

Guide To Understanding Insurance



Table of Contents

Introduction	 1
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Health Insurance Programs

Public (Government) Health Plans

Supplemental Security Income	6
Social Security Disability Income	7
Medicare	7
TRICARE	10
Civilian Health and Medical Program of the Veterans Administration	11
Medicaid	12
State Children's Health Insurance Program	13
Children with Special Healthcare Needs	13
AIDS Drug Assistance Program	14
Comprehensive Health Insurance Programs	14

Laws That Affect Healthcare Benefits

Employment Retirement Income Security Act	15
Consolidated Omnibus Budget Reconciliation Act	15
Employee, Spouse, Dependent Child	16
Health Insurance Portability and Accountability Act	18
Americans with Disabilities Act	20

Note: In this book we talk about co-payment. Co-payment or co-pay means the amount a participant is required to pay for a prescription in accordance with a Plan, which may be a deductible, a percentage of the prescription price, a fixed amount or other charge, with the balance, if any, paid by a Plan.

Introduction

How well do you know your health insurance plan? Do you know whether you have private insurance or public insurance? Whether you have a group plan or an individual plan? Can you see any doctor you want, or must you see an approved doctor? What expenses are you personally responsible for and what expenses will be paid by your insurance? Will your benefits continue if your medical bills exceed \$100,000? \$500,000? And most importantly, what are your options for health plan coverage if you want to change jobs? Will you be covered immediately under your new employer's health plan, or will you have to wait some period of time because of a preexisting condition? Making sense of your health plan is no easy matter; however, you owe it to yourself and your family to understand your health plan as if your life depended on it - because it could.

This booklet was developed to help you:

- Understand the numerous types of health insurance coverage
- Understand current laws that may affect your access to a health plan and healthcare
- Evaluate your existing health plan to ensure your immediate and future medical needs will be met
- Identify other health plans and programs that may offer you more benefits or provide you with health plan coverage if your current plan should terminate

This booklet is not intended to provide you legal advice. You may wish to contact your own legal advisor with regard to laws affecting healthcare and healthcare insurance. If you would like additional information about this booklet or its contents, please contact the Caremark Customer Assistance Hotline at 1-800-331-7171. We hope you find this booklet helpful!

Health Insurance Programs

Overview

Healthcare delivery and financing have changed considerably over the past 20 years. Technological advancements, including new equipment, supplies, and drugs, have significantly improved patients' quality of life. In the past, individuals were restricted to receiving care in their doctor's office, or for serious illnesses, in the hospital. Today they are able to have their medical needs met in a variety of settings including outpatient clinics, ambulatory surgery centers or even in their own home. Unfortunately, these new medical advances have also brought about a substantial increase in healthcare expenses, causing a reevaluation of the manner in which healthcare is currently financed.

Health Insurance

Many health insurance organizations exist in the United States. Blue Cross/Blue Shield plans are probably familiar to most individuals although there are many other private companies through which private insurance plans are available. The majority of individuals have private health coverage through an employer. These group insurance policies usually offer greater benefits at lower costs than individual policies, because the risk is shared across the entire group. With this type of insurance, the employer may pay all or part of the premiums. Individual insurance policies are purchased from an insurance company by a person who pays the premium directly to the insurance company. Several types of employer group health coverage are available: traditional indemnity plans, self-funded plans or Taft-Hartley plans. When purchasing private insurance, two plans are available: a traditional indemnity plan or a managed care plan.

Traditional Indemnity Plans

Q1. What are the types of coverage offered?

A1. Typically, indemnity plans offer basic hospitalization and major medical coverage. Basic hospitalization is usually limited to in-patient services, while major medical can include doctor and nursing services, x-rays and diagnostic services, durable medical equipment, chiropractor services, and prescription drugs. Some policies may stipulate that some drugs (usually non-injectables) are covered under the prescription drug benefit. Some policies also offer homecare and hospice coverage.

Q2. What limitations do I have regarding a choice of provider?

 A_2 . This plan generally has no restriction on your selection of doctor, hospital and other healthcare providers. However, these plans may pay a predetermined amount for services based upon the plan's rule of usual and customary rates for the provider's geographical location. You may be financially responsible for the difference between the amount billed by the provider and the amount paid for the service by your plan.

Q3. What costs will I be responsible for?

3. Typically, you will be responsible for all or part of a premium (depending upon whether this is an individual or group plan), a deductible co-payment (if applicable), and coinsurance. As a general rule, the lower the deductible and coinsurance, the higher the premium. Most plans limit your coinsurance after you have paid the deductible and a certain amount

"out-of-pocket." For example, your plan may stipulate an annual deductible, a coinsurance amount and a maximum out-of-pocket (including the deductible). Before any services can be paid by the insurance plan, you must pay the deductible. After that obligation has been fulfilled, the policy will reimburse the provider a certain percentage based upon your policy. After meeting your out-of-pocket expenses, you are no longer responsible for your coinsurance, and the plan will reimburse 100% of covered services until this policy period ends. For example:

	Plan A	Plan B
Monthly premium	\$300	\$600
Annual deductible	\$1,000	\$500
Coinsurance	20%	10%
Maximum out-of-pocket	\$3,000	\$1,000

$Q_{4.}$ Are there any other costs I might be responsible for?

 $A_{4.}$ You may be responsible for the cost of any non-covered services, as well as any amounts the provider bills in excess of the plan's usual and customary charge.

O5. What about annual or lifetime maximum benefits?

 $A_{\it 5.}$ While basic hospitalization plans don't generally have annual or lifetime maximum benefits, the majority of major medical and prescription drug plans do. Benefit levels for prescription drug plans are usually based on a monthly or annual benefit, if there is a benefit limit. Major medical plans typically have a lifetime maximum. The difference between a \$50,000 and a \$500,000 lifetime maximum is significant, especially if you have a chronic medical condition. Check your

health plan description carefully to determine if you have any benefit limitations.

O₆ Can I be excluded from coverage due to a preexisting condition?

 A_{6} . It depends. Under the Health Insurance Portability and Accountability Act (HIPAA), a preexisting condition clause may not last for more than 12 months (18 months for late enrollees). If you have had continuous coverage without a break of 63 days or more, you may be able to "credit" your previous health coverage against the waiting period of your new insurance plan. Twelve months of continuous coverage before your new plan began would allow you to begin receiving benefits immediately; a lesser amount (for example, 6 months) is still significant, as it would allow the waiting period to be reduced by that time period. If HIPAA rules do not apply, preexisting condition exclusions typically range from 3 to 18 months, during which time you would be completely responsible for payment for services associated with your preexisting condition.

$oldsymbol{Q}$ 7. Who handles complaints about my indemnity insurance carrier?

- $A_{7\!.}$ The state Department of Insurance handles complaints regarding indemnity insurance carriers.

Self-Funded Insurance

Q8. What is self-funded insurance from an employer?

 $A_{\it 8.}$ Self-funded insurance is a way by which employers put money aside for payment of the healthcare (self-fund) rather than buy a traditional indemnity insurance policy for the group.



9. Who offers self-funded plans?

 $A_{\it 9.}$ Many large employers offer self-funded plans.

Q_{10} . Are self-funded plans covered by the same laws that govern indemnity plans?

 $A_{\it 10.}$ No. Self-funded plans are governed by the Employee Retirement Income Security Act (ERISA). This is a federal law, not a state law.

Q11. Do self-funded plans offer the same benefits as indemnity plans?

 $A_{11.}$ Typically, the benefits of a self-funded plan are very similar to those offered by an indemnity plan.

Q12. How will I know what benefits my self-funded plan offers?

 $A_{\it 12.}$ All self-funded plans are required to give the employee a Summary Plan Description with detailed information on what services are covered. deductibles, co-payments, maximum out-of-pocket, lifetime maximums.

Q13. Does HIPAA cover self-funded plans?

 $A_{\it 13.}$ Yes, HIPAA does cover self-funded health plans in the same way it covers indemnity plans.

Q14. Who handles complaints about a self-funded plan?

A14. The United States Department of Labor handles complaints regarding selffunded plans.

Taft-Hartley Plans

Q15. What is a Taft-Hartley plan?

 $A_{\it 15.}$ A Taft-Hartley plan is another name for a union health plan.

Q_{16} . What law covers a Taft-Hartley plan?

A16. A Taft-Hartley plan is also covered by ERISA and is required to do most of the same the things that a self-funded plan is required to do.

*Q*17. Does HIPAA cover a Taft-Hartley plan?

 $A_{\it 17.}$ Yes, HIPAA does cover a Taft-Hartley plan in the same way that it covers indemnity and self-funded plans.

Q18. Who handles complaints regarding . Taft-Hartley plans?

- $A_{\it 18.}$ The United States Department of Labor handles complaints regarding Taft-Hartley plans.

Managed Care Plans

As stated earlier, although advances in the medical field have greatly benefited patients, improvements in the quality of medical care have come at a high cost. The primary goal of managed care is to provide medically appropriate care in a cost-effective manner. To achieve this goal, health plans manage your access to providers, treatment settings, and the number and types of services you may receive as a covered benefit. For example, you may have to choose from a limited list of doctors and hospitals; you may have to receive a referral from your primary care doctor before you can see a specialist; or you may have to receive prior authorization or a second opinion before you can receive a prescribed treatment or products. Once only available from private insurance, managed care plans are now also being offered by public health programs.

Health Maintenance Organizations

Health Maintenance Organizations (HMOs) are managed care plans in which the healthcare provider is also the insurer: Kaiser and Cigna are two examples. This is typically the most limited type of managed care plan, regarding your choice of provider. Care is monitored by a primary care doctor, commonly known as a gatekeeper. This individual is responsible for all referrals, treatment plans, sites of service, treatment and review standards, and has a financial incentive to provide medically appropriate care in a most cost-effective manner.

There are different operating plans of HMOs. The most common are: staff-model, groupmodel and network-model. A staff-model HMO consists of a group of doctors who are either salaried employees of a group practice that is an important part of the HMO plan, or salaried employees of the HMO. Healthcare services in staff plans are delivered at HMOowned health centers. There are two kinds of group-model HMOs: a) the closed-panel plan, in which medical services are delivered in the HMO-owned health center or satellite clinic by doctors who belong to a legally separate medical group that only serves the HMO, and b) the plan in which the group of doctors delivers medical care. A network-model HMO is an organizational form in which the HMO contracts with a network of medical groups to provide healthcare services.

Q19. What are the advantages of this type of plan?

A19. Typically these plans are comprehensive, providing all of the services (and potentially more) that are offered under indemnity plans, or self-funded plans, while being less costly. You are responsible for a premium (there is usually no deductible), and a minimal co-payment per office visit. (The copayment structure typically changes for hospital, ancillary and other services.) These plans usually don't have preexisting condition waiting periods.

Q20. What if I choose to receive care outside of the plan?

 $A_{20.}$ Usually, care you receive outside of the plan is at your own expense. However, there are situations in which care outside of the plan may be covered with a referral from your primary care doctor. For example, care required from a specialist that is not available within the plan, is generally covered with a referral from your primary care doctor. Also, some HMOs now offer a Point of Service (POS) component. Using the POS option, you may select doctors and other healthcare providers who are outside of the plan. However, using the POS option may change your deductible and co-payment obligation.

Preferred Provider Organizations

As compared to an HMO, a Preferred Provider Organization (PPO) is a group of doctors, hospitals, and other practitioners that contracts with a payor to provide services at a discounted rate to preferred providers. Benefits have already been agreed upon with the health plan; therefore, the patient is usually not responsible for the amount the provider may bill in excess of the health plan's usual and customary charge.

Q21. How does a PPO compare with a traditional indemnity plan, selffunded plan, Taft-Hartley plan or an HMO?

 $A_{\it 21.}$ Similar to a traditional indemnity plan, a PPO will usually allow you to see a network provider without a referral from your primary care doctor. Also like an HMO, your out-of-pocket costs may be lower, benefiting from the contractual relationship between your provider and the plan. A PPO provides a larger selection of healthcare providers, better out-of-network benefits, and is less restrictive with accessing specialists. Self-funded plans and Taft-Hartley plans may also be part of a PPO. The Summary Plan Description would specify the financial differences between using the PPO network providers and the non-PPO providers.

Q22. Will my costs be different if I see a provider who is not a member of the PPO?

A22. Yes. If your provider is a participating provider of the PPO, then you will be able to enjoy the special contract rates, which may result in reduced co-payments to you. If your provider is not participating in the PPO plan, you may still receive care, however, your out-of-pocket costs may be higher.

> For example, let's say your provider's normal charge is \$100. As a participating provider, the contracted fee may be \$60. The plan pays 80% of the contracted rate (which is \$48 in this example) and you are responsible for 20% (in this example, \$12). If your provider is non-participating, the plan will still only pay \$48, but you will be responsible not only for the 20% coinsurance (\$12), but also for the difference between your provider's charge of \$100 and the contracted rate of \$60. As a result, for using a non

participating provider, your out-ofpocket expense will be \$52 rather than \$12.

	Participating Provider	Non-Participating Provider
Provider's Charge:	\$100	\$100
Insurance's contracted rate:	\$60	\$60
80% payment by insurance:	\$48	\$48
Patient coinsurance responsibility:	\$12 (\$60 - \$48)	\$52 (\$100 - \$48)
	(400 440)	(100 140)

Public (Government) Health Plans

Supplemental Security Income

Supplemental Security Income, (SSI), is a program run by the Social Security Administration that provides monthly payments to the elderly, the blind, and people with disabilities who have modest income. To receive SSI checks, you must live in the U.S. and be a U.S. citizen or national. (Certain noncitizens may also be eligible.) These monthly payments generally represent \$552 for one person, and \$829 for a couple, however, they can vary based upon your income and what state you live in. In determining your income, the government reviews your cash, bank accounts, stocks and bonds, earnings, Social Security checks, pensions, and non-cash items you receive, such as food, clothing or shelter. There are separate rules for working and non-working applicants.

Contact your nearest Social Security office or call Social Security's toll-free number, 1-800-772-1213, or log on to www.ssa.gov to learn more about this program. You may also contact the Caremark Customer Assistance Hotline at 1-800-331-7171.

Social Security Disability Income

Social Security Disability Income (SSDI), is a program run by the Social Security Administration that provides monthly payments to individuals who have a severe impairment and are unable to perform any gainful work activity (not just the job you were performing at the time the disability began).

23. When do I become eligible for benefits?

 A_{23} . If you have paid social security taxes over a sufficiently long period to be "fully insured," and contributed to the program recently enough to have "disability insured status," you are eligible for benefits after you have been disabled for five months, and if the disability is expected to last at least 12 months.



O_{24.} How are the payments calculated?

 A_{24} . Your payments will be based on your salary and the number of years you have been covered under Social Security.

Q25. How does receipt of SSDI enable me to receive Medicare benefits?

 $A_{25.}$ After 24 months of SSDI benefits, you qualify for Medicare.

Q26. Is there a time limit on SSDI benefits?

 $A_{\it 26.}\,$ No. You will continue to receive a disability benefit as long as your condition keeps you from working. However, your case will be reviewed from time to time to determine whether there has been improvement in your condition, and whether you are still eligible for benefits. If you are still eligible when you reach 65, your disability benefit will automatically convert to retirement benefits.

Q27. How can I learn more about this program?

 $A_{\it 27.}$ Contact your nearest Social Security office or call Social Security's toll-free number, 1-800-772-1213, or log on to www.ssa.gov to learn more about this program. You may also contact the Caremark Customer Assistance Hotline at 1-800-331-7171.

Medicare

Medicare is a federally sponsored health plan for people 65 years of age and older, certain younger people with disabilities (see SSDI discussion), and people with end-stage renal disease. Oualified individuals now have their choice of the traditional Medicare program or Medicare + Choice.

Q28. What is traditional Medicare?

 A_{28} . The traditional Medicare plan is the traditional pay-per-visit arrangement that allows you to be treated by any doctor, hospital, or other healthcare provider that participates in the Medicare program. The traditional Medicare Plan has Part A (Hospital Services) and Part B (Major Medical Services).

29. What is Part A and what are my costs?

 $A_{\it 29.}$ Part A helps pay for care provided in hospitals, skilled nursing facilities (SNFs), hospice, and home health. If

you are eligible, you will be premiumfree, because you or your spouse paid Medicare taxes while you were working. If you don't qualify for premium-free Part A, you may be able to buy it. After payment of a deductible, you will be responsible for the coinsurance, which will vary depending upon the care provided. For example, for hospitals and skilled nursing facilities the coinsurance is calculated for each benefit period (the period of time from admittance to 60 consecutive days past the last hospital in-patient or SNF care day) based upon your length of stay.

230. What is Part B and what are my costs?

 $\mathbf{4}_{30}$. Part B helps pay for doctors, outpatient hospital care, and other medical services, such as physical and occupational therapists, x-rays, preventive services, and limited outpatient drugs (including blood clotting factor) when administered in conjunction with covered Part B services. Effective July 18, 1994, selfadministered blood clotting factors and necessary items furnished to hemophilia patients competent to use such factors to control bleeding without medical or other supervision are covered and reimbursed under Part B. You are automatically eligible for Part B if you are eligible for premium-free Part A. You are also eligible if you are a U.S. citizen or permanent resident aged 65 or older. You will be responsible for a monthly premium, an annual deductible, and coinsurance, which will vary depending upon the service provided. For example, for doctors, medical and surgical services and

supplies, your coinsurance will be 20% of Medicare's approved amount without any out-of-pocket limitation.

Q31. What are Medicare + Choice Plans?

- A31. Recognizing the limitations of the traditional Medicare Plan, Medicare + Choice Plans provide you with a wider array of health plan options. If you have Medicare Parts A and B, do not have end-stage renal disease, and live in the service area of a health plan, your options include:
 - Traditional Medicare Plan with a supplemental plan
 - Managed Care
 - Private Fee-for-Service Plan
 - Medicare Medical Savings Account Plan (MSA)

Q32. What is the benefit of the traditional Medicare Plan with a supplemental plan?

A32. Purchase of one of the 10 standard supplemental insurance policies may provide additional benefits not covered under the traditional Medicare Plan (e.g., prescription drugs), and help pay Medicare's coinsurance amounts and deductibles. There are two types of Medicare supplemental insurance policies: Medigap and Medicare Select. Medigap allows you to go to any doctor or hospital that accepts Medicare. Medicare Select requires you to use plan hospitals, and in some cases, plan doctors.

Q33. What is a Managed Care Plan, and how does it compare with the traditional Medicare Plan? $A_{33.}$ A Managed Care Plan involves a group of doctors, hospitals, and other healthcare professionals who in exchange for a fixed amount of money or other negotiated reimbursement from Medicare, agree to provide care to Medicare beneficiaries. Managed Care Plans include health maintenance plans (HMOs), HMOs with a Point of Service (POS) option and Preferred Provider Organizations (PPOs). A Managed Care Plan, may, or may not, be right for you, depending upon how you value choice of provider, benefits, need for specialists and cost. In comparing the Managed Care Plan to the traditional Medicare Plan, while your choice of provider may be more restricted, your coverage is usually better and your costs are usually less.

> For example, HMOs usually require you to use doctors and hospitals that are members of the plan, while PPOs and HMOs with POS options may allow you to use doctors and hospitals "outside" of the plan (although usually at greater cost). Managed Care Plans must offer vou at least the same covered services available under the traditional Medicare Plan; however, they typically offer greater benefits including coverage for out-patient drugs, vision or dental care, hearing aids, etc. While all plans (traditional and Managed Care) require you to pay the Part B premium, Managed Care Plans are generally less expensive, even when a co-payment per visit or per service is required.

Q₃₄. How does the Private Fee-for-Service Plan operate?

 $A_{34.}$ Under this program you choose a private insurance plan that accepts Medicare beneficiaries. You may go to any doctor or hospital you choose. The insurance plan, rather than the Medicare program, determines the reimbursement amount and pays the provider. You are still responsible for the Medicare Part B premium, as well as any monthly premium the plan charges, and an amount per visit or service. In addition, if the doctor bills more than the plan pays, you are responsible for this difference.

Q_{35} . How do I enroll/disenroll in one of the Medicare Plans?

 $A_{35.}$ If you are not yet 65 and already getting Social Security or Railroad Retirement benefits, you are enrolled automatically in both Parts A and B, and your Medicare card is mailed to you about 3 months before your 65th birthday. If you are disabled, you will be automatically enrolled in both Parts A and B beginning in your 25th month of disability, and your Medicare card will be mailed to you about 3 months before you are entitled to Medicare. Your initial enrollment period starts 3 months before you turn 65 and lasts for 7 months. If you chose not to take Part B when you were first eligible, you can sign up during two enrollment periods: general enrollment period (January 1 through March 31 of each year for coverage that begins on July 1 of that year); special enrollment period (available to individuals who are/were previously covered under a group health plan).

> You may enroll in a Medicare Managed Care Plan or Private Fee-for-Service Plan at any time, simply by contacting the plan and requesting an enrollment

form. The plan cannot refuse to enroll you during your open enrollment period (the first six months after you turn 65 and are enrolled in Medicare Part B). You may disenroll at any time, for any reason, by contacting the plan or the Social Security Administration. Your disenrollment becomes effective as early as the first of the month after your request is received.

You can only enroll in a Medicare Medical Savings Account (MSA) plan during the 3-month period before you are entitled to Part A and Part B, or during November of each year. You must set up a Medicare MSA at a bank or savings institution. You can leave the Medicare MSA Plan by filing a request for disenrollment in November. Your disenrollment becomes effective December 31.

As of January 1, 2002, disenrollment opportunities have become limited.

Q36. What if I can't afford the costs associated with Medicare?

 $A_{\it 36.}$ If you have Medicare Part A and your bank accounts, stocks, bonds, or other resources do not exceed \$4,000 (for an individual), or \$6,000 (for a couple), you may qualify for assistance as a Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB) or Qualifying Individual (QI). The QMB program pays Medicare's premiums, deductibles, and coinsurance for entitled older and disabled people who are qualified for Medicare Part A. If your income is too high to qualify for QMB, you may be able to get help under the SLMB or QI programs. Both SLMB and QI pay your Medicare Part B premium, but do not help with Part A.

*Q*37. How can I learn more about Medicare?

A37. Contact your local Social Security office or Medicare carrier to learn more about this program. Additional information is available online at www.medicare.gov. You may also contact the Caremark Customer Assistance Hotline at 1-800-331-7171.

TRICARE

TRICARE is a regionally managed healthcare program for active duty and retired members of the uniformed services, their families, and survivors.

*Q*38. Are different plans available under TRICARE?

A38. Yes. There is TRICARE Prime (HMO), TRICARE Extra (PPO), TRICARE Standard and TRICARE for Life.

239. What is TRICARE Prime?

 $A_{39.}$ TRICARE Prime is the managed care option. If implemented in your area, you may enroll in this plan at any time; however, there is a one-year commitment. If you are on active duty, you will be enrolled in this plan automatically, and assigned a Primary Care Manager. Your eligible family members may choose to also enroll in this plan, or any of the other plans offered, except TRICARE for LIFE. Under TRICARE Prime, there is no annual deductible, no enrollment fee, and no co-payments for authorized medical visits and prescriptions except for retirees under the age of 65. Retirees under the age of 65 have an annual enrollment fee of \$230 per individual or \$460 per family. Enrollees in the

TRICARE Prime plan have access to medical treatment facilities and TRICARE network providers.

*Q*40. What is TRICARE Standard?

 A_{40} . TRICARE Standard is a fee-for-service option. Enrollment is not required to participate, and beneficiaries may switch between TRICARE Standard and Extra programs at any time, depending upon the choice of doctor. Beneficiaries choosing this plan have the greatest choice of civilian doctors but at a higher cost. Under TRICARE Standard. there is no enrollment fee, however, you are responsible for a deductible plus co-payments depending on your sponsor's status and the type of service received. For example, active duty family members will be responsible for a deductible plus 20% of the allowed charges and a co-payment, while retirees under the age of 65 will be responsible for a deductible plus 25% of the allowed charges.

Q41. What is TRICARE Extra?

 $A_{41.}$ TRICARE Extra is similar to TRICARE Standard, but offers discounts to patients when they use TRICARE network providers. For example, active duty family members will be responsible for a deductible and 15% of the allowed charges, while retirees under the age of 65 will be responsible for a deductible plus 20% of the allowed charges. As with TRICARE Standard, enrollment is not required.

042. What is TRICARE for Life?

 A_{42} . TRICARE for LIFE is a Medigap type program for uniformed service retirees and family members 65 or over and

enrolled in Medicare Part B. Enrollment is automatic with Medicare enrollment.

43. How can I learn more about TRICARF?

 $A_{43.}$ Contact your local TRICARE Service Center, or log on to www.tricare.osd.mil to learn more about this program. You may also contact the Caremark Customer Assistance Hotline at 1-800-331-7171.

Civilian Health and Medical Program of the Veterans Administration (CHAMPVA)

CHAMPVA provides medical coverage to dependents of completely disabled veterans or to dependents of deceased veterans who passed away as a direct result of a serviceassociated disability.

Q44. Will I lose my eligibility if I qualify for Medicare?

 $A_{
m 44.}$ No. If you are 65 years of age or older, and gualify for Medicare, you may be eligible for CHAMPVA for Life which is an extension of CHAMPVA benefits signed into law on June 5, 2001.

Q45. What costs am I responsible for?

 $A_{45.}$ If you receive care at VA healthcare facilities offering the CHAMPVA Inhouse Treatment Initiative (CITI) program, there is no cost share. However, if you receive care outside of the CITI program there is a deductible and a cost share. Note that due to the volume of veterans that they are serving, not all VA healthcare facilities participate in the CITI program.

*Q*46. How can I learn more about CHAMPVA?

 $A_{46.}$ Contact the VA's Health Administration Center, or log on to www.va.gov/hac/champva/champva.html to learn more about this program. You may also contact the Caremark Customer Assistance Hotline at 1-800-331-7171.

Medicaid

Medicaid is a state administered medical assistance program designed to provide medical care to individuals with limited income. The program is funded by a combination of federal, state and local monies.

Q47. How is Medicaid eligibility determined?

 $A_{
m 47.}$ Eligibility is based on a "means test," or a determination of an individual's or family's financial status or other qualifying status. Some states limit eligibility to a "strict" means test. (If income exceeds a maximum level, an applicant is not eligible for benefits.) Applicants with income under this level are considered "categorically needy" and are eligible for benefits. Other states have an additional category of eligible beneficiaries called "medically needy" for people whose income exceeds the maximum eligibility limit, but whose medical expenses reduce their income to within the eligibility levels. "Spend-downs" may be assigned to those individuals. After a designated amount of expenses has incurred, individuals may become eligible for Medicaid. At the point at which the maximum income level is reached, Medicaid will begin to pay for health costs. For example, if the maximum income for eligibility is \$1,000 per month, and the family's

income is \$1,500, with medical expenses of \$750, once the first \$500 is spent on healthcare, effectively bringing income to \$1,000, the remaining \$250 would be covered by Medicaid.

Temporary Assistance for Needy Families (TANF) is a Medicaid program specifically designed to assist families with dependent children. Eligibility is usually based on the family's financial status. TANF replaced the Aid to Families with Dependent Children (AFDC) program in 1997.

148. What benefits are provided?

 $\mathbf{q}_{48.}$ Each state must provide basic benefits established by the federal government in order to qualify as a Medicaid program, and receive federal funding. For example, each state must provide in-patient and out-patient hospital services and doctor services. Beyond these basic benefits, each state can design its own program to include, or exclude, such items as prescription drugs or eyeglasses.

- 249. Can I choose my provider of care?
- $\mathbf{q}_{49.}$ You can receive care from any provider who is a participant in the Medicaid program. If you are in a Medicaid Managed Care Plan, your choices may be further restricted to doctors and other healthcare providers who are part of the Managed Care Plan.

Q50. Who should I contact to learn more about the Medicaid Program?

A50. You may contact your state Medical Assistance office. Or, you may contact the Caremark Customer Assistance Hotline at 1-800-331-7171.

State Children's Health Insurance Program

The State Children's Health Insurance Program (CHIP), Title XXI of the Social Security Act, was enacted in 1997 to enable states to provide coverage to uninsured, low-income children, not currently covered under Medicaid. This program is especially designed to insure children from working families with incomes too high to gualify for Medicaid, but too little to afford private coverage. As an incentive, federal matching funds are provided to states that initiate this program. The eligibility standards define a low-income child as one whose family income is at or below 200% of the federal poverty level. States have the flexibility to create a new program or modify their existing Medicaid program.

Q51. What children are excluded from the Program?

 A_{51} . A child who is eligible for Medicaid, has health insurance, is covered under a group health plan, who is an inmate of a public institution or a patient in an institution for mental disease, or a child who is a member of a family that is eligible for health benefits coverage under a state health benefits plan on the basis of a family member's employment with a public agency in the state. Undocumented immigrant children are not eligible for coverage.

Q_{52} A_{52}

52. What is the cost to the family?

452. The purpose of the CHIP program is to provide low cost or no cost insurance for children. However, each state may implement the program in its own way. Check with your state Medical Assistance office for the costs in your state.

Q53. Is a child eligible for CHIP if other health insurance is available?

 A_{53} . Yes. In some states the availability of other health insurance may not prevent a child from participating in CHIP. However, there is a concern that the goal of this program to expand the total number of children who have health insurance may not be accomplished if children substitute public benefits for private sector benefits.

Q54. How can I learn more about CHIPs?

A54. To learn more about this program, contact your state Medical Assistance office. You may also contact the Caremark Customer Assistance Hotline at 1-800-331-7171

Children with Special Healthcare Needs

Although sometimes called by a slightly different name, almost all states have this type of program which, financed by state tax funds, and often supplemented by family co-payments, provides specialized medical care and rehabilitation to children with long-term catastrophic illnesses whose families are partially or wholly unable to provide for such services.

Q55. Who is eligible for this program?

A55. In those states that have this program, the program is usually available to anyone under the age of 21, who is a resident of the state, and has a longterm catastrophic illness which is eligible for care under the program, and whose family is unable to pay the full cost of recommended treatment. Examples of catastrophic illnesses include individuals with hemophilia, sickle cell anemia, etc.

Q56. If I have other insurance, can I still participate in this Program?

A56. It depends upon your state's program. Understanding that medical care can be very costly, and even a co-payment can create a financial hardship, some states provide secondary coverage for families whose primary health insurance covers less than 100% of charges.

$Q_{57.}$ What is the cost of this Program? $A_{57.}$ The cost will vary by state. However,

most programs base your share of cost on the family size, income tax liability, and program expenditures.

Q58. How can I learn more about this Program?

A58. Contact your state Medical Assistance office or the Caremark Customer Assistance Hotline at 1-800-331-7171.

AIDS Drug Assistance Program

The AIDS Drug Assistance Program (ADAP) provides medications to low-income individuals with HIV disease who have limited or no healthcare coverage from private insurance or Medicaid. All states, the District of Columbia, Puerto Rico, and the Virgin Islands have ADAP Programs.

259. Who is eligible?

4*59.* Each state develops its own income eligibility criteria, typically using the federal poverty level as a basis. Although medical eligibility also varies by state, most require individuals to simply provide proof of HIV diagnosis. However, some states require individuals to demonstrate disease progression, and others have specific criteria for access to protease inhibitors and/or antiretrovirals.

Q60. What drugs are available through ADAP?

A60. As with income and medical eligibility criteria, states are free to decide which drugs to include in their ADAP drug list, and how these drugs will be purchased and distributed to individuals in need.

Q61. How can I learn more about ADAP?

A61. Contact your state Medical Assistance office to learn more about this program. You may also contact the Caremark Customer Assistance Hotline at 1-800-331-7171.

Comprehensive Health Insurance Programs

These programs are mandated by state law and are designed to provide a health plan to individuals who are uninsurable on an individual basis and do not have access to any group or public health plan. Commonly referred to as "state high-risk pools," state Comprehensive Health Insurance Programs are an excellent safety net for individuals who have difficulty in purchasing adequate health insurance coverage due to a preexisting condition.

*Q*_{62.} Is this program available in all states?

 $A_{62.}$ No. Unfortunately, some states have chosen not to develop these programs.

${\it Q}$ 63. How is eligibility determined?

A63. While eligibility may vary from state to state, generally the participant must be a resident of the state and not eligible for COBRA benefits, and have been unable to secure coverage. You do not have to be indigent to qualify for this program. However, the state may limit the number of non-indigent enrollees in the program at any one time.

Q64. What are my costs?

A64. Costs will vary by state, but typically you will be responsible for a premium (generally 150% of the standard average individual rate for non-high risk individuals), deductible and coinsurance.

Q65. Are there annual or lifetime maximum benefits?

A65. Generally there are annual as well as lifetime benefits. Most states offer a lifetime benefit between \$500,000 and \$1,000,000.

Q66. What services are provided under this Program?

A66. Benefits will vary by state, however, usually they include in-patient and outpatient care, prescription drug coverage, diagnostic and x-rays, and preventative care.

Q67. Don't the HIPAA insurance reform provisions eliminate the need for these programs?

 A_{67} . While HIPAA enables people already with group insurance to have access to insurance if they switch jobs to a new employer that offers insurance, or in the individual insurance market, it does not address people who do not now have insurance or have limited access to insurance because of a medical condition. It also does not address the specific rates that can be charged people with health problems switching to new insurance plans that might be prohibitive.

Q68. Who do I contact for additional information?

A68. Contact your state Insurance Commissioner to learn more about availability of this program. You may also contact the Caremark Customer Assistance Hotline at 1-800-331-7171.

Laws That Affect Healthcare Benefits

Employment Retirement Income Security Act

The Employment Retirement Income Security Act (ERISA) sets uniform minimum standards to ensure that employee benefit plans are established and maintained in a fair and financially sound manner. These benefit plans include pension plans as well as welfare plans that are established and maintained to provide health benefits, disability benefits, death benefits, vacation benefits, day care centers, scholarship funds, etc. The provisions of ERISA cover most private sector employee benefit plans. In general, ERISA does not cover plans established or maintained by governmental entities or churches. Employers who fail to comply with ERISA-mandated requirements are subject to civil action.

To learn more about ERISA, contact the U.S. Department of Labor, Pension and Welfare Benefits Administration, or log on to www.dol.gov/dol/topic/health-plans/erisa.htm.

Consolidated Omnibus Budget Reconciliation Act

Since most individuals with health plan coverage receive health benefits through their employer, loss of employment could have tragic consequences. Approximately 90% of individuals with private health plan coverage receive their health benefits through their relationship with an employer. To protect these individuals from loss of coverage that may occur as a result of change or termination in employment, in 1985, Congress passed the Consolidated Omnibus Budget Reconciliation Act (COBRA). COBRA allows former employees, retirees, spouses and dependent children the right to temporary continuation of health coverage at group rates.

Q69. How do I know if my plan is covered by COBRA?

A69. The law generally covers group health plans maintained by employers with 20 or more employees. While it applies to plans in the private sector and those sponsored by state and local governments, it does not apply to plans sponsored by the federal government and certain church-related organizations.



70. When can I use COBRA?

A70. COBRA becomes effective when an individual loses their "qualifying status" for health insurance coverage because of a "qualifying event."These events are identified below.

Employee, Spouse, Dependent Child

- Termination of the covered employee's employment for any reason other than "gross misconduct"
- Reduction in the hours worked by the covered employee
- Employer's Chapter 11 bankruptcy (under some circumstances)
- Divorce or legal separation of the covered employee
- Death of the covered employee
- Covered employee becomes entitled to benefits under Medicare
- Loss of "dependent child" status under plan rules

Q71. How do I determine if I'm eligible to receive COBRA benefits?

A71. Generally, any individual covered by a qualified group health plan on the day before a "qualifying event" is considered eligible for COBRA benefits. This may include an employee, the employee's spouse and dependent children. In addition, any child born to, or placed for adoption with, a covered employee during a period of COBRA continuation coverage would be eligible.

Q72. Under COBRA, how long will my benefits continue?

 $A_{\it 72.}$ Although your employer's plan may provide longer periods of coverage, individuals generally are eligible for a maximum of 18 months for qualifying events due to employment termination or reduction of hours of work. Individuals who qualify for Social Security disability benefits can extend coverage an additional 11 months, for a total of 29 months. For loss of coverage due to Medicare entitlement, divorce or legal separation, death, or loss of "dependent child" status, coverage is available up to 36 months. If a "second" qualifying event (such as, death or a divorce) should occur within the 18/29 month maximum coverage period, then you would be eligible for a 36-month maximum coverage period from the date of the first qualifying event. Of course, you must pay your premiums as directed by your plan in order for coverage to continue.

273. How much will I have to pay to continue my benefits under COBRA?

 $A_{\it 73.}$ The law states that your premium cannot exceed 102% of the cost to the plan. This may be more than you were paying before your "gualifying event," since generally the employer pays a portion of the cost for group health insurance, along with the employee. For disabled individuals receiving an additional 11 months of coverage after the initial 18 months, the premium for those additional 11 months may be increased to 150% of the cost to the plan if the disabled individual was part of the coverage group (subscriber and dependent), but the limit could be 102% if only nondisabled individuals were in the coverage group. You are also responsible for any deductibles or co-payments.

Q74. Am I eligible for COBRA if I have other health insurance coverage?

A74. Yes and No. If you have Medicare or other group health plan coverage prior to the date of COBRA election, you may still be eligible for COBRA. You may have the right to continue with COBRA coverage even though you may be covered under another group health plan, or Medicare, at the time of the COBRA election. However, if you become covered under other group health plan coverage or entitled to Medicare benefits after the date of COBRA election, and the new plan does not have any exclusion or limitation with respect to any preexisting condition of the qualified beneficiary, then your employer has the right to cancel COBRA continuation coverage. If your employer does not cancel your COBRA coverage, you may continue your COBRA coverage subject

to the terms and conditions of all of the health plans under which you participate.

Q75. What are my options when COBRA coverage ends, and I still have no health insurance coverage?

 A_{75} . Some plans allow individuals to convert their group health coverage to an individual policy. If this option is available, you will be notified, and allowed to enroll in a conversion plan within 180 days before COBRA coverage ends. The premium is generally not at the group rate, and the benefits may not be as extensive. The opportunity to convert to an individual policy also relates to non-COBRA plans. You may also have conversion rights under HIPAA as discussed below.

\mathbf{Q} 76. How do I enroll in COBRA?

A76. Generally your employer or plan administrator must determine when a "qualifying event" has occurred. However, you are required to notify the plan administrator if the qualifying event is a divorce, legal separation or your dependent child ceases to be a dependent child under the plan terms. Notice must be provided within 60 days after the date of the qualifying event or the date you would lose coverage, whichever is later.

Q77. Am I eligible for COBRA if I am absent from work due to the Family and Medical Leave Act (FMLA)?

A77. The taking of FMLA leave is not itself considered a qualifying event. However, if a qualifying event occurs immediately prior to, or during, FMLA leave, and

you are unable to return to work at the end of the FMLA leave, then you would be eligible for COBRA continuation coverage.

Q78. If I allow my COBRA coverage to lapse, is my employer obligated to reinstate my coverage?

 A_{78} . No. Your employer is under no obligation to reinstate your coverage for COBRA. If you are a COBRA participant, it is critically important that you keep your premium payments up to date and that you keep a record that will allow you to prove your payments.

Q79. Who should I contact to learn more about COBRA?

A 79. You may contact the U.S. Department of Labor, your employer, or your plan administrator or log on to www.dol.gov/dol/topic/health-plans/cobra.htm to learn more about this program. You may also contact the Caremark Customer Assistance Hotline at 1-800-331-7171.

Health Insurance Portability and Accountability Act

For years, individuals with chronic medical conditions have suffered loss of health insurance as a result of a change or termination of employment. Passage of the federal Health Insurance Portability and Accountability Act (HIPAA) in 1996, helped reduce this anxiety. HIPAA limits exclusions for preexisting conditions, prohibits discrimination against employees and dependents based on their health status, guarantees renewability and availability of health coverage to certain employers and individuals, and protects many workers who lose health coverage by providing better access to individual health insurance coverage. In simple terms, a change in employment may no longer result in loss of health benefits for you and/or your family.

Q_{80.} Do the HIPAA insurance reform provisions apply to everyone?

Aso. HIPAA insurance reform provisions apply to employer-sponsored group health plans (with two or more current employees), insurance companies and health maintenance organizations (HMOs). They also apply to self-insured group health plans and union health plans.

Q81. How do I know if my illness is considered a preexisting condition?

As1. Under the HIPAA insurance reform provisions, if you have a medical condition, but have not received any medical advice, diagnosis, care or treatment within the 6 months prior to your enrollment date in the plan for that condition, then your old condition cannot be considered a "preexisting condition" for which an exclusion can apply. In addition, HIPAA mandates that preexisting condition exclusions cannot be applied to pregnancy.

Q82. How long can I be excluded from receiving benefits from a new health plan because of my preexisting condition?

As2. Thanks to HIPAA insurance reform provisions, a preexisting condition exclusion may not last for more than 12 months (18 months for late enrollees) after your enrollment date, and your new plan must provide you "credit" for the length of time that you had "continuous health coverage," (i.e., without a break of 63 days or more). If

the plan does apply a preexisting condition exclusion period, the plan must make a determination regarding your creditable coverage and the length of any preexisting condition exclusion period that applies to you. For example, if you already had 12 months of continuous health coverage with your previous health plan, you will not have to start over with a new 12-month exclusion. Therefore, you would be immediately eligible to receive benefits for your preexisting condition. In all health plans, a late enrollee is an individual who enrolls in a plan other than on either the earliest date on which coverage can become effective under the terms of the plan or on a special enrollment date.

Q83. How do I prove to my new health plan that I have "credit" and should not be subject to a preexisting condition exclusion period?

 $A_{\it 83.}$ A certificate of creditable coverage must be provided automatically to you by the plan or issuer when you lose coverage under the plan or become entitled to COBRA continuation coverage, and when your COBRA coverage ceases. You may also request a certificate within 24 months of when your coverage ceases. If you do not receive a certificate, other documentation can be used to demonstrate creditable coverage. Documentation, such as pay stubs reflecting deduction for health insurance, explanations of benefits (EOBs), or verification by a doctor can be used.

284. Can I be excluded from coverage based on my health status?

 A_{84} . No. Under the HIPAA insurance reform provisions, group health plans and issuers may not restrict enrollment based on "health status-related factors." These would include your health status, medical condition, claims experience, receipt of healthcare, medical history, genetic information, evidence of insurability, or disability.

Q85. Can I be required to pay more based on my health status?

 A_{85} . Yes and No. If you purchase individual health insurance, depending upon state law, insurers may be able to charge you more depending upon your health status. However, under HIPAA, group health plans may not require you to pay a premium or contribution greater than other similarly situated plan members based on your health status-related factor.

*Q*86. Can HIPAA help if I am unable to obtain group coverage?

- **A**86. Yes. The insurance reform provisions of HIPAA guarantee access to individual insurance if you:
 - have had coverage for at least 18 months where the most recent period of coverage was under a group health plan
 - were not terminated from group coverage because of fraud or nonpayment of premiums
 - are ineligible for COBRA or have exhausted COBRA benefits
 - are ineligible for coverage under another group health plan, Medicare or Medicaid or any other health insurance coverage

Q87. I've identified new individual health insurance, but the premium is too high. Can HIPAA help?

 A_{87} . No. The insurance reform provisions of HIPAA do not establish premium rates, but, as stated above, they do prohibit plans and issuers from charging you more than other individuals in the same plan, because of your health status.

Q_{88} A_{88}

88. What doesn't HIPAA do?

- **4**88. Although the insurance reform provisions of HIPAA provide you with greater protection than ever before, they do have the following limitations:
 - HIPAA does not require an employer to offer or pay for health insurance coverage.
 - HIPAA does not establish premium, co-payment, or deductible rates.
 - HIPAA does not mean that you can carry current health benefits or your current plan or policy with you when moving from one health plan or policy to another.
 - HIPAA does not require plans to offer specific benefits.
 - HIPAA does not stipulate that you will be able to keep your doctor if you change health coverage.
 - HIPAA will not provide credit for your previous coverage against the application of a preexisting condition exclusion period if a break of 63 or more days has occurred.

Q89. How can I learn more about the insurance reform provisions of HIPAA?

As9. You may contact the U.S. Department of Labor, your employer, or your plan administrator or log on to www.dol.gov/dol/topic/health-plans/portability.htm to learn more about this program. You may also contact the Caremark Customer Assistance Hotline at 1-800-331-7171.

Americans with Disabilities Act

In 1990, the Americans with Disabilities Act (ADA) was established to end broad-based and long-standing discrimination against people with disabilities in many aspects of life, including employment, public accommodations, education, transportation, communication, recreation, institutionalization, voting, access to public services, and health services.

Q90. What is the definition of a disability?

A90. The Act states that "disability" means a physical or mental impairment that substantially limits one or more of the major life activities of an individual. For example, the U.S. Supreme Court ruled that an HIV-infected patient whose infection has not progressed to the so-called "symptomatic phase" is disabled within the meaning of the ADA.

Q91. How can I learn more about ADA?

A91. You may contact the U.S. Department of Labor, your employer or your plan administrator or log on to www.usdoj.gov/crt/ada/adahom1.htm to learn more about ADA. You may also contact the Caremark Customer Assistance Hotline at 1-800-331-7171.



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