view.asp?a=1278&q=527068
Healthy Woman Project: Breast and Cervical Cancer Prevention and Treatment Program	*Pennsylvania Department of Health* 1-877-PA-HEALTH. http://www.PAHealthyWoman.com
The Federal Health Coverage Tax Credit (HCTC)	*Internal Revenue Service (IRS)* 1-866-628-HCTC (1-866-628-4282) http://www.irs.gov/individuals/index.html (Click on HCTC) or call HCTC customer service center

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

HELPFUL TERMS

AdultBasic. A state run program that provides basic health insurance to a limited number of low-income residents of Pennsylvania.

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

Alternative Trade Adjustment Assistance (ATAA). ATAA is a benefit for workers at least 50 years old who have obtained different, full-time employment within 26 weeks of the termination of adversely-affected employment. These worker may receive 50% of the wage differential (up to $10,000) during their 2 year eligibility period. To be eligible for the ATAA program, workers may not earn more than $50,000 per year in their new employment. Also, the firm where the workers worked must meet certain eligibility criteria.

Certificate of Creditable Coverage. A document provided by your health plan that lets you prove you had coverage under that plan. Certificates of creditable coverage will usually be provided automatically when you leave a health plan. You can obtain certificates at other times as well. See also Creditable Coverage.

COBRA. Stands for the Consolidated Omnibus Budget Reconciliation Act, a federal law in effect since 1986. COBRA permits you and your dependents to continue in your employer's group health plan after your job ends. If your employer has 20 or more employees, you may be eligible for COBRA continuation coverage when you retire, quit, are fired, or work reduced hours. Continuation coverage also extends to surviving, divorced or separated spouses; dependent children; and children who lose their dependent status under their parent's plan rules. You may choose to continue in the group health plan for a limited time and pay the full premium (including the share your employer used to pay on your behalf) plus a 2% administrative fee. COBRA continuation coverage generally lasts 18 months, or 36 months for dependents in certain circumstances. See also State Continuation Coverage.

Continuous Coverage. Health insurance coverage that is not interrupted by a break of 63 or more days in a row. Employer waiting periods and HMO affiliation periods do not count as gaps in health insurance coverage for the purpose of determining if coverage is continuous. See also Creditable Coverage.

Conversion Policy. Your right, when leaving a fully insured group health plan in Pennsylvania, to convert your policy to an individual health insurance policy. You will not face a new pre-existing condition exclusion period. There are limits on what you can be for conversion policies. See also Fully Insured Group Health Plan, Individual health insurance.

Creditable Coverage. Health insurance coverage under any of the following: a group health plan; individual health insurance; student health insurance in Colorado; 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 a individual health insurance policies that permanently excludes coverage for a health condition, body part, or body system.

Enrollment Period. The period during which all eligible 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 eligible 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 the state of Pennsylvania. See also Self-Insured Group Health Plans.

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

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

Guaranteed Issue. A requirement that health plans must permit you to enroll regardless of your health status, age, gender, or other factors that might predict your use of health services. All health plans sold to small employers in Pennsylvania are guaranteed issue.

Guaranteed Renewability. A feature in health plans that means your coverage cannot be canceled because you get sick. HIPAA requires certain 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, long-term care, Medicare supplement, liability insurance (including automobile insurance) for medical expenses, or coverage for on-site medical clinics. Health insurance also does not mean coverage for limited dental or vision benefits to the extent these are provided under a separate policy.

Health Plan Year. That calendar period during which your health plan coverage is in effect. Many group health plan years begin on January 1, while others begin in a different month.

Health Status. When used in this guide, refers to your medical condition (both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), and disability. See also Genetic Information.

HIPAA. The Health Insurance Portability and Accountability Act was passed in 1996 to help people buy and keep health insurance, even when they have serious health conditions, the law sets basic requirements that all health plans must meet. Since states can and have modified and expanded upon these provisions for state regulated health plans (fully insured group and individual plans), consumers' protections vary from state to state.

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

HMO. Health maintenance organization. A kind of health insurance plan. HMOs usually limit coverage to care from doctors who work for or contract with the HMO. They generally do not require deductibles, but often do charge a small fee, called a co-payment, for services like doctor visits or prescriptions. 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 purchased by individuals who are not connected to an employer group. Individual health insurance is regulated by the state of Pennsylvania.

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

Late Enrollment. Enrollment in a health plan at a time other than the open or a special enrollment period. If you are admitted as 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. Often managed care plans will 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 specialist care without a referral.

Medicaid. A program providing comprehensive health insurance coverage and other assistance to certain low-income Pennsylvanians. 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, based on your health status. Group health plans can restrict your coverage based on other factors (such as part time employment) that are unrelated to health status. See also Group Health Plan, Health Status.

Pennsylvania Children's Health Insurance Program (PaCHIP). A program to help parents get affordable basic health insurance coverage for their uninsured children. Children must be residents of the state for 30 days, may not be covered under any health insurance coverage, must be younger than 17 years of age, and must meet certain family income eligibility guidelines..

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

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

Pre-existing Condition (Individual Health Insurance). Any condition for which medical advice or treatment was recommended or received within a 5-year period immediately preceding the effective date of individual health insurance policy. Pregnancy and genetic information may be treated as a pre-existing condition. See also Pre-existing Condition (Group Health Plans).

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 administer 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 Pennsylvania.

Small Group Health Plans. Plans with at least 2 but no more than 50 eligible 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 some other states, if you are in a fully insured group health plan sponsored by an employer with 2 to 19 employees, you have the right to continue your group coverage when your job ends. Pennsylvania does not have a state continuation coverage law.

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

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

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

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

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