

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

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

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

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

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

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CHAPTER 1

A SUMMARY OF YOUR PROTECTIONS

Numerous state and federal laws make it easier for people with **pre-existing conditions** to get or keep **health insurance**, or to change from one **health plan** to another. A federal law, known as the **Health Insurance Portability and Accountability Act (HIPAA)** sets national standards for all health plans. In addition, states can pass different reforms for the health insurance plans they regulate (**fully insured group health plans** and **individual health insurance policies**), so your protections may vary if you leave Nevada. 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 Nevada resident.

HOW AM I PROTECTED?

In Nevada, 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 Nevada must limit exclusion of pre-existing conditions. There are rules about what counts as a pre-existing condition and how long you must wait before a new health plan will begin to pay for care for that condition. Generally, if you join a new group health plan your old coverage will be credited toward the **pre-existing condition exclusion period**, provided you did not have a long break in coverage (see page 8).*
- *Your health insurance cannot be canceled because you get sick. All health insurance is **guaranteed renewable** (see pages 15 and 23).*
- *If you leave your job, you may be able to remain in your old group health plan for a certain length of time. This is called **COBRA continuation coverage** or **state continuation coverage**. It can help when you are between jobs or waiting for a new health plan to cover your pre-existing condition. There are limits on what you can be charged for this coverage (see page 16).*

- *If you lose your group coverage under your **fully insured group health plan** and meet other requirements, you can buy a **conversion policy**. This is an individual policy from the company that insured your former group. There are limits on what you can be charged for a conversion policy, although they tend to be costly (see page 22).*
- *If you lose your group health plan and meet other qualifications, you will be **HIPAA eligible** and guaranteed the right to buy individual health insurance from any insurance company that sells such plans in Nevada. Insurance companies must offer you a choice of at least two plans. You will not face a new pre-existing condition exclusion period (see page 14).*
- *If you are a small employer buying a group health plan, you cannot be turned down because of the health status, age, or any factor that might predict the use of health services of those in your group. All health plans for small employers must be sold on a **guaranteed issue** basis (see page 24).*
- *If you are a small employer buying a group health plan, you can be charged more, within limits, based on the health status of those in your group. Even with these limits, however, premiums can be significantly higher if someone in your group has a serious health condition (see page 24).*
- *If you have low or modest household income, you may be eligible for free or subsidized health coverage for yourself or members of your family. The Nevada **Medicaid** program offers free health coverage for pregnant women, families with children, elderly and disabled individuals with very low incomes (see Chapter 5).*
- *If your children are 18 years old or younger, do not have health insurance, and meet other qualifications, you may be able to buy insurance for them through the **Nevada Check Up** (see page 28).*
- *If you believe that you have or are at risk for breast or cervical cancer, you may be eligible for free screening and treatment. The **Women's Health Connection** provides qualified women with free breast and cervical cancer screening. In addition, women diagnosed with cancer through this program may be eligible for treatment through the Nevada Medicaid Program (see Chapter 5).*
- *If you lost your health insurance and are receiving benefits from the **Trade Adjustment Assistance (TAA) Program**, you may be eligible for a federal income tax credit to help you pay for new health coverage. This credit is called the Health Coverage Tax Credit (HCTC), and is equal to 65% of the cost of qualified coverage, including COBRA (see page 30).*

- *If you are a retiree aged 55-65 and are receiving benefits from **Pension Benefit Guarantee Corporation (PBGC)**, then you may be eligible for the HCTC (see page 30).*

WHAT ARE THE LIMITS ON MY PROTECTIONS?

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

- *If you change jobs, you usually cannot take your old health benefits with you. Except when you exercise your federal COBRA or state continuation rights, you are not entitled to take your actual group health plan with you when you leave a job. Your new health plan may not cover all of the benefits or the same doctors that your old plan did (see page 13).*
- *If you change jobs, your new employer may not offer you health benefits. Employers are required only to make sure that any health benefits they do offer do not discriminate based on 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. **HMOs** can require **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 plan (see page 8).*
- *Even if you have **continuous coverage**, 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 10).*
- *If you work for certain non-federal public employers in Nevada, not all of the group health plan protections may apply to you (see page 10).*
- *If you are not HIPAA eligible, your access to individual health insurance may depend on your health status. Private insurers are not prohibited from turning you down, charging more, or limiting coverage because of pre-existing conditions (see page 14).*
- *Even if you are HIPAA eligible, you can be turned down for some individual health insurance policies. The law permits insurance companies to limit your choices to two plans (see page 12).*

- *Except when you are HIPAA eligible, the law does not limit what you can be charged for individual health insurance. You can be charged substantially higher initial premiums because of your health status, age, gender, and other characteristics (see page 15).*
- *If you are a small employer buying a group health plan policy, you can be charged more, within limits, due to the health status of those in your group. In addition, you can be charged higher premiums, within limits, because of the age, gender, family size of those in your group, and where your business is located (see page 24).*

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 Nevada, newborns, adopted children and children placed for adoption are automatically covered under the parents' health plan for the first 30 days if the plan covers dependents. The insurer may require that the parent enroll the dependent within the 30 days in order to continue coverage beyond the 30 days.*
- *If you have a disabled child, that child may remain covered under your 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 policyholder for support. Proof of incapacity must be furnished within 31 days of reaching the time limit and may be required periodically thereafter.*
- *When you begin a new job, your employer may require a waiting period before you can sign up for health coverage. These waiting periods, 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, and you will not have health insurance coverage. An HMO affiliation period cannot exceed 2 months (3 months for late enrollees), and you cannot be charged a premium during this time.*
- *If you have to take leave from your job due to illness, the birth or adoption of a child, or to care for a seriously ill family member, you may be able to keep your group health coverage for a limited time. A federal law known as the **Family and Medical Leave Act (FMLA)** guarantees you up to 12 weeks of job-protected leave in these circumstances.*

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

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

If you decide not to return to work at the end of the leave period, your employer may require you to pay back the employer's share of the health insurance premium.

However, if you don't return to work because of factors outside your control (such as a need to continue caring for a sick family member, or because your spouse is transferred to a job in a distant city), you will not have to repay the premium.

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

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

When you first enroll in a group health plan, the employer or insurance company may ask if you have any pre-existing conditions. Or, if you make a claim during the first year of coverage, the plan may **look back** to see whether it was for such a condition. If so, it may 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 during the 6 month period immediately before you joined that plan. This period 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 plans can exclude coverage for pre-existing conditions only for a limited time. The maximum period is 12 months. However, if you enroll late in a group health plan (after you were hired and not during a regular or special enrollment period) you may have a pre-existing condition exclusion period of up to 18 months. You will receive credit towards your pre-existing condition exclusion period for any previous continuous coverage. .*
- *Group health plans that impose pre-existing condition exclusion periods must give you credit for any previous **creditable coverage**. Most types of private and government sponsored health coverage are considered creditable coverage.*

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

What is creditable coverage?

Most health insurance counts as creditable coverage, including:

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

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

What is continuous coverage?

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

Take Art, who has diabetes. Ajax Company covered him under its group health plan for 9 months, but he lost his job and health coverage. Then, *45 days later*, Art found a new job at Beta Corporation and had health coverage for 9 more months. Art changed jobs again. His new company, Charter, has a health plan that covers care for diabetes but excludes pre-existing conditions for 12 months. Charter must cover Art's diabetes care immediately, because his 18 months of prior continuous coverage are credited against the 12-month exclusion.

Now consider a slightly different situation. Assume Art was uninsured for *90 days* between his jobs at Ajax and Beta. In this case, Charter will credit coverage only under Beta's plan toward the 12-month pre-existing condition exclusion period. Charter's plan will begin paying for Art's diabetes care in 3 months (1 year minus 9 months). Art does not get credit for his coverage at Ajax since he had a break of *more than 63 consecutive days*.

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

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 required for other conditions that were not pre-existing.

- *No pre-existing condition exclusion period can be applied without appropriate notice.* Your group health plan must inform you, in writing, if it intends to impose such a period. Also, if needed, it must help you get a certificate of creditable coverage from your old health plan.

LIMITS TO PROTECTIONS FOR CERTAIN GOVERNMENT WORKERS

Federal law permits state, county, and local governments to exempt their employees in self-insured group health plans from some of the protections discussed previously in this chapter. Public employers must make this choice annually. When they do so, they are required to notify the federal government and specify which health insurance protections will not apply to their employees' group health plan.

In the past, a large number of public employers in Nevada 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, and individual health insurance coverage for “HIPAA eligible individuals.”*
- *If you lost your health insurance and are receiving benefits from the **Trade Adjustment Assistance (TAA) Program**, you may be eligible for a federal income tax credit to help you pay for new health coverage. This credit is called the Health Coverage Tax Credit (HCTC), and is equal to 65% of the cost of qualified coverage, including COBRA (see page 30).*
- *If you are a retiree aged 55-65 and are receiving benefits from **Pension Benefit Guarantee Corporation (PBGC)**, then you may be eligible for the HCTC (see page 30).*

CHAPTER 3

YOUR PROTECTIONS WHEN BUYING INDIVIDUAL HEALTH INSURANCE

If you do not have access to employer-sponsored group insurance, you may want to buy individual health insurance from a private health insurance company. However, in Nevada – as in most other states – you have limited guaranteed access to individual health insurance. Whether you can buy individual health insurance may depend on your health status, the kind of coverage you want to buy, and other circumstances. Also, there are some alternatives to individual health insurance coverage – such as COBRA, state continuation coverage, or conversion policies. This chapter summarizes your protections under different kinds of health plan coverage.

INDIVIDUAL HEALTH INSURANCE SOLD BY PRIVATE INSURERS

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

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

- *In general, insurers that sell individual health insurance in Nevada are free to turn you down because of your health status and other factors. When applying for individual health insurance, you may be asked questions about health conditions you have now or had in the past. Depending on your health status, insurers might refuse to sell you coverage or offer to sell you a policy that has special limitations on what it covers.*
- *If you are HIPAA eligible, insurers must offer to sell you two standardized policies. You may select from either a basic or standard health benefit plan. You can choose the policy you want and cannot be turned down because of health status. You can be offered other non-standardized coverage as well, but you may be charged more for that coverage.*
- *In Nevada, you are also HIPAA eligible if your most recent prior creditable coverage was under a basic or standard health benefit plan and was not renewed by an insurer who discontinued offering and renewing individual health insurance policies in the state.*

To be HIPAA eligible, you must meet certain criteria

If you are HIPAA eligible you are guaranteed the right to buy individual health insurance with no pre-existing condition exclusion periods. To be HIPAA eligible, you must meet all of the following:

- You must have had 18 months of continuous creditable coverage, *at least the last day of which was under a group health plan.*
- You also must have used up any COBRA 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.
- 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 policy, because the last day of your continuous health coverage must have been in a group plan. You can become HIPAA eligible again by maintaining continuous coverage and rejoining a group health plan.

- *Under Nevada law, newborns, adopted children and children placed for adoption are automatically covered under the parents' individual health insurance policy for the first 31 days, if the plan covers dependents.* The insurer may require that the parent enroll the baby within the 31 days in order to continue coverage beyond the 31 days.
- *If you have a disabled child, that child may remain covered under your individual health insurance policy after he or she reaches the age at which dependent coverage is usually terminated.* To qualify, your adult son or daughter must be incapable of self-support because of mental retardation or physical disability and must be chiefly dependent on the policy holder for support. Proof of incapacity must be provided within 31 days of reaching the time limit and may be required periodically thereafter.

WHAT WILL MY INDIVIDUAL HEALTH INSURANCE POLICY COVER?

- *It depends on what you buy.* Along with other policies, Nevada insurers are required to sell you two standardized policies. You may select from either a basic or standard health benefit plan. Standardized plans help you compare the cost of policies. You may be offered other non-standardized policies as well, but you may be charged more for that coverage

- *The basic policy covers hospital, skilled nursing, rehabilitation, hospice, emergency care, physician services, laboratory and X-ray services, and prescription drugs. Services are covered with a 50% coinsurance. The lifetime maximum benefit is \$1 million. The basic policy does not cover mental health services, substance abuse services, and maternity care.*
- *The standard policy covers everything that the basic policy covers. Those services are covered with a 20% coinsurance. In addition, the standard policy covers maternity care and limited mental health services, substance abuse services. The lifetime maximum benefit is also \$1 million.*
- *Check with the Nevada Division of Insurance for more information about mandated benefits. You can also visit the Division's website at <http://doi.state.nv.us/> for the summary of benefits for individual basic and standard health benefit plans.*

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *If you are HIPAA eligible and purchasing a guaranteed issue individual health insurance policy, no pre-existing condition exclusion periods can be applied.*
- *Individual health insurers can impose **elimination riders**. This is an amendment to your health insurance policy that permanently excludes coverage for a health condition or even an entire body part or system. Elimination riders cannot be applied to HIPAA eligible individuals.*
- *Nevada insurers can also impose pre-existing condition exclusion periods. Except when you are HIPAA eligible or buying a conversion policy, there are few limits on pre-existing condition exclusion periods in individual health insurance in Nevada. This means that individual health insurers can decide how long to exclude your pre-existing condition.*

Individual health insurance can count as pre-existing conditions only those for which you received a diagnosis, medical advice, or treatment in the 6 months period prior to obtaining the individual policy. Individual health policies can apply pre-existing condition exclusion periods for pregnancy, but not for genetic information.

- In addition, if you make a claim during the first 3 years your policy is in force, the insurer can refuse to pay that claim and others related to the condition if it determines the condition was pre-existing.

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

- *In Nevada, there are limits on how much individual health insurance premiums can vary due to health status, age, gender, and other factors. Even within these limits, however, if you have a serious health condition, your premium may be significantly higher than the rate charged for other individuals. In addition, when you renew your individual coverage, your premiums can increase substantially as you age.*

If you have questions about your premiums, contact the Nevada Division of Insurance.

CAN MY INDIVIDUAL HEALTH INSURANCE POLICY BE CANCELLED?

- *Your coverage cannot be canceled because you get sick. This is called guaranteed renewability. You have this protection provided that you pay the premiums, do not defraud the company, and, in the case of **managed care plans**, continue to live in the plan service area.*
- *You health insurance policy may be canceled if the insurer discontinues your health policy or withdraws from the individual market.*

If you are covered under a basic or standard individual policy and your insurance company discontinues this policy, all other individual health insurance companies must offer you coverage under their basic and standard policies. You cannot be turned down and no pre-existing condition exclusion can be imposed if you apply within 63 days.

Call the Nevada Division of Insurance if you have questions about an insurance company or the renewability of individual health policies.

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

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

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

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

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

Finally, you must have a qualifying event that would cause you to lose your group health 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 use up any COBRA 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 the 60-day period to elect COBRA continuation coverage has expired. In this circumstance, TAA-eligible people have a second 60-day period, starting on the date of their TAA eligibility, to elect COBRA. (However, in no case can COBRA be elected more than 6-months following the original qualifying event (i.e. layoff) that caused the loss of group health plan coverage.)*
- *When COBRA is elected during this special, second election period, coverage starts on the first date of the special election period. Any time that has elapsed between the original qualifying event and the first date of the special election period is not counted as a lapse in coverage in determining continuous coverage history.*

WHAT WILL COBRA COVER?

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

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

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

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

WHAT CAN I BE CHARGED FOR COBRA COVERAGE?

- *You must pay the entire premium (employer and employee share, plus a 2% administrative fee) for COBRA continuation coverage. The first premium must be paid within 45 days of electing COBRA coverage.*
- *If you elect the 11-month disability extension, the premium will increase to 150% of the total cost of coverage. See below for more information about the disability extension.*
- *If you have lost your group health plan and are receiving benefits from the Trade Adjustment Assistance (TAA) program, you may be eligible for a federal income tax credit to help you pay for new health coverage. This credit is called the Health Coverage Tax Credit (HCTC), and it is equal to 65% of the cost of qualified health coverage, including COBRA, and state continuation coverage (see page 30).*
- *If you are a retiree age d 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 page30).*

HOW LONG DOES COBRA COVERAGE LAST?

- *COBRA coverage generally lasts up to 18 months and cannot be renewed. However, dependents are sometimes eligible for up to 36 months of COBRA continuation coverage, depending on their qualifying event. In addition, special rules for disabled individuals may extend the maximum period of coverage to 29 months. To qualify for the disability extension, you must have been disabled at the time of your COBRA qualifying event (such as termination of employment or reduction in hours) or be determined to have become disabled within 60 days of that qualifying event. You must obtain this disability determination from the Social Security Administration, and you must notify your group health plan within 60 days of this disability determination.*

LENGTH OF COBRA COVERAGE

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

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

- *Usually, COBRA continuation coverage ends when you join a new health plan. However, if your new plan has a waiting period or a pre-existing condition exclusion period, you can keep whatever COBRA continuation coverage you have left during that period. For specifics, ask your former employer or contact the U.S. Department of Labor.*
- *COBRA coverage also ends if your employer stops offering health benefits to other employees.*
- *COBRA coverage might end if you are in a managed care plan that is available only to people living in a limited geographic area and you move out of that area. However, if you are eligible for COBRA and are moving out of your current health plan's service area, your employer must provide you with the opportunity to switch to a different plan, but only if the employer already offers other plans to its employees. Some examples of the other plans your employer may offer you are a managed care plan whose service area includes the area you are moving to, or another plan that does not have a limited service area.*

WHAT ABOUT NEVADA CONTINUATION COVERAGE?

Nevada permits certain individuals to continue coverage under their fully insured group health plan, even after they lose eligibility as a member of that group.

- *If your employer offers health benefits and has fewer than 20 workers, you may also be eligible for up to 18 months of continuation coverage under a Nevada law that is similar to COBRA. In some cases, your dependents may be eligible for up to 36 months of state continuation coverage.*

To qualify for continuation coverage, you must have been covered under your former fully insured group health plan for at least 12 months and you must apply within 60 days of losing your group coverage. Also, you must not have left your former job voluntarily.

Like under COBRA, you must pay the entire premium (employer and employee share) for this continuation coverage. Under state continuation, this premium will be 25% higher than your former group health plan premium.

Ask your former employer or the Nevada Division of Insurance about state continuation coverage if you think it applies to you.

CONVERSION POLICIES

If you lose coverage under a fully insured group health plan in Nevada, and meet other requirements, you are guaranteed the right to buy a conversion policy. This is an individual policy sold by the insurance company that covered your former group.

Indemnity health insurance companies in Nevada are required to include conversion rights in their fully insured group health plan policies. HMOs are not required to offer conversion rights, but many do. HMO conversion plans, when available, must follow the same rules that apply to indemnity health plan conversion policies.

WHEN AM I ELIGIBLE FOR CONVERSION COVERAGE?

- *In Nevada, if you have 3 months of coverage through an employer's fully insured group health plan, and you leave that plan, you are eligible to buy a conversion policy. This is an individual policy you get from the company that insured your employer's group plan. All persons seeking conversion coverage must not have or be eligible for other health coverage, including Medicare, group health insurance, or substantially similar individual insurance.*
- *Conversion rights are also available to a surviving spouse and children upon the death of the insured, to a child when the child reaches that age at which dependent coverage is terminated, and to a former spouse and children at divorce.*

- *You do not need to use up your COBRA or state continuation coverage first to buy a conversion policy. However, if you purchase a conversion policy, you will no longer be able to become HIPAA eligible.*
- *Your employer must notify you of your conversion rights within 16 days of termination of your prior group coverage. You must then elect conversion coverage within 15 days of receiving notification. Typically, this is 31 days following termination of group coverage, but in no case more than 91 days following termination of group coverage.*

WHAT DOES A CONVERSION POLICY COVER?

- *You must be offered a choice of two conversion plans. Insurers must offer a basic and a standard health benefit plan for the conversion plan.*
- *The basic policy covers hospital, skilled nursing, rehabilitation, hospice, emergency care, physician services, laboratory and X-ray services, and prescription drugs. These services are covered with a 50% coinsurance. The lifetime maximum benefit is \$1 million. The basic policy does not cover mental health services, substance abuse services, and maternity care.*
- *The standard policy covers everything that the basic policy covers. Those services are covered with a 20% coinsurance. In addition, the standard policy covers maternity care and limited mental health services, substance abuse services. The lifetime maximum benefit is also \$1 million.*
- *Coverage under a conversion plan probably will not be the same as under your prior group health plan, and will probably offer fewer benefits.*
- *Contact the Nevada Division of Insurance for more information about covered benefits or visit the Division's website at <http://doi.state.nv.us/> for the summary of benefits for conversion basic and standard health benefit plans.*

WHAT ABOUT COVERAGE FOR MY PRE-EXISTING CONDITION?

- *You will not have a new pre-existing condition exclusion period for your conversion policy. The conversion policy can only exclude coverage for pre-existing conditions that were excluded under the prior group health plan.*

HOW MUCH CAN I BE CHARGED FOR CONVERSION COVERAGE?

- *Conversion policy premiums may be much more expensive than your former group plan premiums.* There are limits on what you can be charged for a conversion policy, but your health status, age, and other factors will be taken into account in figuring your premiums.

Contact the Nevada Division of Insurance if you have questions about conversion policy premiums.

CAN MY POLICY BE CANCELLED?

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

CHAPTER 4

YOUR PROTECTIONS AS A SMALL EMPLOYER OR SELF-EMPLOYED PERSON

Federal law extends certain protections to employers seeking to buy health insurance for themselves and their workers. Nevada has enacted reforms to expand some of these protections. Generally, small employers are those that employ 2-50 employees. Please note, however, that the definitions of small employer and employee are somewhat different under federal and state law. Check with the Nevada Division of Insurance to be sure that you know which protections apply to your group.

DO INSURANCE COMPANIES HAVE TO SELL ME HEALTH INSURANCE?

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

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

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

- *As a small employer, your premiums can vary, within limits, due to the health status, age, and other characteristics of people in your group.* Even within these limits, however, premiums can be significantly higher if someone in your small group has a serious health condition.

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

- *For groups with more than 50 employees, Nevada does not limit premium variations when coverage is first issued or renewed.*

WHAT PLAN CHOICES DO I HAVE?

- *Insurance companies must offer small employers standardized health plans. Nevada requires all insurers to offer a basic and a standard plan to all small group employers. Carriers also can offer non-standard plans.*
- *Contact the Nevada Division of Insurance for more information about covered benefits or visit the Division's website at <http://doi.state.nv.us/> for the summary of benefits for conversion basic and standard health benefit plans.*

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 premium from your federal income tax.*

A WORD ABOUT ASSOCIATION PLANS

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

CHAPTER 5 FINANCIAL ASSISTANCE

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

MEDICAID

Medicaid is a program that provides health coverage to eligible low-income Nevada residents. Medicaid covers families with children and pregnant women, the elderly, and people with disabilities, if state and federal guidelines are met. Legal residents who are not U.S. citizens may be eligible for Medicaid. Questions concerning immigration status and eligibility should be directed to the Nevada Department of Health and Human Services.

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

In Nevada 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 contact the Nevada Department of Health and Human Services for more information.

Low income persons eligible for Medicaid in Nevada*

<u>Category</u>	<u>Income eligibility (as percent of federal poverty level)</u>
Infant 0-1	133% (monthly income of about \$1,903 for family of 3)
Child 1-5	133%
Child 6-19	100%
Parents	
-Non-working	25%
-Working	86%
Pregnant woman	185%

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

To get an idea of how your income compares to the federal poverty level (FPL),* use the federal poverty guideline issued by the U.S. Department of Health and Human Services for the year 2007:

<u>Size of Family Unit</u>	<u>Poverty Guideline (annual income)</u>
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, 133% of the federal poverty level for a family of 3 would be an annual income of \$22,836, or a monthly income of \$1,903.

- *Parents who receive benefits under **TANF** 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 Medicaid if your family's income meets certain income standards.

- *Very poor elderly or disabled people who get **Supplemental Security Income (SSI)** benefits 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.

- *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 at or below 100% of the federal poverty level, Medicaid will pay your Medicare monthly premium and your Medicare deductibles and coinsurance. This is called the Qualified Medicare Beneficiary (QMB) program.

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

- *If you are uninsured and screened and diagnosed with breast or cervical cancer by the Women's Health Connection program, you may be eligible for full Medicaid Benefits (see below).*
- *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 Nevada Division of Welfare. You can apply for Medicaid at the Nevada Division of Welfare District Office, or at many other designated outreach sites throughout Nevada.

To obtain the locations and telephone number of sites near you, call the Nevada Division of Welfare or visit http://welfare.state.nv.us/main/find_us.htm.

NEVADA CHECK UP

Nevada Check Up is a state-designed program that provides comprehensive health care coverage to low-income Nevada children under the age of 19 who are not eligible for Medicaid and who have been uninsured for 6 months prior to application.

- *A child whose family has a household income at or below 200% of the federal poverty level is eligible for Nevada Check Up.* For a family of three, this works out to an annual income of about \$34,340 or a monthly income of about \$2,862.
- *Eligibility is determined for one year unless the child moves from the state, enrolls in Medicaid, is found to have other insurance coverage, or becomes financially ineligible.* Children who travel outside the state would be covered in case of an emergency.
- *Benefits include well-baby/well-child visits, prescription drugs, mental health benefits, immunizations, and dental and vision services.*
- *Applications for the Nevada Check Up are available statewide at various locations including: Family Resource Centers, Schools, Boy & Girls Clubs, Welfare District Offices, and other designated outreach sites throughout Nevada.* You can also request that an application be sent to you by mail by calling (877) 543-7669.

NEVADA CHECK UP PLUS

Nevada Check Up Plus is an employer sponsored insurance premium subsidy program. This program provides premiums subsidies for parents who work for small employers.

- *To be eligible, you must work for a small employer (2-50 employees), be a parent or guardian of a child, have been uninsured for 6 months prior to applying, and have income at or below 200% FPL.*
- *Nevada Check Up Plus provides eligible individuals with a premium subsidy of up to \$100 per person (\$200 per family) to help defray the cost of employer sponsored health insurance coverage.*
- *For more information, contact Nevada Check Up Plus at (775) 684-3777 or visit them on the web at <http://www.nevadacheckup.state.nv.us/>.*

WOMEN'S HEALTH CONNECTION

Women's Health Connection is the name of Nevada's Breast and Cervical Cancer Early Detection Program that provides education, free screening services and therapeutic care related to breast and cervical cancer to Nevada's eligible female residents.

- *The Women's Health Connection provides qualified women with breast and cervical cancer screening at no cost. Women who are screened through this program and diagnosed with breast and/or cervical cancer may be eligible for treatment through Medicaid*
- *In order to be eligible for screening through the Women's Health Connection program, you must be 40 years of age or older, being uninsured or underinsured, not eligible for Medicaid, not enrolled in Medicare part B and at or below 250% FPL. For a family of three, this is an annual income of no more than \$42,925.*
- *For more information, please contact the Woman's Health Connection Office at (888) 463-8942 (in state only) or visit them on the web at http://health.nv.gov/index.php?option=com_content&task=view&id=55&Itemid=110*

OTHER STATE PROGRAMS

- *There may be other financial assistance programs available. Please call the Nevada Department of Health and Human Services at (775) 684-4000 or visit them on the web at <http://dhhs.nv.gov/>.*

THE FEDERAL HEALTH COVERAGE TAX CREDIT (HCTC)

A federal income tax credit is available to help certain trade dislocated workers and early retirees, and their dependents, buy qualified health insurance coverage. The Health Coverage Tax Credit (HCTC) covers 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. (See Chapter 3 for COBRA and state continuation coverage.)*
 - *Individual health 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 insurance State continuation coverage Conversion coverage	<i>Nevada Division of Insurance</i> (888) 872-3234 (toll free) (775) 687-4270 in Carson City (702) 486-4009 in Las Vegas http://doi.state.nv.us/
Self-insured group health plans COBRA continuation coverage Family and Medical Leave Act	<i>U.S. Department of Labor</i> Employee Benefits Administrator Employee & Employer Assistance Hotline and Publications (866) 444-EBSA (3272) http://www.dol.gov/ebsa
Medicaid	<i>Nevada Division of Health Care Financing & Policy (NV Medicaid)</i> (775) 684-3600 Medicaid http://dhcfp.state.nv.us/index.htm or visit http://welfare.state.nv.us/main/find_us.htm to find the address and phone numbers of a Welfare Office in your area
Nevada Check Up and Nevada Health Check Up Plus	<i>Nevada Division of Health Care Financing & Policy (Nevada Check Up)</i> (877) 543-7669 (775) 684-3777 http://www.nevadacheckup.state.nv.us/
Women's Health Connection	<i>Nevada State Health Division</i> (775) 684-5936 (888) 463-8942 http://health2k.state.nv.us/whc/
The Federal Health Coverage Tax Credit (HCTC)	<i>Internal Revenue Service (IRS)</i> (866) 628-HCTC http://www.irs.gov/individuals/index.html (Click on HCTC)

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

HELPFUL TERMS

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

Alternative Trade Adjustment Assistance (ATAA). ATAA is a benefit for workers at least 50 years old who have obtained different, full-time employment within 26 weeks of the termination of adversely-affected employment. These 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). COBRA continuation coverage generally lasts 18 months, or 36 months for dependents in certain circumstances. See also State Continuation Coverage.

Continuous Coverage. Generally, health insurance coverage that is not interrupted by a break of 63 or more consecutive days. However, when you are joining a fully insured small group health plan in Nevada, coverage counts as continuous if it is not interrupted by a break of 90 days or more. Employer waiting periods and HMO affiliation periods do not count as gaps in health insurance coverage for the purpose of determining if coverage is continuous. See also Affiliation Period, Creditable Coverage, Fully Insured Group Health Plan, HMO, Small Group Health Plan, Waiting Period.

Conversion. Your right, when leaving a fully insured group health plan in Nevada, to convert your policy to an individual policy. Indemnity group health plans must offer conversion rights in Nevada. HMOs are not required to offer conversion rights, but many do. You must have been covered under the group health plan for at least 3 months before you can buy a conversion policy. You can buy conversion coverage instead of, in the course of, or after any COBRA or state continuation coverage you have available. There are rules about what conversion policies must cover and what premiums can be charged. See also COBRA, Fully Insured Group Health Plan, Indemnity Health Plan, HMO, State Continuation Coverage.

Creditable Coverage. Health insurance coverage under any of the following: a group health plan; individual health insurance; Medicare; Medicaid; TRICARE and CHAMPUS (health coverage for military personnel, retirees, and dependents); the Federal Employees Health Benefits Program; Indian Health Service; the Peace Corps; CHIP (Children's Health Insurance Program); state health insurance high risk pool; short-term health insurance policy; or blanket student accident and health insurance policy. See also Continuous Coverage, Group Health Plan, Individual Health Insurance.

Elimination Rider. An amendment permitted in individual health policies contracts that permanently excludes your coverage for a specified health condition. See also Individual Health Insurance.

Enrollment Period. The period during which all employees and their dependents can sign up for coverage under an employer group health plan. Besides permitting workers to elect health benefits when first hired, many employers and group health insurers hold an annual enrollment period, during which all employees can enroll in or change their health coverage. See also Group Health Plan, Special Enrollment Period.

Family and Medical Leave Act (FMLA). A federal law that guarantees up to 12 weeks of job-protected leave for certain employees when they need to take time off due to serious illness, to have or adopt a child, or to care for another family member. When you qualify for leave under FMLA, you can continue coverage under your group health plan.

Fully Insured Group Health Plan. Health insurance purchased by an employer from an insurance company. Fully insured health plans are regulated by Nevada. 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 Nevada are guaranteed issue. If you are HIPAA eligible, insurance companies must offer you a choice of basic and standard health plans that are guaranteed issue. Plans that are guaranteed issue can turn you away for other reasons.

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

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 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, better known as Kassebaum-Kennedy, after the two senators who spearheaded the bill. Passed in 1996 to help people buy and keep health insurance, even when they have serious health conditions, the law sets a national floor for health insurance reforms. Since states can and have modified and expanded upon these provisions, consumers' protections vary from state to state.

HIPAA eligible. Status you attain once you have had 18 months of continuous creditable health coverage. To be HIPAA eligible, you also must have used up any COBRA 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. You are also HIPAA eligible if your most recent prior creditable coverage was under a basic or standard health benefit plan and was not renewed by an insurer who discontinued offering and renewing individual health benefit plans in Nevada. When you are buying individual health coverage, federal eligibility confers greater protections on you than you would otherwise have in Nevada 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.

Indemnity Health Plan. A kind of health plan that reimburses you or your health care provider on the basis of services rendered. Indemnity plans generally do not restrict you to a limited network of providers for covered care. However, indemnity plans often impose other restrictions on covered services. For example, plans can require prior authorization of hospital care or other expensive services.

Individual Health Insurance. Policies for people not connected to an employer group. Individual health insurance are regulated by Nevada.

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

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

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

Nevada Check Up Plus. A state program that provides subsidies for small group insurance premiums to parents or guardians who are uninsured and meet other requirements.

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

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

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

Pre-existing Condition (Individual Health Insurance). Any condition for which medical advice, diagnosis, care, or treatment was ever received, or – in your insurer’s judgment – for which an ordinarily prudent person would have sought care, prior to enrollment in a health plan. Pregnancy can be counted as a pre-existing condition in individual health insurance. Genetic information cannot be considered a pre-existing condition in individual health insurance. See also Genetic Information, 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 insurance only, a rule that permits insurers to exclude as pre-existing any condition for which – in the insurer’s judgment – most people would have sought care or treatment prior to enrolling in individual health insurance.

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 Nevada.

Small Group Health Plans. Plans covering a group with 2 to 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 Nevada, if you are in a fully insured group health plan sponsored by an employer with 2 to 19 employees, you also have rights to continue your health coverage when your job ends involuntarily.

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.