U.S. Directory of Health Coverage Options

How to use this Directory:

Use the Income Worksheet(page "iii") to determine the Federal Poverty Level percentage of you or the person whom you are trying to assist. This percentage usually determines if an individual is eligible for various public programs.

Find your state's Health Coverage Options Matrix for a complete list of private and public health coverage programs, along with additional valuable resources.

Consult the Appendices for our QR code, state-by-state program contact information, uninsured statistics for each state, as well as the glossary of terms found within this book.

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U.S. Directory of Health Coverage Options

A state-by-state guide to helping Americans navigate their public and private health coverage options

CREATED BY

Phil Lebherz

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Foundation for Health Coverage Education

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I want to dedicate this book to the thousands of workers in the private and public health insurance systems across the country who are attempting to reach our goal of lowering the number of uninsured people in America. I especially want to thank Leonard Schaeffer who provided his knowledge, inspiration, and vision to this project.

- Phil Lebherz

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San Francisco Chronicle
Self Magazine
Smart Money, AOL Money & Finance
The Angie Strader Show
The New York Times
The Wall Street Journal
The Washington Post
USA Today
U.S. News & World Report

INCOME WORKSHEET

Step One

Use this worksheet to calculate your family or household total income after deductions.

Step Two

Look for the income amount closest to the number in step one within the chart on the opposite page to determine which percentage of the Federal Poverty Level (FPL) you are.

Step Three

Remember this percentage, as it will help you determine for which public programs you are eligible.

Your monthly income	+	_____
Spouse's monthly income	+	_____
TOTAL INCOME	=	_____

Please fill in the following information, separate from amount that you just calculated:

Begin with $0. For each working parent in the household, add $90.	+	_____
If you pay for childcare for children under the age of 2, add $200 for each child.	+	_____
If you pay for childcare for children over the age of 2, or for a child with disabilities, add $175 for each child.	+	_____
If you receive child support, add $50 for each child.	+	_____
If you pay alimony and/or child support, enter the amount.	+	_____
TOTAL DEDUCTIONS	=	_____

Now, subtract your Total Deductions from your Total Income.

TOTAL INCOME		_____
TOTAL DEDUCTIONS	-	_____

TOTAL INCOME AFTER DEDUCTIONS = _____

Find an amount closest to this total within the chart on the opposite page to determine your Federal Poverty Level (FPL) percentage.

Note: This income worksheet is only intended to serve as a guide. Some factors in determining your eligibility may not be represented above. Deductions listed here are typical for most public programs, but may vary by agency.

FEDERAL POVERTY LEVEL CHART

Your Federal Poverty Level (FPL) Based on monthly family gross income							
Family Size (House-hold)	**100%**	**133%**	**175%**	**200%**	**250%**	**300%**	**400%**
1	$931	$1,238	$1,629	$1,862	$2,327	$2,793	$3,723
2	$1,261	$1,677	$2,206	$2,522	$3,152	$3,783	$5,043
3	$1,591	$2,116	$2,784	$3,182	$3,977	$4,773	$6,363
4	$1,921	$2,555	$3,361	$3,842	$4,802	$5,763	$7,683
5	$2,251	$2,994	$3,939	$4,502	$5,627	$6,753	$9,003
6	$2,581	$3,433	$4,516	$5,162	$6,452	$7,743	$10,323
7	$2,911	$3,871	$5,094	$5,822	$7,277	$8,733	$11,643
8	$3,241	$4,310	$5,671	$6,482	$8,102	$9,723	$12,963
Based on yearly family gross income							
1	$11,170	$14,856	$19,548	$22,340	$27,925	$33,510	$44,680
2	$15,130	$20,123	$26,478	$30,260	$37,825	$45,390	$60,520
3	$19,090	$25,390	$33,408	$38,180	$47,725	$57,270	$76,360
4	$23,050	$30,657	$40,338	$46,100	$57,625	$69,150	$92,200
5	$27,010	$35,923	$47,268	$54,020	$67,525	$81,030	$108,040
6	$30,970	$41,190	$54,198	$61,940	$77,425	$92,910	$123,880
7	$34,930	$46,457	$61,128	$69,860	$87,325	$104,790	$139,720
8	$38,890	$51,724	$68,058	$77,780	$97,225	$116,670	$155,560

- A pregnant woman counts as two for the purpose of this chart.
- Add $330/month for each additional family member after eight.
- Contact individual programs for deduction allowances on child/dependent care; working parent's work expenses; alimony/child support *received* or court ordered amount *paid*.

The following figures are the 2012 HHS poverty guidelines as of January 26, 2012. (Source: http://aspe.hhs.gov/poverty/12poverty.shtml)
Monthly percentage data calculated by FHCE and rounded to the nearest dollar.
Please visit www.CoverageForAll.org for further details and updates on the 48 continuous states, Hawaii and Alaska FPL charts.

Reminder

There is no universal administrative definition of income that is valid for all programs that use the poverty guidelines. The office or organization that administers a particular program or activity is responsible for making decisions about the definition of income used by that program (to the extent that the definition is not already contained in legislation or regulation). To find out the specific definition of income used by a particular program or activity, you must consult the office or organization that administers that program.

PRIVATE HEALTH INSURANCE

Demographic	Small Businesses (2-50 Employees)	Individuals Recently Covered by an Employer Health Plan	Individuals & Families	Individuals with Pre-Existing, Severe, or Chronic Medical Conditions	Low-Income Individuals & Families
Program	**Group Plans** National Association of Health Underwriters 202-552-5060 www.nahu.org	**COBRA** Contact your current carrier. After 18 months continuous group/COBRA coverage, convert to a plan under: **HIPAA** Health Insurance Portability & Accountability Act 866-487-2365 www.dol.gov (Search: HIPAA) **HIPP** Health Insurance Premium Payment Program 855-692-5447 www.myalhipp.com	**Individual Plans** National Association of Health Underwriters 202-552-5060 www.nahu.org	**Alabama Health Insurance Plan (AHIP)** 866-833-3375 334-263-8311 www.alseib.org **Pre-Existing Condition Insurance Plan (PCIP)** Run by the U.S. Department of Health and Human Services 866-717-5826 www.PCIP.gov www.pciplan.com	**Medicaid (SOBRA & MLIF)** 334-242-5000 800-362-1504 insurealabama.adph.state.al.us
Coverage	There is a maximum 6-month look-back/12-month exclusionary period for pre-existing conditions on enrollees that do not have prior coverage. Benefits will vary depending on the chosen plan. ***Pre-Existing Health Conditions Covered***	**COBRA:** Coverage available for 18–36 months depending on qualifying events. Benefits are what you had with your previous employer. **HIPAA:** Benefits are based on program selected. There is no expiration of coverage. **HIPP:** Premium assistance that pays employer-sponsored health insurance or COBRA premiums. The assistance amount depends on the most cost-effective premium available. ***Pre-Existing Health Conditions Covered***	Assorted plans depending on medical needs. There is a maximum look-back period of 60 months and a maximum exclusion period of 24 months for pre-existing conditions on enrollees that do not have prior coverage. Elimination riders are permitted. ***Limits on Pre-Existing Health Conditions May Apply***	**AHIP:** Two plans offered: indemnity and managed care. Both cover Prescription drugs, Outpatient and in-patient care, Durable medical equipment, Mental health, Substance abuse, and Away-from-home emergency care. Managed care also covers Labs, X-rays, Transplants, Maternity, and Rehabilitation care. **PCIP:** Covers broad range of benefits, including primary and specialty care, hospital care, and prescription drugs. ***Pre-Existing Health Conditions Covered***	**Medicaid (SOBRA & MLIF):** Ambulatory surgical center, Birth center services, Child health check-up, Chiropractic care, Durable medical equipment and supplies, Federally qualified health centers, Home health, Hospital inpatient/outpatient care, Laboratory, Licensed midwife, Physician, Podiatry, Prescriptions, Rural health clinics, Therapy, and X-rays. Retroactive benefits available at the time of application for medical services received three months prior. **SOBRA:** Pregnant women ONLY get pregnancy-related services. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Company size 2-50 employees. Eligible employees must work at least 30 hours a week. Owner can count as an employee. Owner name on business license must draw wages from the company.	**GUARANTEED COVERAGE** **COBRA:** Available for employees who work for businesses with 20 or more employees. Have 60 days from date of termination to sign-up. **HIPAA:** Must have had 18 months of continuous coverage and completely exhausted COBRA or state continuation coverage. Must not have lost coverage due to fraud or non-payment of premiums. You have 63 days to enroll. **HIPP:** Must qualify for Medicaid and have access to Employer-Sponsored Insurance or COBRA.	Eligibility is subject to medical underwriting. If you are denied coverage for a medical condition, you may be eligible for AHIP, or PCIP.	**GUARANTEED COVERAGE** **AHIP:** Must be a permanent Alabama resident with at least 18 months of continuous coverage without being terminated due to fraud or failure to pay and be HIPAA eligible. AHIP is specifically aimed at those who have purchased coverage from their employer and whose benefits have run out. **PCIP:** Must have been uninsured for at least 6 months prior to applying. Must prove being a U.S. citizen or legal U.S. resident, an Alabama resident, and having problems getting insurance due to a pre-existing condition.	**GUARANTEED COVERAGE** **Medicaid (SOBRA & MLIF):** Must be a U.S. citizen or legal alien and an Alabama resident. Income Limits: Pregnant Women: 133% FPL. Children Ages 0–5: 133% FPL. Children Ages 6–18: 100% FPL. Parents/Caretakers Living with Children Ages 0–18: 24% FPL. Low-Income Families: 11% FPL Aged, Blind & Disabled: Singles with incomes up to 75% FPL and asset limit of $2,000, and couples with incomes up to 83% FPL with asset limit of $3,000. Elderly & Disabled: If eligible for nursing home: 225% FPL, resource limit of $2,000 **SOBRA:** Must not be eligible for ALL Kids.
Monthly Cost	Costs depend on employer contribution and ± 20% of the insurance company's index rate.	**COBRA:** 102%–150% of group health rates. **HIPAA:** Premiums will depend on plan chosen. **HIPP:** Reimburses the full employer-sponsored insurance premium amount by check monthly. Pays the insurance company directly for people on COBRA or eligible small businesses.	Costs for individual coverage vary. There are no rate caps.	**AHIP: Traditional Indemnity Plan** premiums could range between $147 to $1,172 depending on age, gender, smoker or non-smoker, and plan chosen. **Managed Care Plan** premiums could range between $255 to $1,089 depending on age, gender, and smoker or non-smoker. **PCIP:** $110 to $471 depending on your age.	**Medicaid: $0–$3** for office visits, prescription drugs and some other services. **SOBRA: $50** co-payment for each inpatient hospital stay.

PUBLICLY-SPONSORED PROGRAMS

Demographic	Children in Moderate Income Families	Women	Seniors & Disabled	Trade Dislocated Workers (TAA Recipients)	Veterans
Program	**ALL Kids** 888-373-5437 334-206-5568 877-774-9521 insurealabama.adph.state.al.us www.adph.org/allkids	**Breast & Cervical Cancer Early Detection Program (ABCCEDP)** 877-252-3324 www.adph.org/earlydetection **Plan First** (Family Planning) 888-737-2083 www.adph.org/planfirst	**Medicare** 800-633-4227 www.medicare.gov **Medicare Prescription Drug Program** 800-633-4227 **Alabama State Health Insurance Assistance Program (ASHIAP)** 800-243-5463	**Health Coverage Tax Credit** 866-628-4282 www.irs.gov (Search: HCTC)	**VA Medical Benefits Package** 877-222-8387 www.va.gov www.ebenefits.va.gov
Coverage	Coverage will begin on the first day of the month after application is received. Benefits include 12 months continuous coverage, doctor visits, check-ups, hospital and physician care, immunizations, prescriptions, dental and vision care, emergency services, and mental health/substance abuse services with dedicated phone number available 24 hours a day, 7 days a week. ***Pre-Existing Health Conditions Covered***	**ABCCEDP:** Pelvic exam, Pap smear, Clinical breast exam, Mammogram, and Diagnostic services, such as an ultrasound, colonoscopy, or biopsy, if needed. **Plan First:** Yearly family planning exams, Care support from a social worker or nurse, Some types of birth control (such as birth control pills and Depo-Provera shots), Tubal ligation (tube tying) for women 21 years or older, Lab work (pregnancy and STD testing), and Family planning help.	**Medicare** offers Part A, inpatient care in hospitals and rehabilitative centers; Part B, doctor and some preventive services and outpatient care; Part C allows Medicare benefits through private insurance (Medicare Advantage); Part C includes Parts A, B, and C not covered by Medicare. Part D covers prescription drugs. **ASHIAP** is a Medicare counseling service. ***Pre-Existing Health Conditions Covered***	Inpatient and outpatient care (lab tests, x-rays, etc.), Doctor visits, Preventive and major medical care (surgery, physical therapy, Durable medical equipment, etc.), Mental health and substance abuse care, and Prescription drugs. ***Pre-Existing Health Conditions Covered***	Comprehensive preventive and primary care, outpatient and inpatient services. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Must be under the age of 19 and an Alabama resident and U.S. citizen or eligible immigrant, not be covered by any other health insurance, not be in an institution and be ineligible for Medicaid. Income Limits: Children Ages 0–5: 133%–300% FPL. Children Ages 6–18: 100%-300% FPL.	**GUARANTEED COVERAGE** **ABCCEDP:** Women without insurance or who are underinsured ages 40–64, earning up to 200% FPL. Women under age 40 who have problems with their breasts can undergo a clinical breast exam to determine if they are eligible to receive a free breast cancer screening through the program. **Plan First:** Must be a U.S. citizen or legal alien and an Alabama resident. Must be a woman between the ages of 19 and 55 with an income limit of 133% FPL and have not had surgery to prevent pregnancy.	**GUARANTEED COVERAGE** **Medicare & ASHIAP:** Must be U.S. citizen or permanent U.S. resident, and: 1) If 65 years or older, you or your spouse worked for at least 10 years in Medicare-covered employment, or 2) You have a disability or end-stage renal disease (permanent kidney failure requiring dialysis or transplant) at any age.	**GUARANTEED COVERAGE** Must be receiving TAA (Trade Adjustment Assistance), or Must be 55 years or older and receiving pension from the Pension Benefit Guaranty Corporation (PBGC). Must not be enrolled in certain state plans, or in prison, or receiving 65% COBRA premium reduction, or be claimed as a dependent in tax returns. Must be enrolled in qualified health plans where you pay more than 50% of the premiums. Individuals who are eligible for the federal Health Care Tax Credit can also use their credit funds to purchase a private health insurance product developed by Blue Cross Blue Shield of Alabama.	**GUARANTEED COVERAGE** "Veteran status" = active duty in the U.S. military, naval, or air service and a discharge or release from active military service under other than dishonorable conditions. Certain veterans must have completed 24 continuous months of service.
Monthly Cost	**$0** or small co-pays. Yearly costs range from $52 to $104 per child up to the first 3 children (no cost for additional children). Small co-pays are required at the time of service. There are no co-pays for preventive services.	**ABCCEDP: $0** or minimal share of cost. **Plan First: $0** for family planning services only.	**Medicare: $0** and share of cost for certain services; deductibles for certain plans. Part A: $0–$451 based on length of Medicare-covered employment; Part B: $99.90-$319.70 depending on annual income; Part C: Based on provider; Part D: Varies in cost and drugs covered. **ASHIAP: $0**	**27.5%** of the insurance premium, including COBRA premium if employer contributes less than 50%.	**$0** and share of cost and co-pays depending on income level.

PRIVATE HEALTH INSURANCE

Demographic	Small Businesses (2-50 Employees)	Individuals Recently Covered by an Employer Health Plan	Individuals & Families	Individuals with Pre-Existing, Severe, or Chronic Medical Conditions	Low-Income Children & Families
Program	**Group Plans** Alaska Association of Health Underwriters www.alaskaahu.org	**COBRA** Contact your current carrier. After 18 months continuous group/COBRA coverage, convert to a plan under: **HIPAA** Health Insurance Portability & Accountability Act 866-487-2365 www.dol.gov (Search: HIPAA)	**Individual Plans** Alaska Association of Health Underwriters www.alaskaahu.org	**Alaska Comprehensive Health Insurance Association (ACHIA)** 888-290-0616 www.achia.com **Pre-Existing Condition Insurance Plan (PCIP)** Federal program run by ACHIA 877-505-0510 www.PCIP.gov www.achia.com/ACHIA-FED	**Medicaid** 907-465-3347 800-780-9972 www.hss.state.ak.us (Search: Medicaid)
Coverage	There is a 6-month look-back/12-month exclusionary period for pre-existing conditions if enrollee had no prior coverage, or if prior coverage had a break of more than 63 days. Group coverage as selected by employer with a variety of plan designs available. ***Pre-Existing Health Conditions Covered***	**COBRA:** Coverage available for 18–36 months depending on qualifying events. Benefits are what you had with your previous employer. **HIPAA:** Benefits are based on program selected. There is no expiration of coverage. ***Pre-Existing Health Conditions Covered***	Assorted deductible and plan design options for selection. There are no limits to look-back and exclusionary periods for pre-existing conditions. ***Limits on Pre-Existing Health Conditions May Apply***	**ACHIA:** Offers 6 different comprehensive PPO plans with different deductibles. Offers one traditional non-PPO plan paying 80% of the allowed charges after the $1,000 annual deductible is satisfied. After deductible and out-of-pocket maximum have been satisfied, ACHIA will pay claims at 100%. **PCIP:** Inpatient and outpatient hospital services, physician services, prescription drugs, skilled nursing, home health, hospice, chemotherapy, anesthesia, prosthesis, durable medical equipment, x-rays and laboratory services, oral surgery, physical therapy, substance abuse treatment, mental health services, ambulance, maternity, PKU formula, Pap smear and mammograms. ***Pre-Existing Health Conditions Covered***	Inpatient and outpatient hospital services, Mental health and substance abuse care, Rural health clinics, Nurse, Midwife, Dentist, Optometrist, Physician care, Prescription drugs, Physical therapy, Medical equipment and devices (prosthetics, eyeglasses, dentures, etc.), Preventive care and diagnostic services, Family planning, Labs and x-rays, Home health services (such as nursing services, home health aides). Retroactive benefits available at the time of application for medical services received three months prior. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Company size 2–50. Eligible employees must work at least 30 hours a week. Owner can count as an employee. Proprietor name on license must draw wages.	**GUARANTEED COVERAGE** **COBRA:** Available for employees who work for businesses with 20 or more employees. You have 60 days from date of termination to sign-up. **HIPAA:** Must have had 18 months of continuous coverage and completely exhausted COBRA or state continuation coverage. Must not have lost coverage due to fraud or non-payment of premiums. You have 63 days to enroll.	Eligibility is subject to medical underwriting. If you are denied coverage for a medical condition, you may be eligible for an Alaska Comprehensive Health Insurance Association plan, or PCIP. See next column.	**GUARANTEED COVERAGE** **ACHIA:** Must be a U.S. citizen or legal resident living in Alaska and at least one of the following: 1) You were rejected for health insurance in the last 6 months, or received restrictive riders that reduced coverage, or 2) You have a qualified pre-existing condition, or 3) You have exhausted COBRA, are uninsured, not eligible for any group coverage from private or public sources (e.g. Medicaid, IHS/Native Health Care, etc.), and you were covered under a group health plan in the prior 18 months with no break of more than 90 days, or 4) You are receiving Trade Adjustment Assistance (TAA). **PCIP:** Must have been uninsured for at least 6 months prior to applying. Must prove being a U.S. citizen or legal U.S. resident, an Alaska resident, and having problems getting insurance due to a pre-existing condition.	**GUARANTEED COVERAGE** Must be U.S. citizen or qualified alien and Alaska resident. Income Limits: Family: 185% FPL. Working Disabled: 250% FPL. Aged, Blind & Disabled: Singles with asset limit of $2,000, and couples with asset limit of $3,000. For pregnant women and children, refer to Denali KidCare
Monthly Cost	Costs depend on employer contribution and ± 35% of the insurance company's index rate.	**COBRA:** 102%-150% of group health rates. **HIPAA:** Premiums will depend on plan chosen.	Costs vary dependent on age and medical underwriting. There are no rate caps.	**ACHIA:** $107-$3,218 depending on your age and plan chosen. **PCIP:** $504 to $2,094	**$0** or minimal share of cost. **$50–$200** per day for hospital admission (except for mental institutions).

PUBLICLY-SPONSORED PROGRAMS

Demographic	Moderate Income Children & Families	Adults with Chronic Medical Conditions	Native Americans	Seniors & Disabled	Trade Dislocated Workers (TAA Recipients)
Program	**Denali KidCare** Toll-Free Outside Anchorage 888-318-8890 Anchorage Area 907-269-6529 www.hss.state.ak.us (Search: Denali KidCare)	**Chronic & Acute Medical Assistance (CAMA)** 800-780-9972 www.hss.state.ak.us (Search: CAMA) Or contact the Division of Public Assistance office nearest you.	**Indian Health Services (IHS)** (Alaska Area) 907-729-3686 www.ihs.gov (Search: Alaska)	**Medicare** 800-633-4227 www.medicare.gov **Medicare Prescription Drug Program** 800-633-4227	**Health Coverage Tax Credit** 866-628-4282 www.irs.gov (Search: HCTC)
Coverage	Prevention and treatment services such as: Doctor's visits, Check-ups and screenings, Vision exams and eyeglasses, Dental checkups, Cleanings and fillings, Hearing tests and Hearing aids, Speech therapy, Physical and Mental health therapy, Substance abuse treatment, Chiropractic care, Foot doctor's services, Hospital care, Laboratory tests, Prescriptions, and Medical transportation. ***Pre-Existing Health Conditions Covered***	Prescription drugs and medical supplies, limited to 3 prescriptions per month and no more than a 30-day supply of any drug. Physician services which are directly related to the medical condition that qualifies you for CAMA. Chemotherapy and radiation services for a recipient with cancer requiring chemotherapy, if provided in an outpatient setting. Outpatient laboratory and x-ray services. ***Pre-Existing Health Conditions Covered***	IHS services are provided directly and through tribally-contracted and operated health programs. From private care sources, tribal health programs purchase services for Native American patients in areas where IHS facilities or services are not readily available. IHS-funded, tribally-managed hospitals are located in Anchorage, Barrow, Bethel, Dillingham, Kotzebue, Nome and Sitka. There are 37 tribal health centers, 166 tribal community health aide clinics and five residential substance abuse treatment centers. ***Pre-Existing Health Conditions Covered***	**Medicare** offers Part A, inpatient care in hospitals and rehabilitative centers; Part B, doctor and some preventive services and outpatient care; Part C allows Medicare benefits through private insurance (Medicare Advantage); Part C includes Parts A, B, and C not covered by Medicare. Part D covers prescription drugs. ***Pre-Existing Health Conditions Covered***	Inpatient and outpatient care (lab tests, x-rays, etc.), Doctor visits, Preventive and major medical care (surgery, physical therapy, Durable medical equipment, etc.), Mental health and substance abuse care, and Prescription drugs. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Must be a U.S. citizen and Alaska resident. Income Limits: Children Ages 0–18 with health insurance: 150% FPL. Children Ages 0–18 with no health insurance: 175% FPL. Pregnant with proof of pregnancy from your health care provider with or without health insurance: 175% FPL.	**GUARANTEED COVERAGE** Must be a U.S. citizen or legal alien and resident of Alaska, and have one of following: a terminal illness; cancer requiring chemotherapy; chronic diabetes or diabetes insipidus; chronic seizure disorders; chronic mental illness; chronic hypertension. Must have no other resources to meet the health care you need. Income limit per household: At or less than $300 a month for one person. At or less than $400 a month for two people. Add $100 for each additional person. Must have $500 or less in countable resources that could be used to pay medical bills: cash, bank/credit union accounts, or personal property. CAMA does not count your home, one vehicle, income-producing property, property that is used for your job (boat, fishing gear, etc.), or a fishing permit.	**GUARANTEED COVERAGE** Must exhaust all private, state, and other federal programs. Must be regarded by the local community as an Indian; be a member of an Indian or Alaska Native Tribe or Group under Federal supervision; reside on tax-exempt land or own restricted property; actively participate in tribal affairs; any other reasonable factor indicative of Indian descent; be a non-Indian woman pregnant with an eligible Indian's child for the duration of her pregnancy through post-partum (usually 6 weeks); be a non-Indian member of an eligible Indian's household and the medical officer in charge determines that services are necessary to control a public health hazard or an acute infectious disease which constitutes a public health hazard.	**GUARANTEED COVERAGE** Must be U.S. citizen or permanent U.S. resident, and: 1) If 65 years or older, you or your spouse worked for at least 10 years in Medicare-covered employment, or 2) You have a disability or end-stage renal disease (permanent kidney failure requiring dialysis or transplant) at any age.	**GUARANTEED COVERAGE** Must be receiving TAA (Trade Adjustment Assistance), or Must be 55 years or older and receiving pension from the Pension Benefit Guaranty Corporation (PBGC). Must not be enrolled in certain state plans, or in prison, or receiving 65% COBRA premium reduction, or be claimed as a dependent in tax returns. Must be enrolled in qualified health plans where you pay more than 50% of the premiums.
Monthly Cost	**$0** for eligible children, teens, and pregnant women. 18-year-olds may be required to share a limited amount of the cost for some services.	**$0** or minimal share of cost. **$0** and **$1** per prescription or medical supply.	**$0** or minimal share of cost.	**$0** and share of cost for certain services; deductibles for certain plans. Part A: 0-$451 based on length of Medicare-covered employment; Part B: $99.90-$319.70 depending on annual income; Part C: Based on provider; Part D: Varies in cost and drugs covered.	**27.5%** of the insurance premium including COBRA premium if employer contributes less than 50%.

Demographic	PRIVATE HEALTH INSURANCE				
	Small Businesses (2-50 Employees)	**Individuals Recently Covered by an Employer Health Plan**	**Individuals & Families**	**Individuals with Pre-Existing, Severe, or Chronic Medical Conditions**	**Low-Income Families & Adults**
Program	**Group Plans** National Association of Health Underwriters 202-552-5060 www.nahu.org **Health Care Group of Arizona (HCG)** www.hcgaz.com 602-417-6755	**COBRA** Contact your current carrier. After 18 months continuous group/ COBRA coverage, convert to a plan under: **HIPAA** Health Insurance Portability & Accountability Act 866-487-2365 www.dol.gov (Search: HIPAA)	**Individual Plans** National Association of Health Underwriters 202-552-5060 www.nahu.org	**Pre-Existing Condition Insurance Plan (PCIP)** Run by the U.S. Department of Health and Human Services 866-717-5826 www.PCIP.gov www.pciplan.com	**AHCCCS** Arizona Health Care Cost Containment System (Arizona's Medicaid) 602-417-4000 800-654-8713 www.ahcccs.state.az.us New enrollment is currently "frozen" for childless adults. Childless adults who are already on the AHCCCS Care program will still receive medical services from AHCCCS, but only as long as they stay eligible for AHCCCS **SOBRA Child** 602-417-4000 602-542-9935 www.ahcccs.state.az.us (Search: SOBRA)
Coverage	There is a 6-month look-back/12-month exclusionary period for pre-existing conditions on enrollees that do not have prior coverage. Benefits will vary depending on the chosen plan. ***Pre-Existing Health Conditions Covered***	**COBRA:** Coverage available for 18–36 months depending on qualifying events. Benefits are what you had with your previous employer. **HIPAA:** Benefits are based on program selected. There is no expiration of coverage. ***Pre-Existing Health Conditions Covered***	Up to $5M. Assorted deductibles depending on age and ZIP code. There are no limits to the look-back and exclusion periods on pre-existing conditions. Elimination riders are allowed. ***Limits on Pre-Existing Health Conditions May Apply***	Covers broad range of benefits, including primary and specialty care, hospital care, and prescription drugs. ***Pre-Existing Health Conditions Covered***	**Both:** Preventive care, Doctor's visits, Hospital services, Lab and x-rays, Emergency care, Family planning, Dialysis, Surgery, Behavioral health services, Podiatry, pregnancy, immunizations, physical exams, annual well-woman exams, specialist care, Prescription drugs for non-Medicare recipients. Children under 21 also receive dental, vision, hearing services, and Early and Periodic Screening Diagnosis and Treatment (EPSDT). Retroactive benefits available at the time of application for medical services received three months prior. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Company size 2–50 employees. Eligible employees must work at least 20 hours a week. Owner can count as an employee. Owner name on business license must draw wages from the company. **HCG:** Must be an active small business for at least 60 days, without health coverage for 90 days, provide proof of revenue, meet "bare period" (the 3-month period without insurance, after the employer's health insurance coverage has been discontinued) requirements, have 2-50 eligible employees.	**GUARANTEED COVERAGE** **COBRA:** Available for employees who work for businesses with 20 or more employees. You have 60 days from date of termination to sign-up. **HIPAA:** Must have had 18 months of continuous coverage and completely exhausted COBRA or state continuation coverage. Must not have lost coverage due to fraud or non-payment of premiums. You have 63 days to enroll.	Eligibility is subject to medical underwriting. If you are denied coverage for a medical condition, you may be eligible for PCIP. To learn more, see next column.	**GUARANTEED COVERAGE** Must have been uninsured for at least 6 months prior to applying. Must prove being a U.S. citizen or legal U.S. resident, an Arizona resident, and having problems getting insurance due to a pre-existing condition.	**GUARANTEED COVERAGE** **Both:** Must be an Arizona resident and a U.S. citizen or permanent resident. **AHCCCS:** Income Limits: Children Ages 0–5: Family income up to 133% FPL. Children Ages 6–19: Family income up to 100% FPL. Pregnant Women: Up to 200% FPL. Childless Adults: Up to 100% FPL. Parents/Caretakers Living with their Children ages 0–18: Up to 100% FPL. Aged, Blind & Disabled: Up to 100% FPL. **SOBRA:** Income Limits: Pregnant Women Not Living with Spouse or Parents: 200% FPL Children Ages 0-1: 140% FPL Children Ages 1-5: 133% FPL Children Ages 6-18: 100% FPL
Monthly Cost	Costs depend on employer contribution and ± 60% of the insurance company's index rate based on the health status of the group. **HCG:** Premiums depend on age, gender, group size, and business location.	**COBRA:** 102%–150% of group health rates. **HIPAA:** Premiums will depend on plan chosen.	Costs for individual coverage vary. There are no rate caps.	$104 to $450 depending on your age and plan chosen.	**$0** or minimal share of cost. $0-$30 co-pays.

PUBLICLY-SPONSORED PROGRAMS

Demographic	Children in Moderate Income Families	Women in Need of Cancer Screening	Pregnant Women & Children	Native Americans	Seniors & Disabled
Program	**KidsCare** 877- 764-5437 602- 417-5437 www.kidscare.state.az.us (An enrollment cap is in place for KidsCare due to a lack of funding. Individuals and families can still apply and be placed on a waiting list, and they will be contacted when funding becomes available.) **KidsCare II** 877- 764-5437 602- 417-5437 www.azahcccs.gov (Search: KidsCare II) KidsCare II is currently frozen, but applications continue to be reviewed and applicants will be placed on the waitlist if eligible.	**Well Woman HealthCheck Program** Run by the Arizona Department of Health Services 602-542-1219 azdhs.gov (Search: BCCTP)	**Baby Arizona** 800-833-4642 www.babyarizona.gov	**Indian Health Services (IHS)** **Navajo** 928-871-4811 www.ihs.gov/Navajo **Phoenix Area** 602-364-5179 www.ihs.gov/Phoenix **Tucson Area** 520-295-2405 www.ihs.gov/Tucson	**Medicare** 800-633-4227 www.medicare.gov **Medicare Prescription Drug Program** 800-633-4227
Coverage	**Both:** Doctor's visits, Immunizations, Prescriptions, Lab & x-rays, Early and Periodic Screening Diagnosis and Treatment (EPSDT), Specialist care, Hospital Services, Emergency Care, Physical exams, Behavior health, and more. ***Pre-Existing Health Conditions Covered***	Cancer screening for women, such as clinical breast exams, mammograms, pelvic exams and Pap smear tests. Provides financial help to women who are diagnosed with breast cancer through the program and are unable to qualify for other assistance or to pay for treatment on their own. ***Pre-Existing Health Conditions Covered***	Gives prenatal care to pregnant women while they wait to see if they are eligible for AHCCCS Health Insurance. Staff will put the woman in touch with a doctor in her area that will help her apply for AHCCCS Health Insurance. ***Pre-Existing Health Conditions Covered***	Available programs vary depending on health center and may include primary and child care, prenatal and post delivery care, family planning (birth control), minor surgical and orthopedic care, pharmacy, dental and orthodontics, optometry, nursing, mental health, laboratory and radiology. ***Pre-Existing Health Conditions Covered***	**Medicare** offers Part A, inpatient care in hospitals and rehabilitative centers; Part B, doctor and some preventive services and outpatient care; Part C allows Medicare benefits through private insurance (Medicare Advantage); Part C includes Parts A, B, and C not covered by Medicare. Part D covers prescription drugs. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** **Both:** Must be an Arizona resident and U.S. citizen or a qualified immigrant, under age 19, and ineligible for no-cost Medicaid or employer-based coverage, with no health insurance for the last 3 months at time of application. Must have or apply for a Social Security Number. **KidsCare:** Must have income at or below 200% FPL. Parents with incomes of 200% FPL can also qualify. **KidsCare II:** Must meet KidsCare requirements and have income under 175% FPL. Must currently be on the KidsCare waitlist and has received notice to apply for KidsCare II.	**GUARANTEED COVERAGE** Must be a woman with income at or below 250% FPL. Must have no insurance, or have insurance that does not cover preventive services or that has a high deductible (as determined by the program). For breast cancer screening, patient must be at least 40 years old or any age with qualifying symptoms. For cervical cancer screening, patient must be at least 18 years old. Women screened by the Well Woman HealthCheck Program that are under age 65, who are legal residents of the U.S. and do not have credible coverage may qualify for treatment through AHCCCS.	**GUARANTEED COVERAGE** Must be an Arizona resident and U.S. citizen or qualified non-citizen. For pregnant women, the income limit is 150% FPL. If the mother ends up NOT qualified for AHCCCS due to income, then it's possible to get coverage through KidsCare (see "Children in Moderate Income Families" column).	**GUARANTEED COVERAGE** Must exhaust all private, state, and other federal programs. Must be regarded by the local community as an Indian; is a member of an Indian or Group under Federal supervision; resides on tax-exempt land or owns restricted property; actively participates in tribal affairs; any other reasonable factor indicative of Indian descent; is a non-Indian woman pregnant with an eligible Indian's child for the duration of her pregnancy through postpartum (usually 6 weeks); is a non-Indian member of an eligible Indian's household and the medical officer in charge determines that services are necessary to control a public health hazard or an acute infectious disease which constitutes a public health hazard.	**GUARANTEED COVERAGE** Must be U.S. citizen or permanent U.S. resident, and: 1) If 65 years or older, you or your spouse worked for at least 10 years in Medicare-covered employment, or 2) You have a disability or end-stage renal disease (permanent kidney failure requiring dialysis or transplant) at any age.
Monthly Cost	**KidsCare:** **$10 to $50** per month for one child or $15–$70 a month for two or more children. **KidsCare II:** **$10 to $40** per month for one child or $15–$70 per month for two or more children.	**$0** or minimal share of cost.	**$0** when women begin prenatal care while eligibility is processed.	**$0** or minimal share of cost.	**$0** and share of cost for certain services; deductibles for certain plans. Part A: $0–$451 based on length of Medicare-covered employment; Part B: $99.90-$319.70 depending on annual income; Part C: Based on provider; Part D: Varies in cost and drugs covered.

Demographic	PRIVATE HEALTH INSURANCE				
	Small Businesses (2-50 Employees)	**Individuals Recently Covered by an Employer Health Plan**	**Individuals & Families**	**Individuals with Pre-Existing, Severe, or Chronic Medical Conditions**	**Low-Income Individuals & Families**
Program	**Group Plans** National Association of Health Underwriters 202-552-5060 www.nahu.org	**COBRA/Mini-COBRA** Contact your current carrier. After 18 months continuous group/ COBRA coverage, convert to a plan under: **HIPAA** Health Insurance Portability & Accountability Act 866-487-2365 www.dol.gov (Search: HIPAA)	**Individual Plans** National Association of Health Underwriters 202-552-5060 www.nahu.org	**Comprehensive Health Insurance Pool (CHIP)** 800-285-6477 www.chiparkansas.org **Take Care Arkansas** Federal program run by CHIP Administered by Blue Advantage Administrators 800-285-6477 www.takecarearkansas.org www.chiparkansas.org/pcip www.PCIP.gov	**Medicaid** (Including ARKids First A) 800-482-8988 800-482-5431 501-682-8233 www.medicaid.state.ar.us
Coverage	There is a 6-month look-back/12-month exclusionary period for pre-existing conditions on enrollees that do not have prior coverage. Benefits will vary depending on the chosen plan. **ARHealthNetworks:** Limited benefits every 12 months including 7 inpatient days a year, 2 major outpatient services (emergency room and major services performed in the office), 6 physician office visits, 2 prescriptions a month, maximum annual benefit of $100,000. ***Pre-Existing Health Conditions Covered***	**COBRA:** Coverage available for 18–36 months depending on qualifying events. Benefits are what you had with your previous employer. **Mini-COBRA:** Coverage available for 4 months. Benefits are what you had with your previous employer. **HIPAA:** Benefits are based on program selected. There is no expiration of coverage. ***Pre-Existing Health Conditions Covered***	Assorted plans depending on medical needs. There is a 12-month look-back and 24-month exclusionary period limit for pre-existing conditions on enrollees that do not have prior coverage. ***Limits on Pre-Existing Health Conditions May Apply***	**CHIP:** $1M lifetime benefits, comprehensive coverage of doctor visits, prescription drugs, outpatient and in-hospital care, ambulance, labs and x-rays, skilled nursing care, home health visits, maternity, preventive care, transplants, rehabilitation, durable medical equipment, mental health and substance abuse, and physical and occupational therapy among other services. **Take Care Arkansas:** Covers broad range of benefits, including primary and specialty care, hospital care, and prescription drugs. ***Pre-Existing Health Conditions Covered***	**Medicaid & ARKids First A:** Ambulance service (emergency only), Ambulatory surgical center, Chiropractor, Dental care, Doctor's services, Emergency room services, Home health services, Hospice care, Hospital care, Immunizations, Lab tests and x-rays, Medical equipment, Medical supplies, Non-emergency transportation (net) program, Nurse-midwife (certified), Podiatrist, Pregnancy termination, Prescription drugs, Rural health clinic, Therapy (physical, occupational, or speech), Vision care. Retroactive benefits available at the time of application for medical services received three months prior. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Company size 2–50 employees (including owner). Eligible employees must work at least 30 hours a week. Owner name on business license must draw wages from the company. **ARHealthNetworks:** Must live in Arkansas. Employees must be between the ages of 19–64. Must be a U.S. citizen, or permanent resident for at least 5 years. Income limit of 200% FPL.	**GUARANTEED COVERAGE** **COBRA:** Available for employees who work for employers with 20 or more employees. You have 60 days from date of termination to sign-up. **Mini-COBRA:** Available for employees who work for employers with less than 20 employees. You must have been insured continuously under your previous employer's group policy for at least 3 months prior to enrolling in Mini-COBRA, be ineligible for Medicare, and currently uninsured. You have 10 days from date of termination to sign-up. **HIPAA:** Must have had 18 months of continuous coverage and completely exhausted COBRA or state continuation coverage. Must not have lost coverage due to fraud or non-payment of premiums. You have 63 days to enroll.	Eligibility is subject to medical underwriting. If you are denied coverage for a medical condition, you may be eligible for CHIP or Take Care Arkansas. See next column.	**GUARANTEED COVERAGE** **CHIP:** Must be a resident of Arkansas for at least 90 days or for at least 30 days with evidence of coverage under a Qualified High Risk Pool of another state. Must not be enrolled in or eligible for Part A or B of Medicare, or the Arkansas Medical Assistance Programs. Must not be eligible for group coverage or COBRA, or government programs (must have exhausted this option). May need to prove denial of coverage or offer of higher premium. **Take Care Arkansas:** Must have been uninsured for at least 6 months prior to applying. Must prove being a U.S. citizen or legal U.S. resident, an Arkansas resident, and having problems getting insurance due to a pre-existing condition.	**GUARANTEED COVERAGE** **Medicaid:** Pregnant Women & Children Ages 0–18: Income Limit of 200% FPL. Supplemental Security Income Recipients: Resource limit $2,000 for individuals and $3,000 for couples. **ARKids First A:** Children Ages 0–5: Income limit of 133% FPL. Children Ages 6 –18: Income limit of 100% FPL. Children with family income of 133%–200% FPL who do not meet certain ARKids First B eligibility are also eligible for ARKids First A.
Monthly Cost	Costs depend on employer contribution and ± 25% of the insurance company's index rate. **ARHealthNetworks:** $100 annual deductible (does not apply to office visits & Rx). After deductible, 15% co-coverage will be required. $1,000 maximum out-of- pocket annually, including deductible.	**COBRA/Mini-COBRA:** 102%–150% of group health rates. **HIPAA:** Premiums will depend on plan chosen.	Costs for individual coverage vary.	**CHIP:** $139.93 to $1,697.06 depending on age, gender, and tobacco use. **Take Care Arkansas:** $117.28 to $680.87 depending on age, gender, and tobacco use.	**Medicaid & ARKids First A: $0** or minimal share of cost.

PUBLICLY-SPONSORED PROGRAMS

Demographic	Children in Moderate Income Families	Women	Seniors & Disabled	Trade Dislocated Workers (TAA Recipients)	Veterans
Program	**ARKids First B** (Children's Health Insurance Plan) 888-474-8275 www.arkidsfirst.com	**Breast Care** 877-670-2273 501-661-2513 www.arbreastcare.com **Mother-Infant Program (MIP)** 501-661-2154 www.adhhomecare.org/maternal.htm **Maternity Program** 501-661-2480 800-462-0599	**Medicare** 800-633-4227 www.medicare.gov **Medicare Prescription Drug Program** 800-633-4227 **Senior's Health Insurance Information Program (SHIIP)** 800-224-6330 501-371-2782 insurance.arkansas.gov/seniors/homepage.htm	**Health Coverage Tax Credit** 866-628-4282 www.irs.gov (Search: HCTC)	**VA Medical Benefits Package** 877-222-8387 www.va.gov www.ebenefits.va.gov
Coverage	Ambulance (emergency only), Chiropractor, Dental care (orthodontia included), Durable medical equipment, ER services, EPSDT screens, Family planning, Hearing, Home health, Hospice, Immunizations, Inpatient hospital, Lab and x-ray, Midwife, Outpatient mental and behavioral health, Physician, Podiatry, Prescription drugs, Speech therapy, Transportation, and Vision. ***Pre-Existing Health Conditions Covered***	**Breast Care:** Mammograms, clinical breast exams, pelvic exams and Pap tests , and free follow-up tests or treatment, if needed. **MIP:** Skilled home nursing visits for new mothers and infants to meet their medical, social and nutritional needs. **Maternity Program:** Pregnancy testing, prenatal education and visits that include medical history and physical exam, Pap smear, STD and other lab tests that can harm baby. Postpartum care and birth control. ***Pre-Existing Health Conditions Covered***	**Medicare** offers Part A, inpatient care in hospitals and rehabilitative centers; Part B, doctor and some preventive services and outpatient care; Part C allows Medicare benefits through private insurance (Medicare Advantage); Part C includes Parts A, B, and C not covered by Medicare. Part D covers prescription drugs. **SHIIP** is a Medicare counseling service. ***Pre-Existing Health Conditions Covered***	Inpatient and outpatient care (lab tests, x-rays, etc.), Doctor visits, Preventive and major medical care (surgery, physical therapy, Durable medical equipment, etc.), Mental health and substance abuse care, and Prescription drugs. ***Pre-Existing Health Conditions Covered***	Comprehensive preventive and primary care, outpatient and inpatient services. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Children Ages 0–18 with Family Incomes up to 200% FPL. Children are not eligible if they currently have or have had group or employer-sponsored health insurance within the past 6 months, unless insurance was lost involuntarily. Must choose a primary care physician.	**GUARANTEED COVERAGE** **All:** Must be resident of Arkansas. **Breast Care:** Must be women at least age 40, with income at or below 200% FPL, be uninsured (including no Medicaid or Medicare), or have insurance that do not cover services offered by AR Breast Care. **MIP:** Must be pregnant women. **Maternity Program:** Must be pregnant women. No one will be refused services because they do not have money to pay.	**GUARANTEED COVERAGE** **Medicare & SHIIP:** Must be U.S. citizen or permanent U.S. resident, and: 1) If 65 years or older, you or your spouse worked for at least 10 years in Medicare-covered employment, or 2) You have a disability or end-stage renal disease (permanent kidney failure requiring dialysis or transplant) at any age.	**GUARANTEED COVERAGE** Must be receiving TAA (Trade Adjustment Assistance), or Must be 55 years or older and receiving pension from the Pension Benefit Guaranty Corporation (PBGC). Must not be enrolled in certain state plans, or in prison, or receiving 65% COBRA premium reduction, or be claimed as a dependent in tax returns. Must be enrolled in qualified health plans where you pay more than 50% of the premiums.	**GUARANTEED COVERAGE** "Veteran status" = active duty in the U.S. military, naval, or air service and a discharge or release from active military service under other than dishonorable conditions. Certain veterans must have completed 24 continuous months of service.
Monthly Cost	**$0–$10** co-payments. Exceptions: Durable medical equipment and inpatient hospital care require a 20% co-insurance.	**Breast Care: $0** **MIP: $0** for Medicaid eligible recipients. **Maternity Program: $0** or minimal share of cost.	**Medicare: $0** and share of cost for certain services; deductibles for certain plans. Part A: 0-$451 based on length of Medicare-covered employment; Part B: $99.90-$319.70 depending on annual income; Part C: Based on provider; Part D: Varies in cost and drugs covered. **SHIIP: $0**	**27.5%** of the insurance premium including COBRA premium if employer contributes less than 50%.	**$0** and share of cost and co-pays depending on income level.

Demographic	PRIVATE HEALTH INSURANCE				
	Small Businesses (2-50 Employees)	Individuals Recently Covered by an Employer Health Plan	Individuals & Families	Individuals with Pre-Existing, Severe, or Chronic Medical Conditions	Low-Income Families & Medically-Needy
Program	**Group Plans** California Association of Health Underwriters 800-322-5934 www.cahu.org/consumers	**COBRA/Cal-COBRA** Contact your current carrier. After 18 months continuous group/COBRA coverage, convert to a plan under: **HIPAA** Health Insurance Portability & Accountability Act 866-487-2365 www.dol.gov (Search: HIPAA) **HIPP** Health Insurance Premium Payment www.dhcs.ca.gov (Search: HIPP)	**Individual Plans** California Association of Health Underwriters 800-322-5934 www.cahu.org/consumers	**MRMIP** (Major Risk Medical Insurance Program) 800-289-6574 www.mrmib.ca.gov **Pre-Existing Condition Insurance Plan (PCIP)** Federal program run by the Managed Risk Medical Insurance Board (MRMIB) 877-428-5060 www.PCIP.ca.gov	**Medi-Cal** California's Medicaid Program 800-541-5555 800-786-4346 www.medi-cal.ca.gov Or contact local county social services agency www.dhs.ca.gov
Coverage	Wide selection of plans cover different medical services. No Lifetime Limits. Guarantee issue regardless of pre-existing health conditions. Maximum exclusion of 6 months for pre-existing conditions on certain plans for enrollees with no prior coverage. Employers may allow part-time employees who work 20 hours to be eligible. ***Pre-Existing Health Conditions Covered***	**COBRA:** Coverage available for 18–36 months depending on qualifying events. Benefits are what you had with your previous employer. **Cal-COBRA:** Coverage available for 36 months depending on qualifying events. Benefits are what you had with your previous employer. **HIPAA:** Benefits are based on program selected. There is no expiration of coverage. **HIPP:** HIPP is a premium assistance program to help pay private or employer-sponsored health insurance premiums. ***Pre-Existing Health Conditions Covered***	Wide selection of plans cover different medical services. No Lifetime Limits. Pre-existing conditions may require increased rates or declination. ***Limits on Pre-Existing Health Conditions May Apply***	**MRMIP:** Offers a variety of medical services provided by HMOs and PPOs and has a 3 month exclusion period for pre-existing conditions. There is a $75K annual limit, $750K lifetime limit, and $500 annual deductible. The annual out-of-pocket max is $2,500/$4,000 individual or family. MRMIP enrollees cannot enroll in PCIP. **PCIP:** Primary and specialty care, hospital care, and prescription drugs. There is an annual deductible of $1,500 in-network/$3,000 out-of-network, brand name Rx deductible of $500/$500, and an annual out-of-pocket max of $2,500. ***Pre-Existing Health Conditions Covered***	Health, dental, vision, and prescription coverage. Treatment for special health problems, like breast cancer, kidney problems, nursing home needs, and AIDS. Retroactive benefits available at the time of application for medical services received three months prior. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Company size 2–50 employees. Eligible employees must work at least 30 hours a week. Owner can count as an employee. Owner name on business license must draw wages from the company.	**GUARANTEED COVERAGE** **COBRA:** Available for employees who work for businesses with 20 or more employees. You have 60 days from date of termination to sign-up. **Cal-COBRA:** Available for employees who work for businesses with less than 20 employees. You have 60 days from date of termination to sign-up. **HIPAA:** Must have had 18 months of continuous coverage and completely exhausted COBRA or state continuation coverage. Must not have lost coverage due to fraud or non-payment of premiums. You have 63 days to enroll. **HIPP:** You may be eligible for HIPP if you have a high-cost health condition (e.g., pregnancy, HIV/AIDS), and are eligible for Medi-Cal.	Eligibility is subject to medical underwriting. If you are denied coverage for a medical condition, you may be eligible for MRMIP or PCIP. See next column.	**GUARANTEED COVERAGE** **MRMIP:** Must have been a California resident for at least 12 months. Must have a pre-existing health condition as evidenced by a declination letter within the last 12 months, or offered coverage with a higher premium than MRMIP. Cannot be eligible for Medicare, COBRA or Cal-COBRA. **PCIP:** Uninsured for at least 6 months. Must have a pre-existing health condition as evidenced by a declination letter within the last 12 months, or offered coverage with a higher premium than MRMIP's PPO. Applicant must be a U.S. citizen, Nationals or Lawfully Present. Cannot be eligible for Medicare, COBRA or Cal-COBRA.	**GUARANTEED COVERAGE** Must be a California resident. Pregnant women and children ages 0–1: 200% FPL. Children ages 1–5: 133% FPL. Children ages 6–18: 100% FPL. Parents/caretakers with children under 21 in foster care: 107% FPL. Elderly or disabled: Income limit of 100 % FPL with asset limit of $2,000 for singles and $3,000 for couples.
Monthly Cost	Rates are age–banded and depend on plan, zip code and overall health of the group. Rates are limited by regulation to ±10% of standard approved rates.	**COBRA/Cal-COBRA:** 102%–150% of group health rates. **HIPAA:** Premiums will depend on plan chosen. **HIPP:** **$0**. The exact amount of monthly premiums from health insurance will be reimbursed.	Costs for individual coverage vary.	**MRMIP:** $258.41 - $2,214 depending on your age, region in CA, and program. **PCIP:** $107 - $557 depending on your age and location.	**$0–$5** co-pays.

PUBLICLY-SPONSORED PROGRAMS

Demographic	Children in Low-Income Families	Pregnant Women, Infants, & Moderate Income Children	Adults without Dependents	Immigrants Awaiting Legal Status	Adults in Need of Cancer Screening
Program	**Healthy Kids** (County-Based Programs) Contact Your County's Children's Health Initiative www.cchi4families.org **CaliforniaKids** 818-755-9700 www.californiakids.org **Kaiser Permanente Child Health Plan (KPCHP)** 800-464-4000 info.kp.org/childhealthplan Note: Now opened for Southern California in select counties (Los Angeles, Orange County, Riverside, San Bernadino, San Diego). **Children Health and Disability Prevention (CHDP)** Call your local CHDP provider www.dhs.ca.gov/pcfh/cms/chdp	**Medi-Cal** California's Medicaid Program 800-541-5555 800-786-4346 www.medi-cal.ca.gov **AIM** Access for Infants & Mothers 800-433-2611 www.aim.ca.gov **Healthy Families** 800-880-5305 866-848-9166 www.healthyfamilies.ca.gov Note: Starting in 2013, all children in Healthy Families will move to Medi-cal. No gap in coverage during the transition and children will maintain benefits. No premiums for families 150% FPL and below once moved.	**County Medical Services Program (CMSP)** www.cmspcounties.org **Genetically Handicapped Persons Program (GHPP)** 916-327-0470 800-639-0597 www.dhcs.ca.gov/services/ghpp	**Restricted Medi-Cal** California's Medicaid Program 800-952-5253 www.medi-cal.ca.gov **Family PACT** (Family planning) 800-942-1054 www.familypact.org For local programs contact www.dhs.ca.gov **Healthy Kids** (County-Based Programs) Contact Your County's Children's Health Initiative www.cchi4families.org	**IMPACT** 800-409-8252 www.california-impact.org **Every Woman Counts (EWC)** 800-824-0088 www.dhcs.ca.gov (Search: Every Woman Counts) **WISEWOMAN** 800-511-2300 www.cdc.gov/wisewoman
Coverage	**Healthy Kids:** Doctor's visits, Immunizations, Dental & vision care, Prescriptions, Surgery, and Hospitalization. **CaliforniaKids:** Medical (outpatient only), preventive, dental, and vision care, emergency room ($1,000 annual limit), behavioral health program (requires approval), and prescription drugs. **KPCHP:** Hospital care, Hearing and vision tests, Laboratory and x-ray services for no charge. Doctor office visits, Prescriptions, Urgent care, Emergency visits, and Mental health care (outpatient 20 visits/year) for a fee. **CHDP:** Immunizations; dental, vision, hearing, and nutrition screening; tests for illnesses like anemia, TB and others as needed; health and tobacco education; WIC referral for children up to age 5. ***Pre-Existing Health Conditions Covered***	**Medi-Cal:** Prenatal, pregnancy, and delivery care. Mothers are covered up to 60 days after delivery. Retroactive benefits available at the time of application for medical services received three months prior. **AIM:** Comprehensive medical care for mother provided (not just maternity); mothers covered up to 60 days after delivery; after birth, infant is automatically enrolled in Healthy Families Program up to age 1. **Healthy Families:** Physician, emergency and preventive care; prescription drugs; inpatient and outpatient (medical, mental, and substance abuse) hospital service; family planning and maternity care; medical transportation; durable medical equipment; physical, occupational, and speech therapy; x-ray and lab services; home health care and nursing care. ***Pre-Existing Health Conditions Covered***	**CMSP:** Program availability varies by county; medically-necessary physician and hospital-related services; depending on county, may provide coverage for other services such as dental and vision; benefits vary by county. **GHPP:** Special care center services, hospital stay, outpatient medical care, pharmaceutical services, surgeries, nutrition products and medical foods, durable medical equipment, and other services.	**Restricted Medi-Cal:** Covers emergencies, pregnancy-related care (prenatal and delivery). **Family PACT:** Provides comprehensive family planning services. **Healthy Kids:** Doctor's visits, Immunizations, Dental & vision care, Prescriptions, Surgery, and Hospitalization. ***Pre-Existing Health Conditions Covered***	**IMPACT:** Provides men with Radical prostatectomy, External beam radiation therapy, Hormone therapy, Watchful waiting, Brachytherapy, Chemotherapy, Counseling, Prostate cancer treatment for the initial 12 months, and more. **EWC:** Clinical breast exams, Mammograms, Pelvic exams, and Pap tests. **WISEWOMAN:** Screening and intervention for cardiovascular diseases and education about their signs, symptoms, and prevention. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** **Healthy Kids:** Eligibility varies by county. Must not be eligible for no-cost, full-scope Medi-Cal or Healthy Families. Undocumented children are eligible. **CaliforniaKids:** Must be children ages 0–18 and going to school, not be eligible for other government plans such as Medi-Cal or Healthy Families. No income limits, ages 2-18, must not have a pre-existing condition. **KPCHP:** Must be children ages 0–18 living at or below 300% FPL, be California residents living near Kaiser or in county plan area, uninsured and not be eligible for employer-based coverage. **CHDP:** Must be Medi-Cal recipients under age 21. Children 0–19 years old must have income of 200% FPL or less and not be receiving Medi-Cal. Also eligible are children in Headstart, State Preschool programs, and Foster Care.	**GUARANTEED COVERAGE** **Medi-Cal:** Must be a California resident. Pregnant women and children ages 0–1: 200% FPL. **AIM:** Income limit of 200%–300% FPL. Must be pregnant less than 31 weeks, be a California resident for at least 6 months, with legal immigration status, must not be receiving no-cost Medi-Cal or Medicare Part A and Part B benefits as of the application date, and must be uninsured or insurance has maternity deductible or co-payment of $500 or more. **Healthy Families:** Income Limits: Children Ages 0–1: 200%-250% FPL. Children Ages 1–5: 133%-250% FPL. Children Ages 6–18: 100%-250% FPL. Must be ineligible for no-cost Medi-Cal or employer-based coverage. Must be California residents and legal immigrants or U.S. citizens.	**GUARANTEED COVERAGE** **CMSP:** Must be U.S. citizen or legal resident between ages of 21–64. Must not be eligible for Medi-Cal. Must be a resident of eligible counties. Income can be up to 200% FPL. Property and vehicle limits, and dependents/relatives considered. Participating Counties: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Inyo, Kings, Lake, Lassen, Madera, Marin, Mariposa, Mendocino, Modoc, Mono, Napa, Nevada, Plumas, San Benito, Shasta, Sierra, Siskiyou, Solano, Sonoma, Sutter, Tehama, Trinity, Tuolumne, Yolo, Yuba **GHPP:** Must be diagnosed with a genetic condition that is covered by GHPP. Must be resident of California. Must be 21 years or older (some persons younger than 21 years of age may be eligible); No income limit. Applicants may be required to apply for Medi-Cal.	**GUARANTEED COVERAGE** **Restricted Medi-Cal:** Income limits for pregnant women and children ages 0–1: 200% FPL. Children Ages 1–5: 133% FPL. Children Ages 6–18: 100% FPL. Elderly or Disabled: 133% FPL. **Family PACT**: Must be a California resident with income limit of 200% FPL. Must be uninsured, or ineligible for Medi-Cal. If insured, then insurance must not cover family planning or birth control methods, or patient cannot afford insurance deductible. If Medi-Cal enrollee, then must not have met share of cost. **Healthy Kids:** Eligibility varies by county. Must not be eligible for no-cost, full-scope Medi-Cal or Healthy Families. Undocumented children are eligible.	**GUARANTEED COVERAGE** **IMPACT:** Male California residents over 18 years old that are uninsured or underinsured. Income up to 200% FPL, have abnormal DRE, PSA or diagnosed with prostate cancer. **EWC:** Female California resident and U.S. citizen or legal resident living at or below 200% FPL, over 24 for cervical cancer screening and over 39 for breast cancer screening, and does not have health insurance that covers breast and cervical cancer screening. **WISEWOMAN:** Must be enrolled in BCCTP.
Monthly Cost	**Healthy Kids:** Premiums and co-pays vary by county. **CaliforniaKids:** $75 per child. **KPCHP:** $8-15 per child per month ($45 max per family), co-pays range from $5-$35 for some services with a $250 per child or $500 for two or more children maximum. **CHDP: $0** or minimal share of cost.	**Medi-Cal: $0** or minimal share of cost. **AIM:** 1.5% of family annual income. **Healthy Families: $4–$72** monthly premium per family based on FPL and plan chosen. Up to $15 in co-pays.	**CMSP:** Share-of-Cost = countable net income minus maintenance need. **GHPP:** For some clients, the amount of annual enrollment fee is based on income and family size.	**Restricted Medi-Cal & Family PACT: $0** or minimal share of cost. **Healthy Kids:** Premiums and co-pays vary by county.	**All: $0** or minimal share of cost.

Demographic	PRIVATE HEALTH INSURANCE				
	Small Businesses (1-50 Employees)	Individuals Recently Covered by an Employer Health Plan	Individuals & Families	Individuals with Pre-Existing, Severe, or Chronic Medical Conditions	Low-Income Families & Medically-Needy
Program	**Group Plans** Colorado State Association of Health Underwriters 720-733-8000 www.csahu.org	**COBRA/Colorado Continuation** Contact your current carrier. After 18 months continuous group/COBRA coverage, convert to a plan under: **Colorado Conversion** www.dora.state.co.us/insurance 800-930-3745 303-894-7490 **HIPAA** Health Insurance Portability & Accountability Act 866-487-2365 www.dol.gov (Search: HIPAA) **HIBI** Health Insurance Buy In 303-866-6422 www.colorado.gov (Search: HIBI)	**Individual Plans** Colorado State Association of Health Underwriters 720-733-8000 www.csahu.org	**CoverColorado** (Colorado Medical Insurance Pool) 888-770-1120 303-863-1960 (Enrollment) www.covercolorado.org **GettingUSCovered** Federal program run by the Rocky Mountain Health Maintenance Organization, Inc. 877-779-0387 (Enrollment) 877-397-1109 (Customer Service) www.gettinguscovered.org www.PCIP.gov	**Medicaid** 303-866-3513 (Metro Denver) 800-221-3943 (outside Metro Denver) www.chcpf.state.co.us Contact your local county offices for Medicaid information in your county. www.cdhs.state.co.us/servicebycounty.htm
Coverage	Assorted deductibles. There is a maximum look-back and exclusion period of 6 months for pre-existing conditions on enrollees who do not have prior coverage. ***Pre-Existing Health Conditions Covered***	**COBRA:** Coverage available for 18–36 months depending on qualifying events. Benefits are what you had with your previous employer. **Colorado Continuation:** Benefits are what you had with your previous employer. Coverage lasts up to 18 months. **HIPAA/Colorado Conversion:** Benefits are based on program selected. There is no expiration of coverage. **HIBI:** Premium assistance that pays employer-sponsored health insurance or COBRA premiums. The assistance amount depends on the most cost-effective premium available. ***Pre-Existing Health Conditions Covered***	Different plans will cover different medical services. There is a maximum look-back and exclusion period of 12 months for pre-existing conditions on enrollees who do not have prior coverage. ***Limits on Pre-Existing Health Conditions May Apply***	**CoverColorado:** Hospitalization, Physician care, Diagnostic tests, X-rays, Prescription drugs, and Some mental health care services. If you have not been insured within the past 90 days prior to applying, expenses related to any pre-existing medical condition will not be covered for the first 6 months. If you have been insured for at least 6 continuous months within 90 days of applying, you will not be subject to the 6-month pre-existing waiting period. Retroactive benefits available at the time of application for medical services received three months prior. **GettingUSCovered:** Covers broad range of benefits, including primary and specialty care, hospital care, and prescription drugs. ***Pre-Existing Health Conditions Covered***	Diagnosis, Physician services, check-ups (medical and dental), family planning, maternity, prenatal, and newborn care, prescriptions, hospital services, comfort care, hospice, dental services, drug and alcohol treatment, mental health services. Retroactive benefits available at the time of application for medical services received three months prior. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Company size 1–50. Eligible employees must work at least 24 hours a week. Owner can count as an employee. Proprietor-name on license must draw wages.	**GUARANTEED COVERAGE** **COBRA:** Available for employees who work for businesses with 20 or more employees. You have 60 days from date of termination to sign-up **Colorado Continuation:** Applies to employees of any employer group policy where COBRA doesn't apply. Must have been covered under employer's group plan for six consecutive months, and sign-up within 30 days of termination. **HIPAA:** Must have had 18 months of continuous coverage and completely exhausted COBRA or state continuation coverage. Must not have lost coverage due to fraud or non-payment of premiums. You have 63 days to enroll. **Colorado Conversion:** Available for employees who were covered for less than 6 but more than 3 months by their employer's group plan, or at the end of continuation coverage, or upon termination of a small group policy. You have 31 days to sign-up with no pre-existing health condition exclusion. **HIBI:** Must qualify for Medicaid and have access to Employer-Sponsored Insurance or COBRA	Eligibility is subject to medical underwriting. If you are denied coverage for a medical condition, you may be eligible for CoverColorado, or GettingUSCovered. See next column.	**GUARANTEED COVERAGE** **CoverColorado:** Must have resided in Colorado as a legal resident for at least 6 months prior to applying. You may be HIPAA eligible or transferring from another state's high risk pool. Must have a qualifying health condition. Cannot be eligible for Medicaid, Medicare or any other health insurance. May be eligible through the Trade Adjustment Assistance Act (TAA) Coverage/Health Coverage Tax Credit (HCTC). **GettingUSCovered:** Must have been uninsured for at least 6 months prior to applying. Must prove being a U.S. citizen or legal U.S. resident, a Colorado resident, and having problems getting insurance due to a pre-existing condition.	**GUARANTEED COVERAGE** Must be a Colorado resident and a U.S. citizen or legal alien. Income Limits: Pregnant Women: 185% FPL. Children Ages 0–18: 133% FPL. Parents/Caretakers Living with Children Ages 0–18: 133% FPL. Adults without Dependents: 10% FPL. SSI Aged or Disabled: Asset limit for singles $2,000 and $3,000 for couples.
Monthly Cost	Costs depend on employer contribution and +10% or –25% of the insurance company's index rate.	**COBRA/Colorado Continuation:** 102%–150% of group health rates. **HIPAA/Colorado Conversion:** Premiums will depend on plan chosen. **HIBI:** HIBI reimburses the full employer-sponsored insurance premium amount by check monthly. Pays the insurance company directly for people on COBRA or eligible small businesses	Costs depend on age and county/zone. If you are self-employed and buy your own insurance you are eligible to deduct 100% of the cost of the premium from your federal income tax.	**CoverColorado:** Monthly premiums vary depending on age, gender, tobacco use, and region. **GettingUSCovered:** $184 to $876 depending on age, gender, tobacco use, and region.	**$0** for children and pregnant women. Adults may have a small co-pay.

PUBLICLY-SPONSORED PROGRAMS

Demographic	Low-Income Children	Women in Need of Cancer Screening	Adults without Dependents	Native Americans	Trade Dislocated Workers (TAA Recipients)
Program	**Child Health Plan Plus (CHP+)** 800-359-1991 www.cchp.org **Medicaid** 303-866-3513 (Metro Denver) 800-221-3943 (outside Metro Denver) www.chcpf.state.co.us	**Women's Wellness Connection** 866-951-9355 womenswellnessconnection.org	**AwDC (Adults without Dependent Children)** (Medicaid Expansion) 303-866-3513 (Metro Denver) 800-221-3943 (outside Metro Denver) www.chcpf.state.co.us Note: Currently has a waitlist. Program is limited to 10,000 clients.	**Indian Health Services** 505-248-4500 www.ihs.gov (Search: Albuquerque)	**Health Coverage Tax Credit** 866-628-4282 www.irs.gov (Search: HCTC)
Coverage	**CHP+:** Regular checkups, Immunizations (shots), Prescriptions (medicine), Hospital services, Eyeglasses, Hearing aids, Dental services up to $600 a year including exams, Cleanings, and some other services. **Medicaid:** Diagnosis, Physician services, check-ups (medical and dental), family planning, maternity, prenatal, and newborn care, prescriptions, hospital services, comfort care, hospice, dental services, drug and alcohol treatment, mental health services. Retroactive benefits available at the time of application for medical services received three months prior. ***Pre-Existing Health Conditions Covered***	The program provides breast and cervical cancer screening (mammograms, clinical breast exams, Pap tests and pelvic exams) and selected diagnostic services. Cancer treatment for some women qualified through Medicaid.	Diagnosis, Physician services, check-ups (medical and dental), family planning, maternity, prenatal, and newborn care, prescriptions, hospital services, comfort care, hospice, dental services, drug and alcohol treatment, mental health services. ***Pre-Existing Health Conditions Covered***	Health care team includes, Clinical psychologists, Dental assistants, Dental hygienists, Dental officers, Dieticians, Environmental health staff, Health educators, Medical officers, Medical records staff, Medical technologists, Mental health technicians, Nurses, Nutritionists, Pharmacists, Radiology technologists, Social workers. ***Pre-Existing Health Conditions Covered***	Inpatient and outpatient care (lab tests, x-rays, etc.), Doctor visits, Preventive and major medical care (surgery, physical therapy, Durable medical equipment, etc.), Mental health and substance abuse care, and Prescription drugs. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** **CHP+:** Must be U.S. citizens or permanent residents and live in Colorado (for at least 5 years), be children ages 0–18, or pregnant women ages 19 and over, must not be in prison or mental institutions, must be uninsured or ineligible for Medicaid, and earn up to 250% FPL. **Medicaid:** Children ages 0–18: 133% FPL	**GUARANTEED COVERAGE** Must live in Colorado, be 40–64 years old, underinsured or uninsured, with income at or below 250% FPL, and must not have had Pap or mammogram test in last 12 months.	**GUARANTEED COVERAGE** Must be a Colorado resident and a U.S. citizen or legal alien between ages 19-64. Must be below 10% FPL and not enrolled in Medicare or Medicaid. Some earned income is not counted in determining eligibility.	**GUARANTEED COVERAGE** Must exhaust all private, state, and other federal programs. Must be regarded by the local community as an Indian; is a member of an Indian or Group under Federal supervision; resides on tax-exempt land or owns restricted property; actively participates in tribal affairs; any other reasonable factor indicative of Indian descent; is a non-Indian woman pregnant with an eligible Indian's child for the duration of her pregnancy through postpartum (usually 6 weeks); is a non-Indian member of an eligible Indian's household and the medical officer in charge determines that services are necessary to control a public health hazard or an acute infectious disease which constitutes a public health hazard.	**GUARANTEED COVERAGE** Must be receiving TAA (Trade Adjustment Assistance), or Must be 55 years or older and receiving pension from the Pension Benefit Guaranty Corporation (PBGC). Must not be enrolled in certain state plans, or in prison, or receiving 65% COBRA premium reduction, or be claimed as a dependent in tax returns. Must be enrolled in qualified health plans where you pay more than 50% of the premiums.
Monthly Cost	**CHP+:** **$0** for most members and Native Americans. Enrollment fee based on family size and income: $25 or $75 for one child, $35 or $105 for 2+ children. Co-pays are $2–$15 per visit for routine medical care. **Medicaid:** **$0** or minimal share of cost.	**$0** for most members.	**$0** or minimal share of cost.	**$0** or minimal share of cost.	**27.5%** of the insurance premium including COBRA premium if employer contributes less than 50%.

PRIVATE HEALTH INSURANCE

Demographic	Small Businesses (1-50 Employees)	Individuals Recently Covered by an Employer Health Plan	Individuals & Families	Individuals with Pre-Existing, Severe, or Chronic Medical Conditions	Low-Income Individuals & Families
Program	**Group Plans** National Association of Health Underwriters 202-552-5060 www.nahu.org	**COBRA/Mini-COBRA** Contact your current carrier. After 18 months continuous group/COBRA coverage, convert to a plan under: **HIPAA** Health Insurance Portability & Accountability Act 866-487-2365 www.dol.gov (Search: HIPAA)	**Individual Plans** National Association of Health Underwriters 202-552-5060 www.nahu.org	**Health Reinsurance Association(HRA)** 800-842-0004 www.hract.org/hra **Pre-Existing Condition Insurance Plan (PCIP)** Federal program run by the CT Dept. of Social Services & HRA 800-656-6684 www.PCIP.gov www.ct.gov (Search: Pre-Existing Condition)	**Medicaid** 800-842-1508 TDD/TYY: 800-842-4524 www.dss.state.ct.us (Search: Medicaid) **HUSKY A & C** 877-284-8759 800-656-6684 www.huskyhealth.com
Coverage	Mostly plans with co-pays, some with deductibles. There is a maximum look-back period of 6 months and maximum exclusion period of 12 months for pre-existing conditions on enrollees who do not have any prior coverage. ***Pre-Existing Health Conditions Covered***	**COBRA:** Coverage available for 18-36 months depending on qualifying events. Benefits are what you had with your previous employer. **Mini-COBRA:** Coverage lasts a maximum of 30 months depending on qualifying events. Benefits are what you had with your previous employer. **HIPAA:** Benefits are based on program selected. There is no expiration of coverage. ***Pre-Existing Health Conditions Covered***	Different plans will cover different medical services. There may also be a lifetime maximum of benefits, for example $5M. There is a 12-month look-back and exclusionary period limit for pre-existing conditions. ***Limits on Pre-Existing Health Conditions May Apply***	**HRA:** Choose from 2 individual plans: PPO or a Special Health Care Plan (waiting period of 12 months). Choose from 2 conversion plans: PPO and a Special Health Care Plan (no waiting period, if you qualify). All benefits are the same except the Special Plan, which does not cover outpatient prescriptions. **PCIP:** Covers broad range of benefits, including primary and specialty care, hospital care, and prescription drugs. ***Pre-Existing Health Conditions Covered***	**Medicaid & HUSKY A & C:** Provides full Medicaid health coverage/benefits package, including long-term care/ skilled nursing facility, home health care and non-emergency medical transportation. Some services may need prior approval. Retroactive benefits available at the time of application for medical services received three months prior. **HUSKY A:** includes services available to Children and Youth with Special Health Care Needs (CYSHCN). ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Company size 1–50 employees. If in business 90 days or more, can usually qualify. Owner can count as an employee. Proprietor name on license must draw wages. Self-employed groups have a guaranteed issue right to a specific small employer plan. Eligible employees must work at least 30 hours a week.	**GUARANTEED COVERAGE** **COBRA:** Available for employees who work for businesses with 20 or more employees. You have 60 days from date of termination to sign-up. **Mini-COBRA:** Available for employees who work for businesses with less than 20 employees. You have 30 days from date of termination to sign-up. **HIPAA:** Must have had 18 months of continuous coverage and completely exhausted COBRA or state continuation coverage. Must not have lost coverage due to fraud or non-payment of premiums. You have 63 days to enroll.	Eligibility is subject to medical underwriting. If you are denied coverage for a medical condition, you may be eligible for a Connecticut Health Reinsurance Association Plan or PCIP. See next column.	**GUARANTEED COVERAGE** **HRA:** Guaranteed to all Connecticut residents under the age of 65. If HIPAA-eligible then no pre-existing exclusion period. Eligible if previous coverage was terminated for reasons other than non-payment of premium or fraud. **PCIP:** Must have been uninsured for at least 6 months prior to applying. Must prove being a U.S. citizen or legal U.S. resident, a Connecticut resident, and having problems getting insurance due to a pre-existing condition. Must have a qualifying pre-existing condition.	**GUARANTEED COVERAGE** **Medicaid & HUSKY A:** Must be U.S. citizens or legal permanent residents, and Connecticut residents. Must be children ages 0–18, adults, parents, or caregivers living at or below 185% FPL, or **Husky C:** Aged, Blind and Disabled: Asset limits are as follows: Single person: $1,600 Married couple: $2,400
Monthly Cost	Costs depend on employer contribution and the modified community rate.	**COBRA/Mini-COBRA:** 102%–150% of group health rates. **HIPAA:** Premiums will depend on plan chosen.	Costs depend on age and county/zone. No rate caps.	**HRA:** Premiums vary depending on the applicant's income level, age, sex, family size,and plan chosen. Rates are usually capped by state law at a level between 150% and 200% of standard market rates. **PCIP:** Flat rate of $381 per month regardless of age.	**Medicaid & HUSKY A & C:** **$0** May share in some costs.

PUBLICLY-SPONSORED PROGRAMS

Demographic	Low-Income Adults	Children	Women with Chronic Illnesses	Adults without Dependents	Seniors & Disabled
Program	**HUSKY D** (Medicaid for Low-Income Adults) 866-409-8430 860-269-2031 www.ct.gov/dss (Search: Medicaid) **HUSKY A** 877-284-8759 800-656-6684 www.huskyhealth.com	**HUSKY B & Plus Physical** 877-284-8759 800-656-6684 www.huskyhealth.com	**Connecticut Breast & Cervical Cancer Early Detection Program (CBCCEDP)** www.ct.gov/dph (Search: CBCCEDP) **WISEWOMAN** www.ct.gov/dph (Search: WISEWOMAN) **Both programs:** 860-509-7804 www.dph.state.ct.us	**Charter Oak Health Plan** 877-772-8625 www.ct.gov/coh	**Medicare** (Age 65 and up) 800-633-4227 www.medicare.gov **Medicare Prescription Drug Program** 800-633-4227 **CHOICES Program** (Medicare advice) 800-994-9422
Coverage	**Both:** Inpatient and outpatient hospital services, Physician services, Laboratory services, Prescription drugs, Mental health services, Immunizations, and Emergency services. ***Pre-Existing Health Conditions Covered***	**HUSKY B:** Comprehensive medical care except long-term care and non-emergency medical transportation. **HUSKY Plus:** For HUSKY B recipients with or are at high risk for chronic physical, developmental, behavioral, or emotional conditions and require health and related services beyond that are required by children generally. Services cover severe physical health problems not covered under the basic HUSKY B plan. ***Pre-Existing Health Conditions Covered***	**CBCCEDP:** Office visits, Mammograms, Breast biopsies and ultrasounds, Fine needle aspirations, Pap tests, LEEP, Surgical consultations, Clinical breast exams, and colposcopies and colposcopy-directed biopsies. **WISEWOMAN:** Cardiovascular disease risk assessment and counseling; blood, lipid, and blood glucose screening. Referral for treatment if screening results are elevated.	Primary care, Specialist office visits, Preventive care, Ambulance, Emergency room visit, Prescription medication, Durable medical equipment, Lab and x-ray, Behavioral health services, Inpatient and outpatient services, Pre- and post-natal care. Lifetime maximum benefit of $1 million, annual maximum benefit of $100,000. ***Pre-Existing Health Conditions Covered***	**Medicare** offers Part A, inpatient care in hospitals and rehabilitative centers; Part B, doctor and some preventive services and outpatient care; Part C allows Medicare benefits through private insurance (Medicare Advantage); Part C includes Parts A, B, and C not covered by Medicare. Part D covers prescription drugs. **CHOICES** is a Medicare counseling service. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** **Husky D:** Must be U.S. citizens and Connecticut residents ages 19–64, not receiving Medicare or Supplemental Security Income (SSI), not be pregnant, live at or below 56% FPL. For those living in Region A (mostly southwestern Connecticut), income limit is 68% FPL. There are no asset requirements. **Husky A:** Must be a U.S. citizen or legal permanent resident, and Connecticut resident. Must be a pregnant woman living at or below 250% FPL.	**GUARANTEED COVERAGE** **HUSKY B & Plus:** Must be children ages 0–18, U.S. citizens, and live in Connecticut. **HUSKY B:** May not be available if a child has been covered by health insurance through a parent's employer during the past two months; exceptions to this waiting period include loss of employment and financial hardship. No income limit. Families with incomes greater than 300% FPL can buy into a HUSKY plan. **HUSKY Plus:** Income limit of 185% to 300% FPL.	**GUARANTEED COVERAGE** **CBCCEDP:** Income must be at or below 200% FPL. Must be 19–64 years of age for clinical breast exams and Pap tests, or 40–64 years of age for mammograms. Must be uninsured or have health insurance that excludes routine Pap tests and/or mammograms, or insurance deductible of $1,000 or more. Women ages 65 or older who are not enrolled in Medicare Part B may be eligible to receive CBCCEDP & WISEWOMAN services. **WISEWOMAN:** Must be enrolled in the CBCCEDP, 40 to 64 years old, have an income at or below 200% FPL, have no health insurance or health insurance that excludes routine blood pressure screening, lipid profile, and blood glucose screenings.	**GUARANTEED COVERAGE** Must be uninsured Connecticut residents, ages 19–64 who are U.S. citizens or qualified aliens. There are no income limits.	**GUARANTEED COVERAGE** **Medicare & CHOICES:** Must be a U.S. citizen or permanent U.S. resident, and: 1) If 65 years or older, you or your spouse worked for at least 10 years in Medicare-covered employment, or 2) You have a disability or end-stage renal disease (permanent kidney failure requiring dialysis or transplant) at any age.
Monthly Cost	**Both:** **$0** or minimal share of cost. Medicaid will pay for your benefits only if you bring your gray CONNECT card when visiting a Medicaid-approved provider.	**HUSKY B:** Co-pays $10–$15, prescription drugs and contraceptives $5–$10. **HUSKY Plus:** No additional premiums, no deductible, and no co-pays. Over 300% FPL buy into the plan at negotiated group price. Family's annual cost-sharing less than 5% of income.	**Both:** No co-pays or premiums.	**$446** monthly premium per individual. Primary care office visit: $25 co-pay. Specialist office visit: $35 co-pay. Co-pays, co-insurance and deductibles depend on income and family size.	**Medicare: $0** and share of cost for certain services; deductibles for certain plans. Part A: $0–$451 based on length of Medicare-covered employment; Part B: $99.90-$319.70 depending on annual income; Part C: Based on provider; Part D: Varies in cost and drugs covered. **CHOICES: $0**

PRIVATE HEALTH INSURANCE

Demographic	Small Businesses (1-50 Employees)	Individuals Recently Covered by an Employer Health Plan	Individuals & Families	Individuals with Pre-Existing, Severe, or Chronic Medical Conditions	Low-Income Individuals & Families
Program	**Group Plans** National Association of Health Underwriters 202-552-5060 www.nahu.org	**COBRA** Contact your current carrier. After 18 months continuous group/COBRA coverage, convert to a plan under: **HIPAA** Health Insurance Portability & Accountability Act 866-487-2365 www.dol.gov (Search: HIPAA)	**Individual Plans** National Association of Health Underwriters 202-552-5060 www.nahu.org	**Pre-Existing Condition Insurance Plan (PCIP)** Run by the U.S. Department of Health and Human Services 866-717-5826 www.PCIP.gov www.pciplan.com	**Medicaid** 302-255-9500 800-372-2022 dhss.delaware.gov (Search: Medicaid)
Coverage	All group health insurance carriers can impose a 6-month look-back/12-month exclusionary period for pre-existing conditions on enrollees that do not have prior creditable coverage. Benefits will vary depending on the chosen plan. ***Pre-Existing Health Conditions Covered***	**COBRA:** Coverage available for 18–36 months depending on qualifying events. Benefits are what you had with your previous employer. **HIPAA:** Benefits are based on program selected. There is no expiration of coverage. ***Pre-Existing Health Conditions Covered***	Assorted plans depending on medical needs. There is a maximum look-back period of 60 months and no limit to the exclusion period for pre-existing conditions on enrollees who have no prior coverage. Elimination riders are permitted. ***Limits on Pre-Existing Health Conditions May Apply***	Covers broad range of benefits, including primary and specialty care, hospital care, and prescription drugs. ***Pre-Existing Health Conditions Covered***	Doctor visits, Hospital care, Labs, Prescription drugs, Transportation, Routine shots for children, Mental health and substance abuse services, X-rays, Home health care, Hospice care, Dental care (up to age 21). Retroactive benefits available at the time of application for medical services received three months prior. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Company size 1–50 employees (including owner). Owner name on business license must draw wages from the company. Must be actively engaged in business in at least 50% of its working days during the preceding calendar quarter. Eligible employees must work at least 30 hours a week. Carriers may impose participation requirements on employees and contribution requirements on employers.	**GUARANTEED COVERAGE** **COBRA:** Available for employees who work for businesses with 20 or more employees. You have 60 days from date of termination to sign-up. **HIPAA:** Must have had 18 months of continuous coverage and completely exhausted COBRA or state continuation coverage. Must not have lost coverage due to fraud or non-payment of premiums. You have 63 days to enroll.	Eligibility is subject to medical underwriting. If you are denied coverage for a medical condition, you may be eligible for PCIP. See next column.	**GUARANTEED COVERAGE** Must have been uninsured for at least 6 months prior to applying. Must prove being a U.S. citizen or legal U.S. resident, a Delware resident, and having problems getting insurance due to a pre-existing condition.	**GUARANTEED COVERAGE** Must be U.S. citizens or qualified legal residents living in Delaware. Income Limits: Pregnant Women & Infants Ages 0–1: 185% FPL. Children Ages 1–5: 133% FPL. Children Ages 6–19, Working Parents, and Aged, Blind & Disabled: 100% FPL. Parents/Caretakers Living with Children Ages 0–18: 120% FPL. Childless Adults: 110% FPL. SSI recipients: For singles 75% FPL with asset limit of $2,000; for couples 83% FPL with asset limit of $3,000. Retroactive benefits available at the time of application for medical services received three months prior.
Monthly Cost	Costs depend on employer contribution or health condition of self-employed and ± 35% of the insurance company's index rate.	**COBRA:** 102%–150% of group health rates. **HIPAA:** Premiums will depend on plan chosen.	Costs for individual coverage vary.	$109 to $467 depending on your age and plan chosen.	**$0** premiums or minimal share of cost. Prescription drugs cost a maximum $15/month.

PUBLICLY-SPONSORED PROGRAMS

Demographic	Parents & Children	Children	Adults in Need of Cancer Screening	Seniors & Disabled	Trade Dislocated Workers (TAA Recipients)
Program	**Children & Families First:** **Special Medical, Treatment Foster Care, and Resource Mothers Program** 800-734-2388 www.cffde.org **Adolescent Resource Center (ARC)** www.cffde.org/Services/supportingteens/arc.aspx New Castle County: 302-658-6134, Kent County: 800-924-6977	**Healthy Children Program** 888-822-4530 dhss.delaware.gov (Search: DHCP)	**Screening for Life** 800-464-4357 dhss.delaware.gov (Search: Screening for LIfe)	**Medicare** 800-633-4227 www.medicare.gov **Medicare Prescription Drug Program** 800-633-4227 **ELDER Info** 800-336-9500 www.delawareinsurance.gov (Search: ELDER Info)	**Health Coverage Tax Credit** 866-628-4282 www.irs.gov (Search: HCTC)
Coverage	**Special Medical Foster Care: Parents** receive specialized training for skills (e.g. CPR, use of medical equipment) to care for medically-fragile children. **Treatment Foster Care Program** provides intensive therapy for adolescents who have mental health or behavioral issues. **Resource Mothers Program** helps at-risk pregnant mothers receive the appropriate prenatal and pediatric care to ensure healthy babies. **ARC** offers confidential counseling about sexual health and medical services (e.g. STD testing, contraceptives, etc.) for teens.	Well-baby and well-child checkups, Drug/alcohol abuse treatment, Speech/hearing therapy, Immunizations, Physical therapy, Eye exams, Ambulance services, Prescription drugs, Hospital care, Physician services, X-rays, Lab work, Assistive technology, Mental health counseling, Limited home health and nursing care, Case management and Coordination, Hospice care, and Comprehensive dental service. ***Pre-Existing Health Conditions Covered***	**Women:** Ages 18–49: office visits, clinical breast exams, pelvic exams, Pap tests, breast and cervical cancer education. Ages 40–49: All of the above and mammograms. Ages 50-64: All services above, and digital rectal exam, fecal occult blood test, colonoscopy, and colorectal cancer education. **Men:** Age 40–49: office visits, digital rectal exams, PSA tests, prostate cancer education. Ages 50–64: All of the above and fecal occult blood test, colonoscopy and colorectal cancer education. **For men and women over 65 not eligible for Medicaid:** All benefits. ***Pre-Existing Health Conditions Covered***	**Medicare** offers Part A, inpatient care in hospitals and rehabilitative centers; Part B, doctor and some preventive services and outpatient care; Part C allows Medicare benefits through private insurance (Medicare Advantage); Part C includes Parts A, B, and C not covered by Medicare. Part D covers prescription drugs. **ELDER Info** is a Medicare counseling service that educates and assists Medicare beneficiaries, those eligible for Medicare, and caregivers about Medicare, Medicaid, Medigap, prescription drug benefits, and other issues related to health insurance benefits. ***Pre-Existing Health Conditions Covered***	Inpatient and outpatient care (lab tests, x-rays, etc.), Doctor visits, Preventive and major medical care (surgery, physical therapy, Durable medical equipment, etc.), Mental health and substance abuse care, and Prescription drugs. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Qualified person willing to learn about children's needs and developmental stages, able to work with birth family and Children & Families First on behalf of the child. **Special Medical Foster Care:** Foster parents of children ages 0 -18 who may suffer with chronic or acute medical conditions (e.g. AIDS, cerebral palsy, etc.) and may require supportive technology. **Treatment Foster Care Program:** Foster parents of adolescents ages 12–17 with mental health or behavioral issues, or needing strong supervision and structure. **Resource Mothers Program:** Delaware women who are pregnant and not yet receiving prenatal care. **ARC:** Adolescents ages 12–20.	**GUARANTEED COVERAGE** Must be a U.S. citizen or qualified non-citizen, and live in Delaware. Must be under age 19, with family income at or below 200% FPL. Must not have other comprehensive health insurance coverage or be a dependent of a permanent State employee. Waiting period may apply.	**GUARANTEED COVERAGE** Must be Delaware adults ages 18–64, uninsured or underinsured (have high, unmet deductible, or insurance does not cover Pap tests, mammograms, or screenings (breast, cervical, colorectal, prostate). Must not be eligible for Medicaid or Medicare. Must live between 100% to 250% FPL.	**GUARANTEED COVERAGE** **Both:** Must be a U.S. citizen or permanent U.S. resident, and: 1) If 65 years or older, you or your spouse worked for at least 10 years in Medicare-covered employment, or 2) You have a disability or end-stage renal disease (permanent kidney failure requiring dialysis or transplant) at any age.	**GUARANTEED COVERAGE** Must be receiving TAA (Trade Adjustment Assistance), or Must be 55 years or older and receiving pension from the Pension Benefit Guaranty Corporation (PBGC). Must not be enrolled in certain state plans, or in prison, or receiving 65% COBRA premium reduction, or be claimed as a dependent in tax returns. Must be enrolled in qualified health plans where you pay more than 50% of the premiums.
Monthly Cost	**Special Medical & Treatment Foster Care Program:** Foster parents receive a monthly payment to cover the child's expenses determined by the age and level of care. Medical expenses are covered by Medicaid, the state of Delaware, or the birth family's insurance. **Resource Mothers Program and ARC:** **$0**	**$10** to **$25** and no co-pays depending on income. For every 3 months you pay in advance, you get the 4th month free. Services are free due to funding by the United Way of Delaware, grants from the State as well as private and corporate contributions.	**$0** or share of cost.	**Medicare:** **$0** and share of cost for certain services; deductibles for certain plans. Part A: $0–$451 based on length of Medicare-covered employment; Part B: $99.90-$319.70 depending on annual income; Part C: Based on provider; Part D: Varies in cost and drugs covered. **Elder Info:** **$0**	**27.5%** of the insurance premium including COBRA premium if employer contributes less than 50%.

Demographic	PRIVATE HEALTH INSURANCE				
	Small Businesses (1-50 Employees)	**Individuals Recently Covered by an Employer Health Plan**	**Individuals & Families**	**Individuals with Pre-existing, Severe, or Chronic Medical conditions**	**Low-Income Individuals & Families**
Program	**Group Plans** Florida Association of Health Underwriters 321-244-0427 www.fahu.org	**COBRA/Mini-COBRA** Contact your current carrier. After 18 months continuous group/COBRA coverage, convert to a plan under: **HIPAA** Health Insurance Portability & Accountability Act 866-487-2365 www.dol.gov (Search: HIPAA)	**Individual Plans** Florida Association of Health Underwriters 321-244-0427 www.fahu.org	**Pre-Existing Condition Insurance Plan (PCIP)** Run by the U.S. Department of Health and Human Services 866-717-5826 www.PCIP.gov www.pciplan.com	**Medicaid** 850-488-3560 866-762-2237 www.fdhc.state.fl.us/Medicaid
Coverage	No Lifetime Limits. There is a 6-month look-back/12-month exclusionary period for pre-existing conditions on enrollees with no prior coverage or whose prior coverage had a break of more than 63 days. ***Pre-Existing Health Conditions Covered***	**COBRA:** Coverage available for 18–36 months depending on qualifying events. Benefits are what you had with your previous employer. **Mini-COBRA:** Coverage lasts up to 18 months depending on qualifying events. Benefits are what you had with your previous employer. **HIPAA:** Benefits are based on program selected. There is no expiration of coverage. ***Pre-Existing Health Conditions Covered***	Assorted plans depending on medical needs. There is a 24-month look-back and exclusionary period limit for pre-existing conditions on enrollees with no prior coverage. If eligible for HIPAA portability, pre-existing conditions are covered. ***Limits on Pre-Existing Health Conditions May Apply***	Covers broad range of benefits, including primary and specialty care, hospital care, and prescription drugs. ***Pre-Existing Health Conditions Covered***	Ambulatory, Surgical centers, Birth center services, Child health check ups, Chiropractic care, Durable medical equipment and supplies, Federally qualified health centers, Home health, Hospital inpatient/outpatient care, Laboratory, Licensed midwives, Physician, Podiatry, Prescriptions, Rural health clinics, Therapy, and X-rays. Retroactive benefits available at the time of application for medical services received three months prior. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Company size 1–50 employees. Owner can count as an employee. Owner name on business license must draw wages from the company. Groups of one have open enrollment during limited times during the year. Eligible employees must work at least 25 hours a week. Employers must provide copies of their federal income tax Schedule K or Schedule C forms for insurance carriers. Also, if there is an employee or owner who is not drawing a paycheck, carriers require a letter from CPA or Attorney stating when business was formed and who works for the business and number of hours.	**COBRA:** Available for employees who work for businesses with 20 or more employees. You have 60 days from date of termination to sign-up. **Mini-COBRA:** Available for employees who work for businesses with less than 20 employees. You have 30 days from receiving election notice from insurance carrier to sign-up. **HIPAA:** Must have had 18 months of continuous coverage and completely exhausted COBRA or state continuation coverage. Must not have lost coverage due to fraud or non-payment of premiums. You have 63 days to enroll.	Eligibility is subject to medical underwriting. If you are denied coverage for a medical condition, you may be eligible for PCIP. See next column.	**GUARANTEED COVERAGE** Must have been uninsured for at least 6 months prior to applying. Must prove being a U.S. citizen or legal U.S. resident, a Florida resident, and having problems getting insurance due to a pre-existing condition.	**GUARANTEED COVERAGE** Must be U.S. citizens or legal aliens and Florida residents. Income Limits: Pregnant Women: 185% FPL. Children Ages 0–1: 200% FPL. Children Ages 1–5: 133% FPL. Children Ages 6–18: 100% FPL. Parents/Caretakers: 0-20% FPL Aged, Blind and Disabled: 88% FPL. SSI Recipients: 74% FPL. Parents/Caretakers Living with Children ages 0–18: 53% FPL. Medically-Needy: 20% FPL with asset limits of $5,000 for singles, and $6,000 for couples. No asset or resource requirements for children or pregnant mothers.
Monthly Cost	Costs depend on employer contribution and ± 15% of the indexed rate depending on the health, residence and number of the group members. Groups with 10 or more employees may use group medical questionnaire. Groups of under 10 employees must answer individual medical questionnaires.	**COBRA/Mini-COBRA:** 102%–150% of group health rates. **HIPAA:** Premiums will depend on plan chosen.	Costs for individual coverage vary. There are no rate caps.	$118-$505 depending on your age and plan chosen.	**$0–$3** co-pays per visit. 5% of payment up to $15/visit for non-emergency services in the ER.

PUBLICLY-SPONSORED PROGRAMS

Demographic	Children	Women in Need of Cancer Screening	Seniors & Disabled	Trade Dislocated Workers (TAA Recipients)	Veterans
Program	**Florida KidCare** MediKids, Children's Medical Services 888-540-5437 TTD: 877-316-8748 www.floridakidcare.org **Healthy Kids** 888-540-5437 www.healthykids.org	**Breast & Cervical Cancer Early Detection Program (FBCCEDP)** 800-227-2345 www.doh.state.fl.us/Family/cancer/bcc **Colorectal Cancer Control Program (CRCCP)** 800-227-2345 www.doh.state.fl.us/Family/cancer/crc	**Medicare** 800-633-4227 www.medicare.gov **Medicare Prescription Drug Program** 800-633-4227	**Health Coverage Tax Credit** 866-628-4282 www.irs.gov (Search: HCTC)	**VA Medical Benefits Package** 877-222-8387 www.va.gov www.ebenefits.va.gov
Coverage	**MediKids:** Ambulance, Inpatient/Outpatient services, Specialists, Vision, Hearing, Dental, Prescription drugs, Lab & X-ray, Durable Medical Equipment, Therapies, Nursing, Mental health, Home health, and more. **CMS:** Full range of care, including prevention & early intervention services; primary & specialty care; long term care for children with special health needs. Respites, Genetic Testings, Genetic & Nutrional Counseling, and Parent Support are also included. **Healthy Kids:** Well-child visits, Shots, Hospital stays, Dental coverage, Vision services, Prescriptions, Mental health services, and more. ***Pre-Existing Health Conditions Covered***	**FBCCEDP:** Breast and cervical cancer screening exams clinical breast exams, mammograms, and Pap smears. Some diagnostic exams are covered and referral to treatment as necessary. Outreach, public education and professional education are provided. Treatment for eligible women may be paid by Medicaid. **CRCCP:** Provides limited colorectal cancer screening exams (colonoscopies and immunochemical fecal occult blood tests).	Offers Part A, inpatient care in hospitals and rehabilitative centers; Part B, doctor and some preventive services and outpatient care; Part C allows Medicare benefits through private insurance (Medicare Advantage); Part C includes Parts A, B, and C not covered by Medicare. Part D covers prescription drugs. ***Pre-Existing Health Conditions Covered***	Inpatient and outpatient care (lab tests, x-rays, etc.), Doctor visits, Preventive and major medical care (surgery, physical therapy, Durable medical equipment, etc.), Mental health and substance abuse care, and Prescription drugs. ***Pre-Existing Health Conditions Covered***	Comprehensive preventive and primary care, outpatient and inpatient services. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** **All:** Must be a U.S. citizen or qualified non-citizen and live in Florida. Must be under age 19 years old, uninsured, and have an income at or below 200% FPL. Must not be eligible for Medicaid, or be the dependent of a state employee eligible for health insurance, or be in a public institution. Families who are not eligible for premium assistance may buy Florida KidCare (MediKids or Healthy Kids, not CMS) at the "full pay" premium rate. **Healthy Kids:** Must be between ages 5-18.	**GUARANTEED COVERAGE** **FBCCEDP:** Must be women 50 to 64 years of age, living at or below 200% FPL. Must either be uninsured or have insurance that does not cover breast or cervical cancer screening. **CRCCP:** Must be a man or woman 50-64 years old with no insurance. Must be below 200% FPL.	**GUARANTEED COVERAGE** Must be U.S. citizen or permanent U.S. resident, and: 1) If 65 years or older, you or your spouse worked for at least 10 years in Medicare-covered employment, or 2) You have a disability or end-stage renal disease (permanent kidney failure requiring dialysis or transplant) at any age.	**GUARANTEED COVERAGE** Must be receiving TAA (Trade Adjustment Assistance), or Must be 55 years or older and receiving pension from the Pension Benefit Guaranty Corporation (PBGC). Must not be enrolled in certain state plans, or in prison, or receiving 65% COBRA premium reduction, or be claimed as a dependent in tax returns. Must be enrolled in qualified health plans where you pay more than 50% of the premiums.	**GUARANTEED COVERAGE** "Veteran status" = active duty in the U.S. military, naval, or air service and a discharge or release from active military service under other than dishonorable conditions. Certain veterans must have completed 24 continuous months of service.
Monthly Cost	**All:** Premium is based on household size and monthly income. Most families pay either $15 or $20 per family per month; some families may pay more. There may be co-payments required based on the service provided. No monthly premiums or co-payments required from federally-recognized American Indians.	**Both:** **$0** or minimal share of cost.	**$0** and share of cost for certain services; deductibles for certain plans. Part A: $0–$451 based on length of Medicare-covered employment; Part B: $99.90-$319.70 depending on annual income; Part C: Based on provider; Part D: Varies in cost and drugs covered.	**27.5%** of the insurance premium including COBRA premium if employer contributes less than 50%.	**$0** and share of cost and co-pays depending on income level.

PRIVATE HEALTH INSURANCE

Demographic	Small Businesses (2-50 Employees)	Individuals Recently Covered by an Employer Health Plan	Individuals & Families	Individuals with Pre-Existing, Severe, or Chronic Medical Conditions	Low-Income Families & Medically-Needy
Program	**Group Plans** Georgia Association of Health Underwriters 770-516-4746 www.gahu.org	**COBRA/Mini-COBRA** Contact your current carrier. After 18 months continuous group/COBRA coverage, convert to a plan under: **HIPAA** Health Insurance Portability & Accountability Act 866-487-2365 www.dol.gov (Search: HIPAA) **HIPP** Health Insurance Premium Payment 678-564-1162 ext 131 dch.georgia.gov (Search: HIPP)	**Individual Plans** Georgia Association of Health Underwriters 770-516-4746 www.gahu.org	**Pre-Existing Condition Insurance Plan (PCIP)** Run by the U.S. Department of Health and Human Services 866-717-5826 www.PCIP.gov www.pciplan.com	**Medicaid** 404-656-6060 dch.georgia.gov
Coverage	There is a 6-month look-back/12-month exclusionary period for pre-existing conditions on enrollees that do not have prior creditable coverage or had a lapse of more than 90 days in their prior coverage. Benefits will vary depending on the chosen plan. ***Pre-Existing Health Conditions Covered***	**COBRA:** Coverage available for 18–36 months depending on qualifying events. If beneficiary is age 60 or older when group plan is terminated, then COBRA lasts until beneficiary is Medicare-eligible. Benefits are what you had with your previous employer. **Mini-COBRA:** Benefits are what you had with your previous employer. Mini-COBRA lasts 3 months. **HIPAA:** Benefits are based on program selected. There is no expiration of coverage. **HIPP:** Premium assistance that pays employer-sponsored health insurance or COBRA premiums. The assistance amount depends on the most cost-effective premium available. ***Pre-Existing Health Conditions Covered***	Elimination riders are permitted. There is no limit to the look-back period and there is a maximum exclusion period of 24 for pre-existing conditions on enrollees with no prior coverage. ***Limits on Pre-Existing Health Conditions May Apply***	Covers broad range of benefits, including primary and specialty care, hospital care, and prescription drugs. ***Pre-Existing Health Conditions Covered***	Doctor visits, Hospital care, Labs, Prescription drugs, Transportation, Routine shots for children, Mental health and substance abuse services, X-rays, Home health care, Hospice care, Dental care (up to age 21). Retroactive benefits available at the time of application for medical services received three months prior. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Company size 2–50 employees. Owner can count as an employee. Proprietor name on license must draw wages. Eligible employees must work at least 30 hours a week.	**GUARANTEED COVERAGE** **COBRA:** Available for employees who work for employers with 20 or more employees. Have 60 days from date of termination to sign-up. **Mini-COBRA:** Available for employees who work for employers with less than 20 employees. Must be ineligible for Medicare, have been insured by group plan 6 months prior to date of termination. Qualified individuals must sign up for Mini-COBRA in 63 days after date of receiving notice of right to continue coverage. **HIPAA:** Must have had 18 months of continuous coverage and completely exhausted COBRA or state continuation coverage. Must not have lost coverage due to fraud or non-payment of premiums. You have 63 days to enroll. **HIPP:** Must qualify for Medicaid and have access to Employer-Sponsored Insurance or COBRA.	Eligibility is based on medical underwriting. Must be resident of state or documented immigrant.	**GUARANTEED COVERAGE** Must have been uninsured for at least 6 months prior to applying. Must prove being a U.S. citizen or legal U.S. resident, a Georgia resident, and having problems getting insurance due to a pre-existing condition.	**GUARANTEED COVERAGE** Must be U.S. citizen or lawful alien living in Georgia. Income Limits: Pregnant Women: 200% FPL. Children Ages 0-1: 185% FPL. Children Ages 1-5 : 133% FPL. Children Ages 6-19: 100% FPL. Families with Dependents: Up to 30% FPL. Parents/Caretakers of Children: 49% FPL. Medically-Needy: Singles earning 22% FPL with resource limit of $2,000; couples earning 30% FPL with resource limit of $4,000. Aged, Blind, & Disabled receiving SSI: Singles with an asset limit of $2,000; couples with an asset limit of $3,000.
Monthly Cost	Costs depend on employer contribution and ± 25% of the insurance company's index rate. Annual rate increases are limited to 15%.	**COBRA/ Mini-COBRA:** 102%–150% of group health rates. **HIPAA:** Premiums will depend on plan chosen. **HIPP:** HIPP reimburses the full employer-sponsored insurance premium amount by check monthly. Pays the insurance company directly for people on COBRA or eligible small businesses.	Various price ranges depending on deductible and what plan you buy. There are no rate caps.	$147 to $633 depending on your age and plan chosen.	**$0–$3** per office visit. **$12.50** for non-emergency admission in hospital other than in mental institution.

PUBLICLY-SPONSORED PROGRAMS

Demographic	Children	Infants & Children with Developmental Delays	Women in Need of Cancer Screening	Seniors & Disabled	Trade Dislocated Workers (TAA Recipients)
Program	**PeachCare for Kids** 877-427-3224 www.peachcare.org **Women-Infants-Children (WIC)** 404-657-2900 800-228-9173 wic.ga.gov **Children 1st** 404-656-6679 health.state.ga.us (Search: Children 1st)	**Babies Can't Wait** 404-657-2878 888-651-8224 health.state.ga.us (Search: BCW)	**Breast & Cervical Cancer Program (BCCP)** 404-657-6611 www.georgiacancer.org **Cancer State Aid Program (CSA)** 404-463-5111 www.georgiacancer.org **Women's Health Medicaid Program** 404-657-6611 www.georgiacancer.org	**Medicare** 800-633-4227 www.medicare.gov **Medicare Prescription Drug Program** 800-633-4227 **Georgia Cares** (Assistance for Seniors) 800-669-8387 866-552-4464 www.mygeorgiacares.org	**Health Coverage Tax Credit** 866-628-4282 www.irs.gov (Search: HCTC)
Coverage	**PeachCare for Kids:** Doctor visits, Check-ups, Immunizations, Preventive care, Specialist care, Dental care, Vision care, Hospitalization, Emergency room services, Prescriptions, and Mental health care. **WIC:** Nutrition assessment, health screening, medical history, body measurement (weight and height), hemoglobin check, nutrition education, breast-feeding support and education, and vouchers for food supplements. **Children 1st:** Entry point to Georgia's public health programs. Children 1st screens children for poor health, refers them to appropriate programs, (such as Babies Can't Wait or Medicaid) and monitors children with risky health conditions to ensure their proper development. ***Pre-Existing Health Conditions Covered***	Evaluation and assessments to determine eligibility and scope of services needed. Service coordination that assists the family and other professionals in developing a plan to enhance the child's development. ***Pre-Existing Health Conditions Covered***	**BCCP:** Offers clinical breast examinations, mammograms, and pelvic examinations and Pap tests. If screened and diagnosed for breast or cervical cancer, may be eligible for complete health coverage through Medicaid. **CSA:** Services may include Inpatient and outpatient services, Chemotherapy and radiation centers, Private or retail pharmacies, Home health agencies, and Medical suppliers. **WHMP:** Breast and cervical cancer and cervical pre-cancer treatment. Full coverage Medicaid that includes the full range of services not only cancer treatment. Services continue until all cancer treatment has been provided. ***Pre-Existing Health Conditions Covered***	**Medicare** offers Part A, inpatient care in hospitals and rehabilitative centers; Part B, doctor and some preventive services and outpatient care; Part C allows Medicare benefits through private insurance (Medicare Advantage); Part C includes Parts A, B, and C not covered by Medicare. Part D covers prescription drugs. **Georgia Cares** is a Medicare counseling service. ***Pre-Existing Health Conditions Covered***	Inpatient and outpatient care (lab tests, x-rays, etc.), Doctor visits, Preventive and major medical care (surgery, physical therapy, Durable medical equipment, etc.), Mental health and substance abuse care, and Prescription drugs. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** **PeachCare for Kids:** Must be low-income children under age 19, with family incomes up to 235% FPL, and must be uninsured, ineligible for Medicaid, and be U.S. citizens, certain qualified legal residents, refugees or asylees who reside in Georgia. **WIC:** Must be pregnant or postpartum women and children up to the age of 5 years with family incomes at or below 185% FPL. Must be a Georgia resident and be at nutritional or medical risk, as determined by a health professional. **Children 1st:** Must be Georgia children ages 0 to 5, who are identified to be at risk for poor health and development. There are no financial requirements.	**GUARANTEED COVERAGE** Must be children 0–3 years old, of any income, who meet one of the following: 1) Have a diagnosed physical or mental condition which is known to result in a developmental delay, such as blindness, Down syndrome, or Spina Bifida. 2) Have a diagnosed developmental delay confirmed by a qualified team of professionals.	**GUARANTEED COVERAGE** **BCCP:** Income at or below 200% FPL, uninsured, and ineligible for Medicaid or Medicare. Must have been one year or more since last mammogram and/or Pap test or have symptoms suspicious of breast or cervical cancer. Age 40 or older: May be eligible for clinical breast and pelvic examinations, Pap tests, mammograms, and diagnostic evaluations Age 35-39: May be eligible for diagnostic evaluation if they have symptoms highly suspicious of breast cancer. Age less than 40: May be eligible for clinical breast and pelvic examinations, diagnostic services, and Pap tests. **CSA:** Must be uninsured or underinsured and a resident of Georgia and a U.S. citizen living below 300% FPL. **WHMP:** Must be unisured and a resident of Georgia and a U.S. citizen living below 200% FPL. Must be under 65 years old and diagnosed with breast or cervical cancer or cervical pre-cancer.	**GUARANTEED COVERAGE** **Both:** Must be U.S. citizen or permanent U.S. resident, and: 1) If 65 years or older, you or your spouse worked for at least 10 years in Medicare-covered employment, or 2) You have a disability or end-stage renal disease (permanent kidney failure requiring dialysis or transplant) at any age.	**GUARANTEED COVERAGE** Must be receiving TAA (Trade Adjustment Assistance), or Must be 55 years or older and receiving pension from the Pension Benefit Guaranty Corporation (PBGC). Must not be enrolled in certain state plans, or in prison, or receiving 65% COBRA premium reduction, or be claimed as a dependent in tax returns. Must be enrolled in qualified health plans where you pay more than 50% of the premiums.
Monthly Cost	**PeachCare for Kids:** **$0** for children under age 6, $10–$35 for one child, max of $70 for two or more children. **WIC & Children 1st:** **$0** or minimal share of cost.	**$0** or fees based on a sliding fee scale for families unable to pay.	**All:** **$0** or minimal share of cost.	**Both:** **$0** and share of cost for certain services; deductibles for certain plans. Part A: $0–$451 based on length of Medicare-covered employment; Part B: $99.90-$319.70 depending on annual income; Part C: Based on provider; Part D: Varies in cost and drugs covered.	**27.5%** of the insurance premium including COBRA premium if employer contributes less than 50%.

PRIVATE HEALTH INSURANCE

Demographic	Small Businesses (1-50 Employees)	Individuals Recently Covered by an Employer Health Plan	Individuals & Families	Individuals with Pre-Existing, Severe, or Chronic Medical Conditions	Low-Income Individuals & Families
Program	**Group Plans** National Association of Health Underwriters 202-552-5060 www.nahu.org **Prepaid Health Care Law (PHC)** 808-586-9188 hawaii.gov/labor/dcd/aboutphc.shtml	**COBRA /Prepaid Health Care Continuation (PHC)** Contact your current carrier. After 18 months continuous group/COBRA coverage, convert to a plan under: **HIPAA** Health Insurance Portability & Accountability Act 866-487-2365 www.dol.gov (Search: HIPAA) **Hawaii Insurance Continuation Program (H-COBRA)** 808-733-9360 hawaii.gov (Search: H-COBRA)	**Individual Plans** National Association of Health Underwriters 202-552-5060 www.nahu.org	**Pre-Existing Condition Insurance Plan (PCIP)** Run by the U.S. Department of Health and Human Services 866-717-5826 www.PCIP.gov www.pciplan.com	**QUEST** 800-316-8005, 808-524-3370 www.med-quest.us hawaii.gov/dhs/health/medquest There are various plans: QUEST, QUEST-Expanded, QUEST-ACE, and QUEST-Net. **QUEST Expanded (QExA)** 866-928-1959 www.qexa.org NOTE: There is a QUEST enrollment cap of 125,000. Single childless adults cannot be enrolled, even if they meet all other requirements. Cap is lifted when enrollment is below 125,000 individuals on Dec. 31 of any year.
Coverage	Hawaii has no law defining size of small group market. Most carriers define it as 1–50 employees, others as 1–100. There's a maximum look-back and exclusion period of zero months. Insurers cannot impose pre-existing condition exclusion. **PHC:** Requires employers to provide health insurance that covers hospital, medical, diagnostic and maternity benefits for eligible employees. If employee has 2 or more employers, then the employer who provides coverage is the one who 1) pays the most wages or 2) employs the employee for at least 35 hours/week. ***Pre-Existing Health Conditions Covered***	**COBRA:** Coverage available for 18–36 months depending on qualifying events. Benefits are what you had with your previous employer. **PHC Continuation:** Pays part of employee's premium for 3 months in case of employee disability and inability to work. **HIPAA:** Benefits are based on program selected. There is no expiration of coverage. **H-COBRA:** H-COBRA pays premiums for COBRA-eligible HIV-positive people who cannot afford premiums, or for those ineligible for group coverage (such as COBRA) but who can convert from group to individual coverage under HIPAA. H-COBRA pays only for HIPAA plans that cover prescription drugs. ***Pre-Existing Health Conditions Covered***	Elimination riders are permitted. There is no limit to the look-back period, but there is a maximum exclusion period of 36 months. Options vary depending on applicant needs and plan selected. ***Limits on Pre-Existing Health Conditions May Apply***	Covers broad range of benefits, including primary and specialty care, hospital care, and prescription drugs. ***Pre-Existing Health Conditions Covered***	**All:** 1-month waiting period for all services (except emergency and urgent care) unless under age 21. **QUEST:** Inpatient and outpatient hospital and clinical services (including x-rays and lab exams), Physician, Nursing facility and home health services, Prescription drugs, Biological and medical supplies and equipment, Vision and dental, Family planning and maternity, Psychiatric and psychological services, Diagnostic, screening, preventive and rehabilitative services, Medical transportation, Respiratory and hospice care, Emergency and urgent care. Early Periodic Screening, Diagnosis and Treatment (EPSDT) available for enrollees under age 21. Retroactive benefits available at the time of application for medical services received three months prior. **QUEST-ACE & QUEST-Net:** Limited prescription drugs, Medical, urgery, psychiatric and substance abuse services (cataract and heart surgeries not covered). 10 inpatient, 12 outpatient, and 6 mental health visits. ER for actual emergencies. Preventive and restorative dental care. No maternity benefits for adults ages 21 or older, unless income of pregnant woman's family is at or below 185% FPL. **QeXA:** Same as QUEST, plus home/community-based care, institutional services, and services of health care coordinator and primary care doctor. ***Pre-Existing Health Conditions Covered***
Eligibility	Company size: 1–50 employees. Owner can count as an employee. Proprietor's name on license must draw wages. **PHC:** Employers must get approved health plans from authorized health care contractor. Eligible employees must work at least 20 hours a week, earn at least 86.67 times Hawaii's minimum wage, have worked for 4 consecutive weeks, and must be uninsured at time of enrollment. Not eligible for coverage under PHC: Federal, State and County workers; agricultural seasonal workers; real-estate or insurance sales people paid only on commission; people working for son, daughter or spouse; children under 21 working for father or mother.	**GUARANTEED COVERAGE** **COBRA:** Available for employees who work for businesses with 20 or more employees. You have 60 days from date of termination to sign-up. **PHC Continuation:** Employee must be eligible under PHC Law. See "Small Businesses (1–50 employees)" column on left. **HIPAA:** Must have had 18 months of continuous coverage and completely exhausted COBRA or state continuation coverage. Must not have lost coverage due to fraud or non-payment of premiums. You have 63 days to enroll. **H-COBRA:** Must live in Hawaii. Must be diagnosed as HIV positive, eligible for COBRA or for converted individual plan under HIPAA, and have income up to 300% FPL.	Medical underwriting is allowed without restriction.	**GUARANTEED COVERAGE** Must have been uninsured for at least 6 months prior to applying. Must prove being a U.S. citizen or legal U.S. resident, a Hawaii resident, and having problems getting insurance due to a pre-existing condition.	**GUARANTEED COVERAGE** **All:** Must be U.S. citizen or legal immigrant and Hawaii resident and not be in a public institution. **QUEST:** Must not be qualified for health coverage from employer (except General Assistance and AFDC recipients). Must not be blind, disabled, or Medicare-eligible, and must be under 65 years old. Income limit of 100% FPL. Asset limits of $2,000 for a household of one, $3000 for two, and $250 for each additional family member. Also eligible: Pregnant women and children under 1 living at or below 185% FPL, children ages 1-5 living at or below 133% FPL. and children ages 6-18 (foster children up to age 21) living at or below 100% FPL with no asset limits requirements for either. **QUEST-ACE:** Same as QUEST, but must be childless living at or below 133% FPL. **QUEST-Net:** Same as QUEST, but living at or below 133% FPL with asset limit of $5,000 for a household of one, $7,000 for two, and $500 for each added member. **QeXA:** Must be 65 and older, or certified blind or disabled living at or below 100% FPL with asset limits of $2,000 for singles, and $3,000 for couples.
Monthly Cost	Costs depend on employer contribution. Rates must be approved by the state Dept. of Insurance. **PHC:** Employer must pay at least 50% of premium. Employees pay no more than 1.5% of monthly wage.	**COBRA:** 102%–150% of group health rates. **PHC Continuation:** Employer must pay at least 50% of premium. Employees pay no more than 1.5% of monthly wage. **HIPAA:** Premiums will depend on plan chosen. **H-COBRA:** Pays the insurance company directly for people on COBRA.	Various price ranges depending on deductible and what plan you buy. There are no rate caps.	$116 to $500 depending on your age and plan chosen.	**QUEST:** **$0** or **$30** if self-employed and earning 100% FPL. **QeXA & QUEST-ACE:** **$0** **QUEST-Net:** **$60** full premium if earning 100% FPL and at least 19 years old. 50% of full premium if self-employed and earning 100% FPL or below. Full or part of premium if earning 250% FPL or more and age 18 and younger.

PUBLICLY-SPONSORED PROGRAMS

Children	Women in Need of Cancer Screening	Adults with Substance Abuse Problems	Seniors & Disabled	Trade Dislocated Workers (TAA Recipients)	Demographic
Hawaii's Medical Service Association (HMSA) Children's Plan 808-948-5555 www.hmsa.com (Search: Children's Plan)	**Breast & Cervical Cancer Control Program** 808-692-7460 www.hawaii.gov (Search: BCCCP)	**Department of Health Alcohol & Drug Abuse Division** 808-692-7507 www.hawaii.gov (Search: ADAD)	**Medicare** 800-633-4227 www.medicare.gov **Medicare Prescription Drug Program** 800-633-4227 **Sage Plus** 888-875-9229	**Health Coverage Tax Credit** 866-628-4282 www.irs.gov (Search: HCTC)	Program
Office visits, Routine and preventive care, Gynecological exams, Emergency services, Surgeries, Anesthesia, Diagnostic lab and x-ray services, Inpatient and outpatient hospital services, Maternity care, Mental health and substance abuse services, and Prescription drugs, and more. There is a 12-month waiting period for maternity-related services. ***Pre-Existing Health Conditions Covered***	Clinical breast and pelvic exams, mammograms, Pap tests, and follow-up diagnostic care for abnormal results.	Comprehensive system of services to meet the treatment and recovery needs of individuals and families. Inpatient and outpatient programs. Residential programs, day treatment programs, intensive outpatient programs, outpatient treatment, therapeutic living programs, residential social detoxification programs, methadone maintenance outpatient programs. ***Pre-Existing Health Conditions Covered***	**Medicare** offers Part A, inpatient care in hospitals and rehabilitative centers; Part B, doctor and some preventive services and outpatient care; Part C allows Medicare benefits through private insurance (Medicare Advantage); Part C includes Parts A, B, and C not covered by Medicare. Part D covers prescription drugs. **Sage Plus** is a Medicare counseling service. ***Pre-Existing Health Conditions Covered***	Inpatient and outpatient care (lab tests, x-rays, etc.), Doctor visits, Preventive and major medical care (surgery, physical therapy, Durable medical equipment, etc.), Mental health and substance abuse care, and Prescription drugs. ***Pre-Existing Health Conditions Covered***	Coverage
GUARANTEED COVERAGE Must be uninsured children ages 31 days to 18 years old. Must be a Hawaii resident for at least 6 months (based on the parent's or guardian's residency). Must not qualify for any other insurance, including QUEST. There is no household income limit or citizenship requirement.	**GUARANTEED COVERAGE** Must be women ages 50 to 64, uninsured or underinsured with incomes at or below 250% FPL.	**GUARANTEED COVERAGE** Treatment services have, as a requirement, priority admission for pregnant women and injection drug users.	**GUARANTEED COVERAGE** **Medicare & Sage Plus:** Must be U.S. citizen or permanent U.S. resident, and: 1) If 65 years or older, you or your spouse worked for at least 10 years in Medicare-covered employment, or 2) You have a disability or end-stage renal disease (permanent kidney failure requiring dialysis or transplant) at any age.	**GUARANTEED COVERAGE** Must be receiving TAA (Trade Adjustment Assistance), or Must be 55 years or older and receiving pension from the Pension Benefit Guaranty Corporation (PBGC). Must not be enrolled in certain state plans, or in prison, or receiving 65% COBRA premium reduction, or be claimed as a dependent in tax returns. Must be enrolled in qualified health plans where you pay more than 50% of the premiums.	Eligibility
$73	**$0** or minimal share of cost.	**$0** or share of cost. Costs vary depending on which program you choose.	**Medicare: $0** and share of cost for certain services; deductibles for certain plans. Part A: $0 - $451 based on length of Medicare-covered employment; Part B: $99.90-$319.70 depending on annual income; Part C: Based on provider; Part D: Varies in cost and drugs covered. **Sage Plus: $0**	**27.5%** of the insurance premium including COBRA premium if employer contributes less than 50%.	Monthly Cost

PRIVATE HEALTH INSURANCE

Demographic	Small Businesses (2-50 Employees)	Individuals Recently Covered by an Employer Health Plan	Individuals & Families	Individuals with Pre-Existing, Severe, or Chronic Medical Conditions	Low-Income Individuals & Families
Program	**Group Plans** Idaho Association of Health Underwriters 208-323-0611 www.iahu.org **Access to Health Insurance (AHI)** 866-326-2485 www.accesstohealthinsurance.idaho.gov	**COBRA** Contact your current carrier. After 18 months continuous group/COBRA coverage, convert to a plan under: **HIPAA** Health Insurance Portability & Accountability Act 866-487-2365 www.dol.gov (Search: HIPAA)	**Individual Plans** Idaho Association of Health Underwriters 208-323-0611 www.iahu.org	**High Risk Reinsurance Pool Plans (HRP)** 208-334-4250 800-721-3272 www.doi.idaho.gov **Pre-Existing Condition Insurance Plan (PCIP)** Run by the U.S. Department of Health and Human Services 866-717-5826 www.PCIP.gov www.pciplan.com	**Medicaid** 800-926-2588 TDD: 208-332-7205 www.healthandwelfare.idaho.gov (Search: Medicaid) See backside of Matrix for welfare office information.
Coverage	Up to $5M lifetime maximum, assorted deductibles. There is a maximum 6-month look-back/12-month exclusionary period for pre-existing conditions on enrollees that do not have prior coverage or whose prior coverage lapsed for more than 63 days. **AHI:** Premium assistance program that makes health insurance more affordable for employees of qualified small businesses. ***Pre-Existing Health Conditions Covered***	**COBRA:** Coverage available for 18–36 months depending on qualifying events. Benefits are what you had with your previous employer. **HIPAA:** Benefits are based on program selected. There is no expiration of coverage. ***Pre-Existing Health Conditions Covered***	Carriers must guarantee coverage for at least three products (basic, standard and catastrophic) to all individual market consumers with 12 months of creditable coverage, and elimination riders are not permitted. Assorted deductibles depending on age and ZIP code. ***Limits on Pre-Existing Health Conditions May Apply***	**HRP:** Maternity care, Prescription drugs, Preventive services, Nursing, Therapies, Home health care, Hospice, Ambulance services, Durable medical equipment, Psychiatric and substance abuse services. All insurers sell the same 5 HRP plans that cover the same health benefits, but cost sharing varies. **PCIP:** Covers broad range of benefits, including primary and specialty care, hospital care, and prescription drugs. ***Pre-Existing Health Conditions Covered***	Depending on plan chosen (Standard, Basic, Enhanced, and Medicare-Medicaid Coordinated), services include Primary care, Hospital services, Lab and x-ray, Physician services, Midwife, Nursing home coverage (over age 21), Family planning, Home health, Emergency, Medical transportation, Preventive health, Nutrition, Prescription drugs, Dental, Vision, Mental health, Therapies, Durable medical equipment and supplies, Prosthetics/orthotics, School-based services, Nursing facility services, Intermediate care facilities for developmentally challenged persons, Psychosocial rehabilitation, Private duty nursing, Home and community-based waiver services, Service coordination. Retroactive benefits available at the time of application for medical services received three months prior. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Company size is 2–50 employees (including owner). Owner name on business license must draw wages from the company. Eligible employees must work at least 30 hours a week. Or, by agreement between the employer and the carrier, an eligible employe can work 20–30 hours per week. **AHI:** Employers must operate an Idaho small business, currently not offer health insurance, must pay at least 50% of the employee's premium, and have at least one employee eligible for premium assistance. Employees must work for a participating small business, be at least 18, uninsured, U.S. citizens or legal residents, live in Idaho with incomes of or less than 185% FPL.	**GUARANTEED COVERAGE** **COBRA:** Available for employees who work for businesses with 20 or more employees. You have 60 days from date of termination to sign-up. **HIPAA:** Must have had 18 months of continuous coverage and completely exhausted COBRA or state continuation coverage. Must not have lost coverage due to fraud or non-payment of premiums. You have 63 days to enroll.	Eligibility is subject to medical underwriting. If you are denied coverage for a medical condition, you may be eligible for HRP or PCIP. See next column.	**GUARANTEED COVERAGE** **HRP:** There are 4 ways to be eligible: 1) You are under age 65, uninsured and unqualified for any group insurance including Medicaid and Medicare, were turned down for health coverage due to pre-existing conditions, offered premiums that were unaffordable. Or, 2) You lost your health insurance not due to fraud or non-payment of premium, and had group coverage for at least 12 months prior, had taken and exhausted your COBRA benefits, and you are ineligible for Medicaid or Medicare. Or, 3) You receive Trade Adjustment Assistance (TAA). Or, 4) If you are eligible under 1, 2 or 3 above but are insured, then the lifetime benefit maximum of your current policy must be at least $500,000 and there must be reasonable probability that you will exceed your policy's lifetime benefit maximum in 90 days. **PCIP:** Must have been uninsured for at least 6 months prior to applying. Must prove being a U.S. citizen or legal U.S. resident, an Idaho resident, and having problems getting insurance due to a pre-existing condition.	**GUARANTEED COVERAGE** Must be a U.S. citizen or legal non-citizen and Idaho resident. Income Limits: Pregnant Women and Children Ages 0-5: 133% FPL (co-payments vary depending on the families' qualifying income). Children Ages 6-18: 100% FPL. Parents/Caretakers Living with Children Ages 0–18: 39% FPL Aged, Blind, and Disabled: Singles earning up to 78% FPL with asset limit of $2,000; couples earning up to 83% FPL with asset limit of $3,000. Adults with or without Dependents: 22% FPL.
Monthly Cost	Costs depend on employer contribution and ± 50% of the insurance company's index rate. **AHI:** Premium assistance of up $500 per month, per family.	**COBRA:** 102%–150% of group health rates. **HIPAA:** Premiums will depend on plan chosen.	Costs for individual coverage vary. Rates can vary no more than ±50% of the base individual market rate.	**HRP:** $128 to $1,943 depending on plan chosen, age, tobacco use, and gender, **PCIP:** $133 to $571 depending on your age and plan chosen.	**$0** or minimal share of cost.

PUBLICLY-SPONSORED PROGRAMS

Demographic	Children	Women in Need of Cancer Screening	Immigrants Awaiting Legal Status	Seniors & Disabled	Trade Dislocated Workers (TAA Recipients)
Program	**Idaho Health Plan** 800-926-2588 www.healthandwelfare.idaho.gov (Click: Children > Idaho State Health Plan)	**Women's Health Check** 800-926-2588 www.healthandwelfare.idaho.gov (Search: Health Check)	**Emergency Medicaid** 800-926-2588 TDD 208-332-7205 866-326-2485 (Emergency Processing Center) See backside of Matrix for welfare office information.	**Medicare** 800-633-4227 www.medicare.gov **Medicare Prescription Drug Program** 800-633-4227	**Health Coverage Tax Credit** 866-628-4282 www.irs.gov (Search: HCTC)
Coverage	Regular checkups, Immunizations, Prescription drugs, Lab tests and x-rays, Hospital visits, and more. ***Pre-Existing Health Conditions Covered***	Annual clinical breast examinations, (CBE) mammograms, pelvic examinations, and Pap tests. After three consecutive normal Pap tests, Women's Health Check will cover one Pap test every three years. Diagnostic services, if needed.	Emergencies, Deliveries (not prenatal or postpartum care), Kidney dialysis, and Treatment for breast and cervical cancer. ***Pre-Existing Health Conditions Covered***	**Medicare** offers Part A, inpatient care in hospitals and rehabilitative centers; Part B, doctor and some preventive services and outpatient care; Part C allows Medicare benefits through private insurance (Medicare Advantage); Part C includes Parts A, B, and C not covered by Medicare. Part D covers prescription drugs. ***Pre-Existing Health Conditions Covered***	Inpatient and outpatient care (lab tests, x-rays, etc.), Doctor visits, Preventive and major medical care (surgery, physical therapy, Durable medical equipment, etc.), Mental health and substance abuse care, and Prescription drugs. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Must be a U.S. citizen or legal resident under 19 years old with income limit at or below 185% FPL. Eligible for premium assistance if income is at or below 185% FPL.	**GUARANTEED COVERAGE** Must be women living up to 200% FPL and are uninsured or have health insurance that does not cover mammograms or Pap tests. Women ages 50–65 are eligible for Pap tests, clinical breast exams and mammograms. Women ages 40–49 are eligible for Pap tests (women who have not had a Pap test in the last 5 years are a priority for enrollment). Limited enrollment and services for uninsured women ages 30–49 who have confirmed suspicious symptoms of breast cancer or cervical cancer. Age 30-39 and have symptoms suspicious of cervical cancer confirmed by a health care professional. Women 65 or older are also qualified if they are not eligible for Medicare or do not have Medicare Part B.	**GUARANTEED COVERAGE** U.S. citizenship not required. Income Limits: Pregnant Women and Children Ages 0-5: 133% FPL (co-payments vary depending on the families' qualifying income). Children Ages 6-18: 100% FPL. Parents/Caretakers Living with Children Ages 0–18: 39% FPL Aged, Blind & Disabled: Singles earning up to 78% FPL with asset limit of $2,000; couples earning up to 83% FPL with asset limit of $3,000. Adults with or without Dependents: 22% FPL.	**GUARANTEED COVERAGE** Must be U.S. citizen or permanent U.S. resident, and: 1) If 65 years or older, you or your spouse worked for at least 10 years in Medicare-covered employment, or 2) You have a disability or end-stage renal disease (permanent kidney failure requiring dialysis or transplant) at any age.	**GUARANTEED COVERAGE** Must be receiving TAA (Trade Adjustment Assistance), or Must be 55 years or older and receiving pension from the Pension Benefit Guaranty Corporation (PBGC). Must not be enrolled in certain state plans, or in prison, or receiving 65% COBRA premium reduction, or be claimed as a dependent in tax returns. Must be enrolled in qualified health plans where you pay more than 50% of the premiums.
Monthly Cost	**$0** or **$15** depending on income.	**$0** or minimal share of cost	**$0** or minimal share of cost	**$0** and share of cost for certain services; deductibles for certain plans. Part A: $0–$451 based on length of Medicare-covered employment; Part B: $99.90-$319.70 depending on annual income; Part C: Based on provider; Part D: Varies in cost and drugs covered.	**27.5%** of the insurance premium including COBRA premium if employer contributes less than 50%.

PRIVATE HEALTH INSURANCE

Demographic	Small Businesses (2-50 Employees)	Individuals Recently Covered by an Employer Health Plan	Individuals & Families	Individuals with Pre-Existing, Severe, or Chronic Medical Conditions	Low-Income Families & Individuals
Program	**Group Plans** Illinois Association of Health Underwriters www.isahu.com	**COBRA/Illinois Continuation Coverage (ICC)** Contact your current carrier. After 18 months continuous group/ COBRA coverage, convert to a plan under. **HIPAA** Health Insurance Portability & Accountability Act 866-487-2365 www.dol.gov (Search: HIPAA)	**Individual Plans** Illinois Association of Health Underwriters www.isahu.com	**Comprehensive Health Insurance Plan (CHIP)** 217-782-6333 (Illinois Residents) 800-962-8384 (General Info) 866-851-2751 (Eligibility Info) www.chip.state.il.us **Pre-Existing Condition Insurance Plan(IPXP)** 877-210-9167 TTY: 866-883-8551 www.insurance.illinois.gov/ipxp www.PCIP.gov	**Medicaid** 800-843-6154 www.hfs.illinois.gov/medical/apply.html **FamilyCare** 866-255-5437 www.familycareillinois.com
Coverage	There is a maximum look-back period of 6 months and a maximum exclusion period of 12 months for pre-existing conditions on enrollees who have no prior coverage. Benefits will vary depending on the chosen plan. ***Pre-Existing Health Conditions Covered with Some Limitations***	**COBRA:** Coverage available for 18–36 months depending on qualifying events. Benefits are what you had with your previous employer. **ICC:** Benefits are what you had with your previous employer. Length of coverage for A) Ex-employees: 12 months, B) Dependents and divorced/widowed spouses under age 55: 2 years, and C) 55 years or older divorced/widowed spouses and spouses of retired employees: Until eligible for Medicare. **HIPAA:** Benefits are based on program selected. There is no expiration of coverage. ***Pre-Existing Health Conditions Covered***	There is a maximum look-back period and maximum exclusion period of 24 months for pre-existing conditions on enrollees who have no prior coverage. Elimination riders are permitted. Covers certain state mandated items, however Illinois does not require standardization. Coverage options vary by carrier, but most offer plans that are HSA (Health Savings Account) compatible. ***Limits on Pre-Existing Health Conditions May Apply***	**CHIP:** Inpatient and outpatient care, Doctor visits, Surgery, Preventive care, Diagnostic care, X-rays, Home health care, Skilled nursing care, Hospice, Transplant coverage, Speech, Physical and occupational therapy, Mental health and chemical dependency, Separate prescription drug card. You can also choose a High Deductible Health Plan. **IPXP:** Covers broad range of benefits, including primary and specialty care, hospital care, and prescription drugs. ***Pre-Existing Health Conditions Covered***	**Medicaid:** Different program variations covering Medical, Dental and Vision, Prescriptions, Hospitalization and more depending on program. Programs for people with either MS, nursing home needs, kidney dialysis, breast and cervical cancer, AIDS, TB, hyper-alimentation, pregnancy. Retroactive benefits available at the time of application for medical services received three months prior. **FamilyCare:** Covers doctor visits, specialty medical services, hospital care, emergency services, prescription drugs and more. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Company size 2–50 employees. Eligible employees must work at least 25 hours a week. Owner can count as an employee. Proprietor name on license must draw wages.	**GUARANTEED COVERAGE** **COBRA:** Available for employees who work for employers with 20 or more employees. You have 60 days from date of termination to sign-up. **ICC:** Available for employees who work for employers of any size. Ex-employees, dependents, spouses, and ex-spouses must have been covered for 3 continuous months before qualifying event. Must elect within 30 days of getting election notice or qualifying event (whichever is later), but no later than 60 days after job termination. **HIPAA:** Must have had 18 months of continuous coverage and completely exhausted COBRA or state continuation coverage. Must not have lost coverage due to fraud or non-payment of premiums. You have 63 days to enroll.	Eligibility is based on medical underwriting. Must be resident of state or documented immigrant. If you are denied coverage for a medical condition, you may be eligible for CHIP or IPXP. See next column.	**GUARANTEED COVERAGE** **Both:** Must be U.S. citizens or legal residents and living in Illinois. **CHIP:** Can be covered in 6 ways: 1) Federal Eligibility: Most recent coverage must have been group plan lasting 18+ months with no break of 90+ days, and lost coverage not due to fraud or non-payment of premium, and exhausted all COBRA coverage. Not eligible for any group plans; HCTC: are TAA or PBGC Certified with at least three months of prior creditable coverage; 2) HIPAA Plan: Must be both Federal- and HIPAA-eligible; 3) HCTC Plan: Must be both Federal- and HCTC- eligible; 4) Traditional Plan: Must be denied coverage due to pre-existing conditions or have a similar plan but costs them more than CHIP, has one of the covered pre-existing conditions; 5) Medicare Plan: Must be enrolled in Medicare parts A and B; 6) Presumptive Condition: Must prove having a qualified medical condition and be under 65 years old. **IPXP:** Must have been uninsured for at least 6 months prior to applying. Must prove being a U.S. citizen or legal U.S. resident, an Illinois resident, and having problems getting insurance due to a pre-existing condition.	**GUARANTEED COVERAGE** **Both:** Must be U.S. citizens or qualified aliens and live in Illinois. **Medicaid:** Income Limits: Children Ages 1–18: 133% FPL. Pregnant Women & Infants: 200% FPL if the mother is enrolled in Medicaid at time of birth. If not, infants with family incomes of 133% FPL. Parents/Caretakers Living with Children Ages 0–18: 185% FPL. Aged, Blind & Disabled: 100% FPL. SSI Recipients: 40% FPL. Medically-Needy: 100% FPL. **FamilyCare:** Offers health care coverage to parents living with their children 18 years old or younger. Relatives who are caring for children in place of their parents: 133% FPL.
Monthly Cost	Costs depend on employer contribution and ± 25% of the insurance company's index rate	**COBRA:** 102%–150% of group health rates. **ICC:** Premiums are 100% of group health rate plus administration fee of 2%. Premiums for dependents must be less than the rate charged to an employee if dependent child were an employee PLUS the amount of employer's premium contribution if dependent child were an employee. **HIPAA:** Premiums will depend on plan chosen.	Various price ranges depending on deductible and what you buy.	**CHIP:** $23.10 to $2,636 depending on age, gender, location, tobacco use, deductible, plan chosen, any other option you have chosen. **IPXP:** $76-$755 depending on your age, residence, and tobacco use.	**Medicaid:** **$0** or minimal share of cost. **FamilyCare:** **$2–$3.65** co-pays for doctor visits and prescriptions.

PUBLICLY-SPONSORED PROGRAMS

Demographic	Children	Women	Seniors & Disabled	Trade Dislocated Workers (TAA Recipients)	Veterans
Program	**All Kids** 866-255-5437 www.allkids.com	**Illinois Breast & Cervical Cancer Program (IBCCP)** Women's Health-Line 888-522-1282 www.cancerscreening.illinois.gov **Healthy Women** 800-226-0768 (Health Benefits Hotline) www.illinoishealthywomen.com	**Medicare** 800-633-4227 www.medicare.gov **Medicare Prescription Drug Program** 800-633-4227 Illinois Cares Rx ended on June 30, 2012. Contact your Medicare Part D plan for rate changes.	**Health Coverage Tax Credit** 866-628-4282 www.irs.gov (Search: HCTC)	**VA Medical Benefits Package** 877-222-8387 www.va.gov www.ebenefits.va.gov
Coverage	Doctor visits, Hospital stays, Prescription drugs, Vision care and eyeglasses, Dental care, Regular checkups, Immunization shots, Medical equipment, Speech and physical therapy for children who need them. ***Pre-Existing Health Conditions Covered***	**IBCCP:** Offers mammograms, breast and pelvic exams, and Pap tests. If enrolled in IBCCP and diagnosed with cancer through the program's screenings, can be eligible to receive treatment. **Healthy Women:** Covers family planning (birth control) and patient education. Certain services provided such as physical exams, Pap tests, lab tests for family planning, testing and medicine for STDs found during a family planning visit, and sterilization. Also covers mammograms, multivitamins and folic acid if they are ordered by the doctor during the family planning visit. ***Pre-Existing Health Conditions Covered***	Offers Part A, inpatient care in hospitals and rehabilitative centers; Part B, doctor and some preventive services and outpatient care; Part C allows Medicare benefits through private insurance (Medicare Advantage); Part C includes Parts A, B, and C not covered by Medicare. Part D covers prescription drugs. ***Pre-Existing Health Conditions Covered***	Inpatient and outpatient care (lab tests, x-rays, etc.), doctor visits, preventive and major medical care (surgery, physical therapy, durable medical equipment, etc.), mental health and substance abuse care, and prescription drugs. ***Pre-Existing Health Conditions Covered***	Comprehensive preventive and primary care, outpatient and inpatient services. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Must be Illinois resident, age 18 or younger and uninsured or underinsured for 12 months to be eligible regardless of income. Can qualify even if they had insurance within the past 12 months, as long as family annual income is below the following: 2-person family: $44,100; 3-person family: $55,600; 4-person family: $67,100; 5-person family: $78,500; Income limit is higher for larger families. All Kids Assist and All Kids Share have an income limit of 150% FPL. All Kids Premium Level 1 and Level 2 have an income limit of 300% FPL.	**GUARANTEED COVERAGE** **IBCCP:** Must be women ages 35–64 living in Illinois without health insurance (younger women may be eligible in some cases). **Healthy Women:** Must be Illinois women ages 19–44, U.S. citizens or legal permanent resident with a Social Security number, and earn up to 200% FPL, and must have lost regular medical benefits from the Illinois Department of Healthcare and Family Services (HFS). Ineligible if pregnant, had tubes tied, had a hysterectomy or have health coverage for birth control.	**GUARANTEED COVERAGE** Must be U.S. citizen or permanent U.S. resident, and: 1) If 65 years or older, you or your spouse worked for at least 10 years in Medicare-covered employment, or 2) You have a disability or end-stage renal disease (permanent kidney failure requiring dialysis or transplant) at any age.	**GUARANTEED COVERAGE** Must be receiving TAA (Trade Adjustment Assistance), or Must be 55 years or older and receiving pension from the Pension Benefit Guaranty Corporation (PBGC). Must not be enrolled in certain state plans, or in prison, or receiving 65% COBRA premium reduction, or be claimed as a dependent in tax returns. Must be enrolled in qualified health plans where you pay more than 50% of the premiums.	**GUARANTEED COVERAGE** "Veteran status" = active duty in the U.S. military, naval, or air service and a discharge or release from active military service under other than dishonorable conditions. Certain veterans must have completed 24 continuous months of service.
Monthly Cost	Premiums and co-pays depend on family income and number of children.	**$0** or minimal share of cost.	**$0** and share of cost for some services; deductibles for some plans. Part A: $0–$451 based on length of Medicare-covered employment; Part B: $99.90-$319.70.10 based on annual income; Part C: Based on provider; Part D: Varies in cost and drugs covered.	**27.5%** of the insurance premium including COBRA premium if employer contributes less than 50%.	**$0** and share of cost and co-pays depending on income level.

PRIVATE HEALTH INSURANCE

Demographic	Small Businesses (2-50 Employees)	Individuals Recently Covered by an Employer Health Plan	Individuals & Families	Individuals with Pre-Existing, Severe, or Chronic Medical Conditions	Low-Income Individuals & Families
Program	**Group Plans** Indiana Association of Health Underwriters www.inahu.org	**COBRA** Contact your current carrier. After 18 months continuous group/COBRA coverage, convert to a plan under: **HIPAA** Health Insurance Portability & Accountability Act 866-487-2365 www.dol.gov (Search: HIPAA)	**Individual Plans** Indiana Association of Health Underwriters www.inahu.org	**Indiana Comprehensive Health Insurance Association (ICHIA)** 800-552-7921 317-614-2133 www.ichia.org (Choose: Guest) **Pre-Existing Condition Insurance Plan (PCIP)** Run by the U.S. Department of Health and Human Services 866-717-5826 www.PCIP.gov www.pciplan.com	**Medicaid** (Indiana Family and Social Services Administration) 800-403-0864 www.in.gov/fssa www.indianamedicaid.com
Coverage	Different plans cover different medical services. There is a maximum 6-month look-back and a maximum 9-month exclusionary period for pre-existing conditions on enrollees that do not have prior coverage. ***Pre-Existing Health Conditions Covered***	**COBRA:** Coverage available for 18–36 months depending on qualifying events. Benefits are what you had with your previous employer. **HIPAA:** Benefits are based on program selected. There is no expiration of coverage. ***Pre-Existing Health Conditions Covered***	Covers certain state-mandated items. However Indiana does not require standardization. Coverage options vary by carrier, but most offer plans that are HSA (Health Savings Account) compatible. There is a maximum 12-month look-back and a maximum 10-year exclusionary period limit for pre-existing conditions on enrollees who have no prior coverage. Elimination riders are not allowed. ***Pre-Existing Health Conditions Covered with Some Limitations***	**ICHIA:** Inpatient hospital services, Mental illness/substance abuse, Prescription drugs, Professional services, Skilled home health care, Skilled nursing facility, Surgical expenses, Transplant services. Coverage for spouse and dependents also available. **PCIP:** Covers broad range of benefits, including primary and specialty care, hospital care, and prescription drugs. ***Pre-Existing Health Conditions Covered***	Preventive services, Behavior and mental health services, Eye care, Diabetes self care management training, Inpatient/outpatient hospital care, Home health care & services; transportation, Dental, Pregnancy care, and Emergency care. Retroactive benefits available at the time of application for medical services received three months prior. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Company size 2–50 employees. Owner can count as an employee. Proprietor-name on license must draw wages. Eligible employees must work at least 30 hours a week.	**GUARANTEED COVERAGE** **COBRA:** Available for employees who work for businesses with 20 or more employees. You have 60 days from date of termination to sign-up. **HIPAA:** Must have had 18 months of continuous coverage and completely exhausted COBRA or state continuation coverage. Must not have lost coverage due to fraud or non-payment of premiums. You have 63 days to enroll.	Eligibility is based on medical underwriting. Must be resident of state or documented immigrant. If you are denied coverage for a medical condition, you may be eligible for an ICHIA or PCIP plan. See next column.	**GUARANTEED COVERAGE** **ICHIA:** Must live in Indiana, be ineligible for Medicaid and private insurance that provide coverages equal to that of ICHIA's. Must first apply to Medicaid, PCIP, and HIP no more than 60 days prior to applying to ICHIA. A) Must have prior coverage under a group plan for at least 18 months with no lapse of more than 63 days, did not lose your health insurance due to fraud or non-payment of premiums, and you're ineligible any public health insurance. B) You can prove you were denied coverage due to pre-existing health conditions. **PCIP:** Must have been uninsured for at least 6 months prior to applying. Must prove being a U.S. citizen or legal U.S. resident, Indiana resident, and having problems getting insurance due to a pre-existing condition.	**GUARANTEED COVERAGE** Must be U.S. citizens or permanent legal residents for at least five years, and Indiana residents. Income Limits: Pregnant Women: 200% FPL. Aged, Blind & Disabled: The income of the individual can be up to 300% of the maximum SSI benefit amount. Infants Ages 0–1: 133% FPL. Children Ages 1–5 133% FPL. Children Ages 6-19 100% FPL. Parents/Caretakers Living with Children ages 0-18: 24% FPL.
Monthly Cost	Costs depend on employer contribution and ± 35% of the insurance company's index rate. At renewal, increases are limited to 15% per year from the original rate.	**COBRA:** 102%–150% of group health rates. **HIPAA:** Premiums will depend on plan chosen.	No rate caps. Various price ranges depending on deductible and what plan you buy.	**ICHIA:** $144.78 to $1,687.36. Premiums based on age, gender, geographic area, and plan chosen. **PCIP:** $124 to $532 depending on your age and plan chosen.	**$0** or minimal share of cost.

PUBLICLY-SPONSORED PROGRAMS

Demographic	Children with Chronic Medical Conditions	Pregnant Women & Children	Women in Need of Cancer Screening	Adults without Dependents	Seniors & Disabled
Program	**Children's Special Health Care Services (CSHCS)** 800-475-1355 www.in.gov (Search: CSHCS)	**Hoosier Healthwise** 800-889-9949 www.in.gov (Search: Hoosier Healthwise) There are 3 plans or "packages" available: A, B and C.	**Breast & Cervical Cancer Program (BCCP)** 855-435-7178 317-233-7405 www.in.gov (Search: BCCP)	**Healthy Indiana Plan (HIP)** 877-438-4479 www.hip.in.gov	**Medicare** (Age 65 and up) 800-633-4227 www.medicare.gov **Medicare Prescription Drug Program** 800-633-4227
Coverage	Treatment for chronic medical conditions such as severe asthma, autism, cerebral palsy, arthritis, congenital heart disease, cystic fibrosis, chromosomal disorders, renal disease seizures and more. Diagnostic evaluations, comprehensive well child and sick child care, specialty care and other services related to the eligible medical conditions, immunizations, prescription drugs, routine dental care, community referrals and information. ***Pre-Existing Health Conditions Covered***	**Packages A & C**: Hospital care, Doctor visits, Check ups , Well-child visits, Clinic services, Prescription drugs, Lab and x-ray, Mental health and substance abuse services, Medical supplies and equipment, Home health care, Dental and vision care, Therapies, Hospice care, Transportation, Family planning services, Nurse practitioner and nurse midwife services, Foot care, and Chiropractors. **Package A:** nursing facility services and over-the-counter drugs. **Package B:** Pregnancy-related care only, such as prenatal care, conditions that may complicate pregnancy, delivery, and 60 days after delivery. **Package C:** Does not cover nursing facility services or over-the-counter drugs, and only covers insulin and surgery, x-rays, labs and hospital stays involving the foot. ***Pre-Existing Health Conditions Covered***	Colonoscopies (with or without biopsies), Liquid-based cytology tests every other year, High risk panel, HPV testing, Office visits, Pelvic exams/tests, Clinical breast exams (CBEs) Mammograms (screening and diagnostic) Diagnostic breast ultrasounds, Breast biopsies, and Consultations ***Pre-Existing Health Conditions Covered***	**HIP:** Physician services, Prescription drugs, Diagnostic exams, Home Health services, Outpatient hospital, Inpatient hospital, Hospice, Preventive services, Family planning, Case and disease management, Mental health coverage, and Substance abuse treatment. Free preventive services including annual exams, smoking cessation, and mammograms. Does not cover vision, dental or maternity services. ***Pre-Existing Health Conditions Covered***	Part A, inpatient care in hospitals and rehabilitative centers; Part B, doctor and some preventive services and outpatient care; Part C allows Medicare benefits through private insurance (Medicare Advantage); Part C includes Parts A, B, and C not covered by Medicare. Part D covers prescription drugs. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Must be Indiana resident ages 0–21 years old, with income limit of 250% FPL and a qualifying medical condition. Applicant does not have to be a U.S. citizen to apply, but the child and/or the family cannot be in the country on a visa. Applicant must apply for Indiana Hoosier Healthwise/ Medicaid. Must have severe chronic illnesses that have lasted or will last two years or conditions that require special devices or would produce disabling physical conditions if untreated. Cystic fibrosis patients can apply at any age and stay on the program for life as long as they remain financially eligible.	**GUARANTEED COVERAGE** **All:** Must be U.S. citizens or qualified aliens and Indiana residents. **Package A:** Pregnant women and parents/caretaker relatives living with children under the age of 18. Adults ages 18 to 20 living with caretaker relative who meets the financial requirements can be covered but their caretaker relative is not eligible. Income limit of 19% FPL and asset limit of $1,000 for pregnant women and 150% FPL for children up to age 19. **Package B:** Pregnant women living 20%–200% FPL. **Package C:** Children ages 0–18. Income limit of 250% FPL.	**GUARANTEED COVERAGE** Must be U.S. citizens or be legal immigrants and residents of Indiana, uninsured or underinsured, and earn up to 200% FPL. Age Limits: Ages 40–49, and ages 65 and older not enrolled in Medicare: Office visits and Pap tests. Ages 50–64: All of the above and mammograms.	**GUARANTEED COVERAGE** **HIP:** Must be a U.S. citizen or legal resident and live in Indiana. Must not be eligible for Medicaid or Medicare. Must be ages 19 to 64. Must earn income of 22% FPL to 200% FPL. Must have been uninsured for at least six months and have no access to employer-offered health insurance.	**GUARANTEED COVERAGE** Must be U.S. citizen or permanent U.S. resident, and: 1) If 65 years or older, you or your spouse worked for at least 10 years in Medicare-covered employment, or 2) You have a disability or end-stage renal disease (permanent kidney failure requiring dialysis or transplant) at any age.
Monthly Cost	**$0** or minimal share of cost.	**Packages A & B: $0** **Package A:** May have to pay between $0.50 to $3.00 co-pay for pharmacy, transportation, and emergency services. **Package C: $0** if income is 150% FPL or below. If child living 151%–250% FPL, premiums are required. Premiums are $22–$33 for one child, and $33–$50 for two or more children.	**$0**	**HIP: 2%–5%** of the family's gross income. No co-pays except for ER use which will cost below $25 a visit.	**$0** and share of cost for certain services; deductibles for certain plans. Part A: $0–$451 based on length of Medicare-covered employment; Part B: $99.90-$319.70 depending on annual income; Part C: Based on provider; Part D: Varies in cost and drugs covered.

PRIVATE HEALTH INSURANCE

Demographic	Small Businesses (2-50 Employees)	Individuals Recently Covered by an Employer Health Plan	Individuals & Families	Individuals with Pre-Existing, Severe, or Chronic Medical Conditions	Low-Income Families & Individuals
Program	**Group Plans** Iowa Association of Health Underwriters www.eiahu.org	**COBRA/Mini-COBRA** Contact your current carrier. After 18 months continuous group/ COBRA coverage, convert to a plan under: **HIPAA** Health Insurance Portability & Accountability Act 866-487-2365 www.dol.gov (Search: HIPAA) **HIPP** Health Insurance Premium Payment 888-346-9562	**Individual Plans** Iowa Association of Health Underwriters www.eiahu.org	**Health Insurance Plan of Iowa (HIPIOWA)** 877-793-6880 www.hipiowa.com **HIPIOWA-FED** Federal program run by the Iowa Comprehensive Health Association 877-505-0513 hipiowafed.com www.PCIP.gov	**Medicaid** 515-256-4600 www.ime.state.ia.us/Members **Medicaid for Employed People with Disabilities (MEPD)** www.ime.state.ia.us (Search: MEPD) **Both:** 800-338-8366 Contact the Iowa Department of Human Services. www.dhs.state.ia.us
Coverage	Up to $5M lifetime maximum, assorted deductibles. There is a maximum look-back period of 6 months and a maximum exclusion period of 12 months for pre-existing conditions on enrollees with no prior coverage or whose coverage had a break of more than 63 days. ***Pre-Existing Health Conditions Covered***	**COBRA:** Coverage available for 18–36 months depending on qualifying events. Benefits are what you had with your previous employer. **Mini-COBRA:** Benefits are what you had with your previous employer. Coverage lasts 9 months. **HIPAA:** Benefits are based on program selected. There is no expiration of coverage. **HIPP:** Premium assistance that pays employer-sponsored health insurance or COBRA premiums. The assistance amount depends on the most cost-effective premium available. ***Pre-Existing Health Conditions Covered***	Up to $5M lifetime maximum, assorted deductibles. Elimination riders are permitted. There is a 12-month look-back and exclusionary period limit on pre-existing health conditions for standardized guarantee issue policies. For all other individual policies, there is a maximum 60-month look-back and a maximum 12-month exclusionary period limit on pre-existing health conditions. ***Limits on Pre-Existing Health Conditions May Apply***	**HIPIOWA:** Offers five comprehensive preferred provider plans each with a pharmacy benefit to choose from and a Medicare carveout plan. Will not pay for any pre-existing injury or sickness for the first six months of coverage. **HIPIOWA-FED:** Covers broad range of benefits, including primary and specialty care, hospital care, and prescription drugs. ***Pre-Existing Health Conditions Covered with Some Limitations***	**All:** Inpatient and outpatient hospital services, physician services, medical and surgical dental services, nursing facility services for persons aged 21+, family planning services, nurse/midwife services, chiropractors, podiatrists, optometrists, psychologists, dental services, physical therapy, therapies for speech hearing and language disorders, occupational therapy, prescribed drugs, prosthetic devices, vision, mental health, hospice care and more. Retroactive benefits available at the time of application for medical services received three months prior. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Company size 2–50 employees. Owner can count as an employee. Proprietor name on license must draw wages. Eligible employees must work at least 30 hours a week.	**GUARANTEED COVERAGE** **COBRA:** Available for employees who work for businesses with 20 or more employees. You have 60 days from date of termination to sign-up. **Mini-COBRA:** Available for employees who work for businesses with less than 20 employees. Must have had group coverage for at least 3 continuous months before date of termination. Must elect coverage within 31 days of termination. **HIPAA:** Must have had 18 months of continuous coverage and completely exhausted COBRA or state continuation coverage. Must not have lost coverage due to fraud or non-payment of premiums. You have 63 days to enroll. **HIPP:** Must qualify for Medicaid and have access to Employer-Sponsored Insurance or COBRA.	Eligibility is based on medical underwriting. Must be resident of state or documented immigrant. If you are denied coverage for a medical condition, you may be eligible for HIPIOWA or HIPIOWA-FED See next column.	**GUARANTEED COVERAGE** **HIPIOWA:** 1) Must live in Iowa and prove residency of at least 60 days in Iowa, denial of insurance coverage in the last 9 months due to qualified pre-existing conditions, or offer of insurance with substantially reduced benefits (e.g. elimination riders) or premiums higher than that of HIPIOWA's, or loss of health insurance not due to non-payment of premium. Or 2) if living in Iowa (not required to prove length of residency), can be qualified if one is a beneficiary of Trade Adjustment Assistance, HIPAA-eligible, or current holder of Basic and Standard Policy. **HIPIOWA-FED:** Must have been uninsured for at least 6 months prior to applying. Must prove being a U.S. citizen or legal U.S. resident, an Iowa resident, and having problems getting insurance due to a pre-existing condition.	**GUARANTEED COVERAGE** **All:** Must be a U.S. citizen or legal alien and resident of Iowa. **Medicaid:** Pregnant Women: 300% FPL. Parents/Caretakers Living with Children Ages 0–18: 82% FPL. Children Ages 0–5: 133% FPL. Children Ages 6–19: 100% FPL. Aged, Blind & Disabled: Singles earning 75% FPL with asset limit $2,000, and couples earning 83% FPL with asset limit of $3,000. **MEPD:** Must be disabled (as determined by Department of Human Services), be under 65 years old, employed or self-employed, with income limit of 250% FPL and asset limits of $12,000 for singles and $13,000 for couples. Is not eligible for any other Medicaid coverage group other than QMB, SLMB, or Medically-Needy
Monthly Cost	Costs depend on employer contribution and ± 25% of the insurance company's index rate.	**COBRA/Mini-COBRA:** 102%–150% of group health rates. **HIPAA:** Premiums will depend on plan chosen. **HIPP:** Reimburses the full employer-sponsored insurance premium amount by check monthly. Pays the insurance company directly for people on COBRA or eligible small businesses.	Costs for individual coverage vary.	**HIPIOWA:** $106.61 to $1302.20 depending on age, gender, tobacco use, and plan chosen. **HIPIOWA-FED:** $157.35 to $792.98 depending on your age and tobacco use.	**Medicaid:** **$0** or minimal share of cost. **MEPD:** **$0** unless income is above 150% FPL. Otherwise, premiums range from $34 to $660 based on income. $1-$3 co-pays.

PUBLICLY-SPONSORED PROGRAMS

Demographic	Adults without Dependents & Pregnant Women	Children in Moderate Income Families	Immigrants Awaiting Legal Status	Native Americans	Trade Dislocated Workers (TAA Recipients)
Program	**IowaCare** 515-256-4606 866-890-5966 www.ime.state.ia.us (Search: IowaCare)	**HAWK-I** 800-257-8563 TDD: 888-422-2319 www.hawk-i.org	**Emergency Medicaid** 800-338-8366 www.ime.state.ia.us/Members	**Indian Health Services** 605-226-7582 www.ihs.gov (Search: Aberdeen)	**Health Coverage Tax Credit** 866-628-4282 www.irs.gov (Search: HCTC)
Coverage	Inpatient and outpatient hospital, physician or advanced registered nurse practitioner, and dental services. Care received is based on county. Specialty care needs will be referred to University of Iowa Hospitals and Clinics or Broadlawns Medical Center. Unlike Medicaid, IowaCare is not an entitlement, meaning that it depends on specific appropriations. ***Pre-Existing Health Conditions Covered***	Qualified children receive services through a health plan participating in the program: doctor visits, outpatient hospital services, vaccines and shots (immunizations) emergency care, inpatient hospital services, prescriptions, vision, dental, hospice, speech and physical therapy, nursing care services, chiropractic care mental health/substance abuse. Each county has one or more health plans. ***Pre-Existing Health Conditions Covered***	Up to 3 days of Medicaid is available to pay for the cost of emergency services for aliens who do not meet citizenship, alien status, or social security number requirements. The emergency services must be provided in a facility such as a hospital, clinic, or office that can provide the required care after the emergency medical condition has occurred.	Inpatient and outpatient services, Physical therapy, Pediatric, Optometry, Diabetes, Emergency rooms, Specialty care, Medical supplies, Lab & x-ray, Ambulance. ***Pre-Existing Health Conditions Covered***	Inpatient and outpatient care (lab tests, x-rays, etc.), Doctor visits, Preventive and major medical care (surgery, physical therapy, Durable medical equipment, etc.), Mental health and substance abuse care, and Prescription drugs. Can use credit to purchase plan through HIPIOWA. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Must be Iowa adults ages 19– 64 with income limit of 200% FPL, not be eligible for Medicaid, and be uninsured. Pregnant women with incomes at or below 300% FPL, if medical costs can bring their monthly incomes to 200% FPL. Individuals who do not meet the 200% FPL test, but who receive State Papers services for chronic health problems. Proof of immigration status is required for non-U.S. citizens.	**GUARANTEED COVERAGE** Must be a U.S. citizen or a qualified alien and live in Iowa, be under 19 years old, with an income up to 300% FPL. Must have no other health insurance. Must not be a dependent of a State of Iowa employee. Children who qualify for Medicaid cannot get HAWK-I.	**GUARANTEED COVERAGE** U.S. citizenship not required. Income Limits: Pregnant Women: 300% FPL. Parents/Caretakers Living with Children Ages 0–18: 83% FPL. Children Ages 0–5: 133% FPL. Children Ages 6–19: 100% FPL. Aged, Blind & Disabled: Singles earning 75% FPL with asset limit $2,000, and couples earning 83% FPL with asset limit of $3,000.	**GUARANTEED COVERAGE** Must exhaust all private, state, and other federal programs. Must be regarded by the local community as an Indian or Alaska Native; is a member of an Indian or Alaska Native Tribe or Group under Federal supervision; resides on tax-exempt land or owns restricted property; actively participates in tribal affairs; any other reasonable factor indicative of Indian descent; is a non-Indian woman pregnant with an eligible Indian's child for the duration of her pregnancy through postpartum (usually 6 weeks); is a non-Indian member of an eligible Indian's household and the medical officer in charge determines that services are necessary to control a public health hazard or an acute infectious disease which constitutes a public health hazard.	**GUARANTEED COVERAGE** Must be receiving TAA (Trade Adjustment Assistance), or Must be 55 years or older and receiving pension from the Pension Benefit Guaranty Corporation (PBGC). Must not be enrolled in certain state plans, or in prison, or receiving 65% COBRA premium reduction, or be claimed as a dependent in tax returns. Must be enrolled in qualified health plans where you pay more than 50% of the premiums.
Monthly Cost	**$0** for those earning 150% FPL or less. Otherwise: 1 member: $51 to $65. 2+ members: $69 to $86 for each member.	**$0** for income less than 150% FPL. $10-$20 for income between 150% FPL and 300% FPL. Maximum payment of $40. No cost for Native Americans.	**$0** or minimal share of cost.	**$0** or minimal share of cost.	**27.5%** of the insurance premium including COBRA premium if employer contributes less than 50%.

PRIVATE HEALTH INSURANCE

Demographic	Small Businesses (2-50 Employees)	Individuals Recently Covered by an Employer Health Plan	Individuals & Families	Individuals with Pre-Existing, Severe, or Chronic Medical Conditions	Low-Income Families & Children
Program	**Group Plans** National Association of Health Underwriters 202-552-5060 www.nahu.org	**COBRA/Mini-COBRA** Contact your current carrier. After 18 months continuous group/ COBRA coverage, convert to a plan under: **HIPAA** Health Insurance Portability & Accountability Act 866-487-2365 www.dol.gov (Search: HIPAA)	**Individual Plans** National Association of Health Underwriters 202-552-5060 www.nahu.org	**Kansas Health Insurance Association (KHIA)** 800-362-9290 www.khiastatepool.com **Pre-Existing Condition Insurance Plan (PCIP-KS)** Federal program run by KHIA 877-505-0511 www.khiastatepool.com/KHIA-FED/ www.PCIP.gov	**Medicaid** 800-766-9012 www.kmap-state-ks.us **Women-Infants-Children (WIC)** 785-296-1320 www.kansaswic.org
Coverage	Up to $5M lifetime maximum, assorted deductibles. There is a maximum 3-month look-back and exclusionary period for people with no prior coverage or whose prior coverage lapsed for more than 63 days. Carriers must provide immunizations for children ages 0–6 , mammograms, Pap smears, prostate screenings, osteoporosis testing and diabetic supplies, minimum mental health/substance abuse services. ***Pre-Existing Health Conditions Covered***	**COBRA:** Coverage available for 18–36 months depending on qualifying events. Benefits are what you had with your previous employer. **Mini-COBRA:** Coverage available for 18 months. Benefits are what you had with your previous employer. **HIPAA:** Benefits are based on program selected. There is no expiration of coverage. ***Pre-Existing Health Conditions Covered***	Up to $5M, assorted deductibles depending on age and ZIP code. There is a no limit to the look-back period and there is a 24-month limit on exclusionary period limit for pre-existing conditions on enrollees with no prior coverage. Elimination riders are permitted. ***Pre-Existing Health Conditions Covered with Some Limitations***	**KHIA:** Prevention services, Inpatient hospital care, Therapies (physical, speech, occupational), oral surgery, Spinal manipulation, Maternity, Emergency room and ambulatory services, Durable medical equipment, Mental health and substance abuse, Nursing, Home health, and Prescription drugs. If prior health coverage had a lapse of 31 days or more, there will be a 90-day pre-existing condition exclusion in KHIA coverage. **PCIP-KS:** Covers broad range of benefits, including primary and specialty care, hospital care, and prescription drugs. ***Pre-Existing Health Conditions Covered***	**Medicaid:** Office visits, Checkups, Immunizations, Inpatient and outpatient hospital services, Lab and x-ray, Prescription drugs, Eye doctor exams and glasses, Hearing services and speech, Physical and occupational therapy, Dental services for children (checkups, cleanings, sealants, x-rays and fillings), Inpatient and outpatient mental health services, and substance abuse services, Medical transportation. Retroactive benefits available at the time of application for medical services received three months prior. **WIC:** Immunization screening and breastfeeding support, as well as Nutrition education and supplemental foods to infants, children and women who are pregnant, postpartum or are breastfeeding. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Company size 2–50 employees. Owner can count as an employee. Owner name on business license must draw wages from the company. Eligible full-time employees must work at least 30 hours per week and must not be temporary or substitute employees.	**GUARANTEED COVERAGE** **COBRA:** Available for employees who work for businesses with 20 or more employees. You have 60 days from date of termination to sign-up. **Mini-COBRA:** Must have been insured continuously under your previous employer's group policy for at least 3 months prior to termination. You have 31 days from date of termination or from date of receiving election notice from insurance company to sign-up. **HIPAA:** Must have had 18 months of continuous coverage and completely exhausted COBRA or state continuation coverage. Must not have lost coverage due to fraud or non-payment of premiums. You have 63 days to enroll.	Eligibility is subject to medical underwriting. If you are denied coverage for a medical condition, you may be eligible for KHIA or PCIP-KS. See next column.	**GUARANTEED COVERAGE** **KHIA:** 1) Must be ineligible for Medicare or Medicaid, prove residency in Kansas for at least 6 months prior to enrollment, and one of the following: denial of health coverage by 2 insurance carriers due to pre-existing conditions; offer of insurance with rates higher than KHIA's or with no coverage for pre-existing condition (elimination rider); insurance involuntarily terminated not due to non-payment of premium. Or 2) Must live in Kansas (not required to prove length of residency) and be eligible for HIPAA plans or Trade Adjustment Assistance (TAA). **PCIP-KS:** Must be a U.S. citizen or lawfully present in the U.S. and have been uninsured for at least 6 months prior to applying. Must have had a problem getting insurance due to a pre-existing condition.	**GUARANTEED COVERAGE** **All:** Must be Kansas resident. **Medicaid:** Must be a U.S. citizen or a qualifying alien. Income Limits: Children Ages 1–5: 133% FPL. Children Ages 6–18: 100% FPL. Pregnant Women & Infants Ages 0–1: 150% FPL. Parents/Caregivers Living with Children Ages 0–18: 32% FPL (if more than 4 household members, add $61 for each added member). Medically-Needy: $495/month with asset limit of $2,000 for singles and $3,000 for couples. Aged, Blind & Disabled: 75% FPL with asset of limit of $2,000 for singles, and 83% FPL with asset limit of $3,000 for couples. **WIC:** Must be women who are pregnant, or breastfeeding up to baby's first birthday, non-breastfeeding mothers with babies up to six months old, or children under 5 years old. Income limit of 185% FPL.
Monthly Cost	Costs depend on employer contribution and ± 25% of the insurance company's index rate.	**COBRA/Mini-COBRA:** 102%-150% of group health rates. **HIPAA:** Premiums will depend on plan chosen.	Costs for individual coverage vary. There are no rate caps.	**KHIA:** $166.29 to $2,082.20 depending on your age, gender, tobacco use and deductible. **PCIP-KS:** Premiums based on age and tobacco use. Must be at or less than 100% of the average market rate for similar insurance policies.	**Medicaid & WIC: $0** or minimal share of cost.

PUBLICLY-SPONSORED PROGRAMS

Demographic	Children	Children with Special Needs	Women	Low-Income Individuals	Seniors & Disabled
Program	**HealthWave** 800-792-4884 TTY: 800-792-4292 www.kdheks.gov/hcf/healthwave	**Children & Youth with Special Health Care Needs (CYSHCN)** 800-332-6262 785-296-1313 www.kdheks.gov/cyshcn	**Women's Health Care & Family Planning Services** 800-332-6262 785-296-1307 www.kdheks.gov (Search: Family Planning) **Early Detection Works** 877-277-1368 785-296-1207 www.kdheks.gov/edw	**MediKan** 800-766-9012 888-369-4777 www.kdheks.gov (Search: MediKan)	**Medicare** 800-633-4227 www.medicare.gov **Medicare Prescription Drug Program** 800-633-4227 **Senior Health Insurance Counseling of Kansas (SHICK)** 800-860-5260 www.kdads.ks.gov
Coverage	Office visits, Checkups, Immunizations, Inpatient and outpatient hospital services, Lab and x-ray, Prescription drugs, Eye doctor exams and glasses, Hearing services and speech, Physical and occupational therapy, Dental services for children (checkups, cleanings, sealants, x-rays and fillings), Inpatient and outpatient mental health and substance abuse services, and Medical transportation. ***Pre-Existing Health Conditions Covered***	Helps those at risk for disabilities or chronic disease. Diagnostic services limited to one-time evaluation to determine if medically eligible, with no income requirement, for youth under 22 years old. Services also include Outpatient medical specialty care, Hospitalizations, Surgery, Durable medical equipment and medications, Limited therapy (physical and occupational), Case management that develops health care plan for each patient. Outreach clinics do specialty diagnosis, consultation, and follow-along care as close to the child's home as possible. Services cover hearing loss, orthopedic conditions, neurological impairment, cardiac diseases, and genetic diseases, counseling and planning. ***Pre-Existing Health Conditions Covered***	**Women's Health Care & Planning Services:** Pap smears, Urinalysis, Screening for anemia, Hypertension, and abnormal conditions of the breast and cervix, Pregnancy testing and counseling, Contraceptive methods including abstinence, Screening and treatment for sexually transmitted diseases. If problems are discovered which are beyond the scope of the clinics, appropriate referrals will be made by the health care provider. Clients are seen by appointments. **Early Detection Works:** Clinical breast exams, Mammograms, Pap tests, and Diagnostic services. ***Pre-Existing Health Conditions Covered***	Limited benefits to adults whose applications for federal disability are being reviewed by the Social Security Administration. Average monthly benefit from General Assistance is $100. The program is time-limited to 24 months per person; however, assistance is continued for those who have an ongoing pending application for Social Security benefits (including the appeal process). The scope of MediKan's services is similar to that of Medicaid's, but some restrictions and limitations apply. Health benefits include medical care in acute situations and during catastrophic illness. ***Pre-Existing Health Conditions Covered***	**Medicare** offers Part A, inpatient care in hospitals and rehabilitative centers; Part B, doctor and some preventive services and outpatient care; Part C allows Medicare benefits through private insurance (Medicare Advantage); Part C includes Parts A, B, and C not covered by Medicare. Part D covers prescription drugs. **SCHICK** is a Medicare counseling service. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** All applicants will be screened for Medicaid eligibility first. Must be a U.S. citizen or qualifying resident and live in Kansas. Must be children ages 0–18 living at or below 232% FPL. Must not already be covered by comprehensive and reasonably accessible health insurance, or be eligible for Medicaid. Children whose parents have access to the State group health insurance plan are not eligible.	**GUARANTEED COVERAGE** Income Limits: 185% FPL and asset limit of 15% of income. For PKU (Phenylketonuria) food: 300% FPL and asset limit of 25% of income. Must be a Kansas resident who is 1) Under 22 years old with a medical condition covered by the program, or 2) Of any age who has a metabolic condition with incomes up to 385% FPL. Conditions include spina bifida, cleft palate/cleft lip; acquired or congenital heart disease; burns requiring surgery; major orthopedic problems requiring surgery; limited gastrointestinal or genitourinary conditions requiring surgery; hearing loss; vision disorders (limited); selected craniofacial anomalies; seizures (outpatient care and drugs only); juvenile rheumatoid arthritis; genetic and metabolic conditions.	**GUARANTEED COVERAGE** **Women's Health Care & Planning Services:** Must be of reproductive age (women must be non-menopausal). No residency or citizenship requirements. **Early Detection Works:** Must be Kansas women ages 40–64, not have insurance or have insurance policies that have high deductibles or do not pay for these services covered Early Detection Works. Must be ineligible for Medicare Part B or Medicaid/MediKan. Income limit of 214% FPL.	**GUARANTEED COVERAGE** The MediKan health program covers adults with disabilities who do not qualify for Medicaid, but are eligible for services under the State's General Assistance program. Applicants for general assistance and MediKan are screened by Kansas Health Policy Authority for potential enrollment in Medicaid if they appear to meet federal requirements for disability. To be qualified for General Assistance, patient must meet disability criteria as determined through the state's disability determination process. Recipients must pursue federal Social Security disability benefits. Must be a Kansas resident and U.S. citizen or a qualified non-citizen.	**GUARANTEED COVERAGE** **All:** Must be U.S. citizen or permanent U.S. resident, and: 1) If 65 years or older, you or your spouse worked for at least 10 years in Medicare-covered employment, or 2) You have a disability or end-stage renal disease (permanent kidney failure requiring dialysis or transplant) at any age.
Monthly Cost	Families with incomes above 150% FPL must pay premiums between $20 and $75.	**$0** CYSHCN will pay after private insurance and Medicaid are billed. For metabolic formula, CYSHCN will pay for all or part of charges based on income FPL %: 0-185%: 100% of eligible charges 186-285%: 50% of eligible charges 286-385%: 25% of eligible charges	**Women's Health Care & Planning Services:** Sliding fee scale based on income and number of household members. **Early Detection Works:** **$0** or minimal share of cost.	**$0** or minimal share of cost.	**Medicare:** **$0** and share of cost for certain services; deductibles for certain plans. Part A: $0–$451 based on length of Medicare-covered employment; Part B: $99.90-$319.70 depending on annual income; Part C: Based on provider; Part D: Varies in cost and drugs covered. **SHICK:** **$0**

PRIVATE HEALTH INSURANCE

Demographic	Small Businesses (2-50 Employees)	Individuals Recently Covered by an Employer Health Plan	Individuals & Families	Individuals with Pre-Existing, Severe, or Chronic Medical Conditions	Low-Income Families & Medically-Needy
Program	**Group Plans** National Association of Health Underwriters 202-552-5060 ww.nahu.org	**COBRA/Mini-COBRA** Contact your current carrier. After 18 months continuous group/ COBRA coverage, convert to a plan under: **HIPAA** Health Insurance Portability & Accountability Act 866-487-2365 www.dol.gov (Search: HIPAA)	**Individual Plans** National Association of Health Underwriters 202-552-5060 ww.nahu.org	**Kentucky Access** 866-405-6145 www.kentuckyaccess.com **Pre-Existing Condition Insurance Plan (PCIP)** Run by the U.S. Department of Health and Human Services 866-717-5826 www.PCIP.gov www.pciplan.com	**Medicaid** 800-635-2570 www.chfs.ky.gov/dms
Coverage	Benefits will vary depending on the chosen plan. There is a maximum 6-month look-back period and a maximum 12-month exclusionary period for pre-existing conditions on enrollees that do not have prior creditable coverage or whose prior coverage had a lapse of more than 63 days. ***Pre-Existing Health Conditions Covered***	**COBRA:** Coverage available for 18–36 months depending on qualifying events. Benefits are what you had with your previous employer. **Mini-COBRA:** Coverage available for 18 months. Benefits are what you had with your previous employer. **HIPAA:** Benefits are based on program selected. There is no expiration of coverage. ***Pre-Existing Health Conditions Covered***	All insurers are required to offer a "standard plan" which offers the same benefits regardless of the insurer. Insurers are required to offer certain benefits such as maternity stay and mammograms. There is a maximum 6-month look-back and maximum 12-month exclusionary period limit for pre-existing conditions on enrollees that do not have prior coverage. ***Pre-Existing Health Conditions Covered with Some Limitations***	**Kentucky Access:** Offers 4 health plans: Traditional Access (indemnity), Premier Access (PPO), Premier Access Child Only (PPO, and Preferred Access (PPO). Benefits include Inpatient care, ambulatory/hospital outpatient surgery, Transplants, Office visit, Diagnostic services, Allergy testing and treatments, Maternity care emergency services, Ambulance, Urgent care services, Preventive services, Well-child and adolescent care, Well-adult care, Mental health, Autism substance abuse, Prescription drugs and oral contraceptives, Manipulative treatment home health care, Skilled nursing facility, Medical supplies, Durable medical equipment, Prosthetic devices, Orthotic devices, Services, Hospice services. **PCIP:** Covers broad range of benefits, including primary and specialty care, hospital care, and prescription drugs. ***Pre-Existing Health Conditions Covered***	Hospital care (inpatient and outpatient), Nursing home care, Physician services, Laboratory and x-ray services, Immunizations and other early and periodic screening, Diagnostic and treatment (EPSDT) services for children, Health center (FQHC) and Rural health clinic (RHC) services, Nurse midwife and nurse practitioner services. Chiropractor, Dental, Durable medical equipment (DME), Family planning, Hearing, Hospice, Medical transportation, Organ transplant, Pharmacy, Podiatry, Renal dialysis and Vision. Retroactive benefits available at the time of application for medical services received three months prior. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Company size 2–50 employees. Owner can count as an employee. Proprietor name on license must draw wages. "Eligible employee" means any full- or part-time employee actively engaged in employer's business, has satisfied employer's waiting period requirements, and has received a voucher from employer to buy health benefit plan.	**GUARANTEED COVERAGE** **COBRA:** Available for employees who work for employers with 20 or more employees. You have 60 days from date of termination to sign-up. **Mini-COBRA:** Available for employees who work for employers with less than 20 employees. You must have been insured continuously under your previous employer's group policy for at least 3 months prior to enrolling in Mini-COBRA. You must sign-up within 31 days from date of receiving notice of your right to continue coverage. **HIPAA:** Must have had 18 months of continuous coverage and completely exhausted COBRA or state continuation coverage. Must not have lost coverage due to fraud or non-payment of premiums. You have 63 days to enroll.	Medical underwriting determines eligibility. If you are denied coverage for a medical condition, you may be eligible for Kentucky Access or PCIP. See next column.	**GUARANTEED COVERAGE** **Kentucky Access:** One of the following 1) Must be Kentucky resident for at least 12 months and rejected for health coverage due to pre-existing condition, or were offered coverage with premiums higher than rates in Kentucky Access, or have a qualified high-cost pre-existing conditions. Or, 2) You participate in the state's GAP (Guaranteed Acceptance Program). Or 3) You are HIPAA-eligible. Coverage extends to dependents of Kentucky Access enrollees. **PCIP:** Must have been uninsured for at least 6 months prior to applying. Must prove being a U.S. citizen or legal U.S. resident, a Kentucky resident, and having problems getting insurance due to a pre-existing condition.	**GUARANTEED COVERAGE** Must be U.S. citizens or qualified aliens and residents of Kentucky: Income Limits: Pregnant Women & Infants Ages 0–1: 185% FPL. Children Ages 1–18: 200% FPL. Parents/Caretakers Living with Children Ages 0–18 (after deducting expenses for work and child care): 59% FPL. Aged, Blind & Disabled: Singles earning 75% FPL with asset limit of $2,000; couples earning 83% FPL with asset limit of $4,000. Working Disabled: Must be ages 16 to 64, meet the Social Security definition of disabled, earn up to 250% FPL, have asset limit of $5,000, and prove to be employed or self-employed (e.g. pay stubs).
Monthly Cost	Costs depend on employer contribution and ± 35% of the insurance company's index rate.	**COBRA/Mini-COBRA:** 102%–150% of group health rates. **HIPAA:** Premiums will depend on plan chosen.	Rates are ± 35% of the base individual market rate.	**Kentucky Access:** $178.41 to $1,640.31 depending on your age, gender, and plan chosen. No family rates. **PCIP:** $98 to $424 depending on your age and plan chosen.	**$0** or nominal co-payment.

PUBLICLY-SPONSORED PROGRAMS

Demographic	Children	Children with Chronic Illnesses	Women in Need of Cancer Screening	Seniors & Disabled	Veterans
Program	**KCHIP** 877-524-4718 877-524-4719 TTY www.kidshealth.ky.gov **Women-Infants-Children (WIC)** 800-462-6122 800-648-6056 TTY chfs.ky.gov (Search: WIC)	**Commission for Children with Special Health Care Needs (CCSHCN)** 502-429-4430 chfs.ky.gov/ccshcn	**Kentucky Women's Cancer Screening Program** 502-564-3236 chfs.ky.gov (Search: Cancer Screening)	**Medicare** 800-633-4227 www.medicare.gov **Medicare Prescription Drug Program** 800-633-4227 **State Health Insurance Assistance Program (SHIP)** chfs.ky.gov (Search: SHIP)	**VA Medical Benefits Package** 877-222-8387 www.va.gov www.ebenefits.va.gov
Coverage	**KCHIP:** Doctor visits, Dental care, Hospitalization, Outpatient hospital services, Psychiatrists, Laboratory tests and x-rays, Vision exams, Hearing services, Mental health services, Prescription drugs, Glasses, Immunizations, Well-child checkups, Physical therapy, Speech therapy, and many other services. **WIC:** Nutrition education and services, breastfeeding promotion and education, monthly food prescription of nutritious foods, and access to maternal, prenatal and pediatric health care services. ***Pre-Existing Health Conditions Covered***	CCSHCN offices in 12 locations, satellite clinics in physician offices and other settings, office visits, therapy (physical, occupational, speech), audiology services, related lab and follow-up services, X-rays and lab tests, medication, durable medical equipment. Primary medical care is not covered. ***Pre-Existing Health Conditions Covered***	Clinical breast exams, Screening mammograms, Diagnostic tests, Cervical cancer screening, Pap tests, and Pelvic examinations. ***Pre-Existing Health Conditions Covered***	**Medicare** offers Part A, inpatient care in hospitals and rehabilitative centers; Part B, doctor and some preventive services and outpatient care; Part C allows Medicare benefits through private insurance (Medicare Advantage); Part C includes Parts A, B, and C not covered by Medicare. Part D covers prescription drugs. **SHIP** is a Medicare counseling and application service. ***Pre-Existing Health Conditions Covered***	Comprehensive preventive and primary care, outpatient and inpatient services. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** **KCHIP:** Must be U.S. citizens or qualified aliens and live in Kentucky. Must not be eligible for any other insurance, including individual, group or public. Must be children under age 19, with incomes at or below 200% FPL. **WIC:** Must live in Kentucky and be pregnant or have a pregnant woman or infant in the family who receives Medicaid, or have a member of your family who receives KTAP, or have a household income at or below 185 FPL%.	**GUARANTEED COVERAGE** Must be a Kentucky resident under 21 years old, with a medical condition that usually responds to treatment provided by the program. Income limit is 200% FPL. Also provided are free eye examinations to all school age children who fall between 200%–250% FPL and are without insurance coverage for vision.	**GUARANTEED COVERAGE** Must be women residing in Kentucky ages 40–64. Must be uninsured or underinsured, ineligible for Medicaid, and living at or below 100%% FPL. Women younger than 40 are eligible to receive screening services only if they have a family history of breast cancer. Pap tests are provided to uninsured women living at or below 250% FPL.	**GUARANTEED COVERAGE** **All:** Must be U.S. citizen or permanent U.S. resident, and: 1) If 65 years or older, you or your spouse worked for at least 10 years in Medicare-covered employment, or 2) You have a disability or end-stage renal disease (permanent kidney failure requiring dialysis or transplant) at any age.	**GUARANTEED COVERAGE** "Veteran status" = active duty in the U.S. military, naval, or air service and a discharge or release from active military service under other than dishonorable conditions. Certain veterans must have completed 24 continuous months of service.
Monthly Cost	**KCHIP:** **$0** premium depending on income. $1 to $3 co-pays for prescriptions, $6 for non-emergency ER admissions, $2 for allergy testing. Annual out-of-pocket maximum of $450. **WIC:** **$0** to minimal share of cost.	Sliding-scale fee based on income.	**$0** or minimal share of cost depending on income level.	**Medicare:** **$0** and share of cost for certain services; deductibles for certain plans. Part A: $0–$451 based on length of Medicare-covered employment; Part B: $99.90-$319.70 depending on annual income; Part C: Based on provider; Part D: Varies in cost and drugs covered. **SHIP:** **$0**	**$0** or share of cost and co-pays depending on income level.

PRIVATE HEALTH INSURANCE

Demographic	Small Businesses (2-50 Employees)	Individuals Recently Covered by an Employer Health Plan	Individuals & Families	Individuals with Pre-Existing, Severe, or Chronic Medical Conditions	Low-Income Individuals & Families
Program	**Group Plans** Louisiana Association of Health Underwriters www.la-ahu.org	**COBRA/Mini-COBRA** Contact your current carrier. After 18 months continuous group/COBRA coverage, convert to a plan under: **HIPAA** Health Insurance Portability & Accountability Act 866-487-2365 www.dol.gov (Search: HIPAA) **LaHIPP** 888-695-2447 www.lahipp.dhh.louisiana.gov	**Individual Plans** Louisiana Association of Health Underwriters www.la-ahu.org	**Louisiana Health Plan(LHP)** 800-736-0947 225-926-6245 (Baton Rouge) www.lahealthplan.org **Pre-Existing Condition Insurance Plan (PCIP)** Run by the U.S. Department of Health and Human Services 866-717-5826 www.PCIP.gov www.pciplan.com	**Medicaid** 888-342-6207 new.dhh.louisiana.gov (Search: Medicaid)
Coverage	There is a maximum 6-month look-back and a maximum 12-month exclusionary period for pre-existing conditions on enrollees who do not have prior creditable coverage or whose prior coverage lapsed more than 63 days. Benefits will vary depending on the chosen plan. ***Pre-Existing Health Conditions Covered***	**COBRA:** Coverage available for 18–36 months depending on qualifying events. Benefits are what you had with your previous employer. **Mini-COBRA:** Coverage available for 12 months. Benefits are what you had with your previous employer. **HIPAA:** Benefits are based on program selected. There is no expiration of coverage. **LaHIPP:** Premium assistance that pays employer-sponsored health insurance or COBRA premiums. The assistance amount depends on the most cost-effective premium available. ***Pre-Existing Health Conditions Covered***	Assorted plans depending on medical needs. There is a 12-month look-back and exclusionary period limit for pre-existing conditions on enrollees with no prior coverage. ***Limits on Pre-Existing Health Conditions May Apply***	**LHP:** High Risk and HIPAA Pools that provide comprehensive coverage. Services include Physician visits and services, Prescription drugs, Inpatient and outpatient hospital care, Inpatient and outpatient mental health and substance abuse services, Skilled nursing care, Home health, Hospice, Lab, X-rays and chemotherapy, Durable medical equipment, Therapy (physical, speech and occupational), Preventive and wellness care. High Risk Pool has 6-month waiting period for pre-existing conditions. HIPAA Pool has 12-month pre-existing condition waiting period for spouse or dependents of enrollee, but none for enrollee, or for child enrolled in HIPAA Pool less than 63 days after birth or adoption. **PCIP:** Covers broad range of benefits, including primary and specialty care, hospital care, and prescription drugs. ***Pre-Existing Health Conditions Covered***	Audiological, Chemotherapy, and chiropractic care, Dental, EPSDT (children under age 21), Durable medical equipment, Family planning, Hearing aids, Hemodialysis, Home health, Hospice, Hospital inpatient and outpatient services, Immunizations, Long-term and community care, Medical transportation, Mental health, Midwife services, Therapy (multi-systemic, occupational, physical, speech therapy and language evaluation), Optical and orthodontic services, Nurses, Elderly care, Prescription drugs, Physician services, Podiatry, Prenatal care, Rehabilitation services, Rural health clinics, STD clinics, Substance abuse services, Tuberculosis clinics, Lab and x-rays. Retroactive benefits available at the time of application for medical services received three months prior. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Company size 2–50 employees. Owner can count as an employee. Owner name on business license must draw wages from the company. "Eligible employee" is defined by insurance carrier.	**GUARANTEED COVERAGE** **COBRA:** Available for employees who work for businesses with 20 or more employees. You have 60 days from date of termination to sign-up. **Mini-COBRA:** Available for employees who work for employers with less than 20 employees. Must have been covered by group insurance continuously for 3 months prior to enrolling in Mini-COBRA. Surviving spouse at least age 55 and covered by deceased spouse's policy is eligible until qualified for other group insurance. Surviving spouse can cover dependents who were insured by deceased spouse's policy as long as they remain eligible under that policy. You must sign up for Mini-COBRA and pay for it on or before the date of termination of group insurance. Surviving spouses have 90 days after date of death to sign-up. **HIPAA:** Must have had 18 months of continuous coverage and completely exhausted COBRA or state continuation coverage. Must not have lost coverage due to fraud or non-payment of premiums. You have 63 days to enroll. **LaHIPP:** Must qualify for Medicaid and have access to Employer-Sponsored Insurance or COBRA.	Eligibility is subject to medical underwriting. Elimination riders are permitted. If you are denied coverage for a medical condition, you may be eligible for LHP or PCIP. See next column.	**GUARANTEED COVERAGE** **LHP:** High Risk Pool: Must prove 6-month residency in Louisiana, denial of health coverage by 2 insurance companies due to pre-existing conditions within one year. Must not be eligible for or covered by any private or public health insurance (including COBRA). Must not be in public institution. HIPAA Pool: Must be a Louisiana resident, HIPAA-eligible, and not be in a public institution. Also qualified are those eligible for Trade Adjustment Assistance (TAA), or pensions from the Pension Benefit Guarantee Corporation (PBGC). **PCIP:** Must have been uninsured for at least 6 months prior to applying. Must prove being a U.S. citizen or legal U.S. resident, a Louisiana resident, and having problems getting insurance due to a pre-existing condition.	**GUARANTEED COVERAGE** Must be U.S. citizens or qualified aliens and live in Louisiana. Income Limit: Parents/Caretakers Living with Children Ages 0–18: 25% FPL. Medically-Needy: Monthly income limit for singles: in urban counties is $100, in rural is $921, with asset limit to both of $2,000; monthly income limit for couples in urban counties is $192, and in rural is $1,671 with asset limit for both of $3,000. Pregnant Women: 200% FPL. Children Ages 0-5: 133% FPL. Children Ages 6-19: 100% FPL. Aged, Blind, & Disabled: Singles earning up to 75% FPL with asset limit of $2,000; couples earning up to 83% FPL with asset limit of $3,000
Monthly Cost	Costs depend on employer contribution. Rates vary ± 35% of the insurance company's index rate but only for employers with 3–35 eligible employees.	**COBRA/Mini-COBRA:**102%–150% of group health rates. **HIPAA:** Premiums will depend on plan chosen. **LaHIPP:** Reimburses the full employer-sponsored insurance premium amount by check monthly. Pays the insurance company directly for people on COBRA or eligible small businesses.	Costs for individual coverage vary. There are no rate caps.	**LHP:** $102.79 to $1,108.02 based on age, gender, region, tobacco use and deductible. **PCIP:** $129 to $553 based on age and plan chosen.	**$0** or minimal share of cost.

PUBLICLY-SPONSORED PROGRAMS

Demographic	Children in Moderate Income Families	Children with Special Health Care Needs	Women	Seniors & Disabled	Veterans
Program	**LaCHIP** Children's Health Insurance Plan 877-252-2447 www.lachip.org **Women-Infants-Children (WIC)** 800-251-2229 new.dhh.louisiana.gov (Search: WIC)	**Children's Special Health Services (CSHS)** 504-896-1340 new.dhh.louisiana.gov (Search: CSHS) Note: CSHS is now a family resource center.	**Breast & Cervical Cancer Prevention (BCCP)** 888-342-6207, 888-599-1073 labchp.lsuhsc.edu **LaMOMS** 888-342-6207, TTD: 800-220-5404 new.dhh.louisiana.gov (Search: LaMOMS) **Take Charge** 888-342-6207 new.dhh.louisiana.gov (Search: Take Charge)	**Medicare** 800-633-4227 www.medicare.gov **Medicare Prescription Drug Program** 800-633-4227	**VA Medical Benefits Package** 877-222-8387 www.va.gov www.ebenefits.va.gov
Coverage	**LaCHIP:** Provides Medicaid coverage for Doctor visits for primary care as well as preventive and emergency care, Immunizations, Prescription medications, Hospitalization, Home health care and many other health services. **WIC:** Nutrition education and services, breastfeeding promotion and education, monthly food prescription of nutritious foods, and access to maternal, prenatal and pediatric health care services. ***Pre-Existing Health Conditions Covered***	Health care services, Medical tests and procedures, Hospitalization, Therapies, Home health services, Medical equipment and supplies, Parent/family support services (parent liaisons), Medications and special diets, Nursing, Nutrition and social services follow-up, Care coordination, Case management, and Resource development, or over 21 years of age for the Cystic Fibrosis program.	**BCCP:** Clinical breast exams, Mammograms, Pelvic exams, Pap tests. Retroactive benefits available at the time of application for medical services received three months prior if a Medicaid provider was used and if the service is covered by Medicaid. **LaMOMS:** Pregnancy-related services, delivery and care up to 60 days after the pregnancy ends including doctor visits, lab work/tests, prescription medicines and hospital care. **Take Charge:** 4 office visits per year on services (such as lab tests) for family planning (e.g. contraceptives) and approved medication and supplies.	Offers Part A, inpatient care in hospitals and rehabilitative centers; Part B, doctor and some preventive services and outpatient care; Part C allows Medicare benefits through private insurance (Medicare Advantage); Part C includes Parts A, B, and C not covered by Medicare. Part D covers prescription drugs. ***Pre-Existing Health Conditions Covered***	Comprehensive preventive and primary care, outpatient and inpatient services. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** **LaCHIP:** Must be a U.S. citizen or qualified alien and live in Louisiana. Must be under 19 years old, not covered by health insurance (including Medicaid). Income limit of 200% FPL. **WIC:** Must live in Louisiana. Must be pregnant or postpartum women, or children under age 5, living up to 185% FPL.	**GUARANTEED COVERAGE** Children under age 21, living in Louisiana, have a condition covered by CSHS, would benefit from rehabilitation services, have a long-term condition that requires specialty care and a multi-disciplinary treatment team. Deafness, Seizures, Cerebral palsy, Spina bifida, Scoliosis, Hydrocephalus, Glaucoma, Frequent urinary tract infections, cystic fibrosis are some qualifying conditions. Any child in Medicaid meets the financial criteria. Income limit of 200% FPL. Children who do not qualify for Medicaid may be financially eligible for CSHS as determined by a CSHS eligibility counselor.	**GUARANTEED COVERAGE** **BCCP:** U.S. citizens or qualified aliens ages 40-64, priority given to women ages 50-64 at or below 200% FPL who are uninsured or under insured. Eligibility continues until the course of treatment ends or the criteria for the program are no longer met and may begin up to three months before the month a woman applies for Medicaid. **LaMOMS:** Pregnant women at or under 200% FPL **Take Charge:** Women ages 19–44 residing in Louisiana with incomes below 200% FPL, without health insurance or whose insurance policies do not cover family planning services.	**GUARANTEED COVERAGE** Must be U.S. citizen or permanent U.S. resident, and: 1) If 65 years or older, you or your spouse worked for at least 10 years in Medicare-covered employment 2) You have a disability or end-stage renal disease (permanent kidney failure requiring dialysis or transplant) at any age.	**GUARANTEED COVERAGE** "Veteran status" = active duty in the U.S. military, naval, or air service and a discharge or release from active military service under other than dishonorable conditions. Certain veterans must have completed 24 continuous months of service.
Monthly Cost	**LaCHIP: $0** or minimal share of cost **WIC: $0** or minimal share of cost.	**$0** or minimal share of cost.	**All: $0** or minimal share of cost.	**$0** and share of cost for certain services; deductibles for certain plans. Part A: $0–$451 based on length of Medicare-covered employment; Part B: $99.90-$319.70 depending on annual income; Part C: Based on provider; Part D: Varies in cost and drugs covered.	**$0** and share of cost and co-pays depending on income level.

Demographic	PRIVATE HEALTH INSURANCE				
	Small Businesses (1-50 Employees)	**Individuals Recently Covered by an Employer Health Plan**	**Individuals & Families**	**Individuals with Pre-Existing, Severe, or Chronic Medical Conditions**	**Low-Income Families & Medically -Needy**
Program	**Group Plans** Maine Association of Health Underwriters www.meahu.org **Dirigo Choice** 877-892-8391 207-287-9900(TTY) www.dirigohealth.maine.gov	**COBRA/ Mini-COBRA** Contact your current carrier. After 18 months continuous group/ COBRA coverage, convert to a plan under: **Maine Continuity Law** www.maine.gov/pfr/insurance/consumer/lostgrouphealth_2009.htm **HIPAA** Health Insurance Portability & Accountability Act 866-487-2365 www.dol.gov (Search: HIPAA)	**Individual Plans** Maine Association of Health Underwriters www.meahu.org	**Pre-Existing Condition Insurance Plan (PCIP)** Run by the Dirigo Health Agency 877-892-8391 www.dirigohealth.maine.gov www.PCIP.gov	**MaineCare** (Medicaid) 800-977-6740 (Member Services) www.maine.gov/bms
Coverage	Medical underwriting is prohibited. Pre-existing conditions can be excluded for a limited time depending upon the type of group plan you are joining. There is a maximum look-back/exclusion period of 6–12 months for pre-existing conditions for enrollees with no prior coverage or whose coverage lapsed 90 days or more. Benefits will vary depending on the chosen plan. ***Pre-Existing Health Conditions Covered***	**COBRA:** Coverage available for 18 to 36 months depending on qualifying events, benefits are the same as what you had with your previous employer. **Mini-COBRA:** Coverage lasts up to 12 months. Benefits are what you had with your previous employer. **HIPAA/Maine Continuity Law:** Benefits are based on the program selected and there is no expiration of coverage. ***Pre-Existing Health Conditions Covered***	Depends on plan chosen. Carriers are required to offer standardized plans and certain benefits, such as mammograms, childhood immunizations and automatic coverage for newborns or adopted children. There is a maximum look-back and exclusion period of 12 months for pre-existing conditions. ***Pre-Existing Health Conditions Covered***	Primary and specialty care, hospital care, and prescription drugs. There are two deductible choices: a) $1,750 or b) $2,500. Out-of-Pocket limit for a) $3,500 and for b) $5,600. ***Pre-Existing Health Conditions Covered***	Adult family care services, Ambulatory care and surgery, Ambulance services, Dialysis, Case management, Nursing services, Chiropractic, Community support, Benefits for the elderly and for members with mental and physical disabilities, Dental, Family planning, Hearing aids, Home health, Hospice, Inpatient and outpatient Hospital services, Laboratory and x-ray services, Medical supplies and durable medical equipment, Behavioral health, nursing, Therapy (occupational, physical), Vision, Physician services, Preventive health services, Podiatry, medical imaging services, Rehabilitation services, Rural health clinics, Speech and hearing services, Transportation services, STD screening, and more. Retroactive benefits available at the time of application for medical services received three months prior. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Company size 1–50 employees Owner can count as an employee. Proprietor-name on license must draw wages. Employees must work at least 30 hours a week, and must not be employees who work on a temporary or substitute basis. Carrier's minimum participation requirements may not exceed 75% of all eligible employees. **DirigoChoice:** See requirements in "Moderate Income Individuals, Families & Employees"	**GUARANTEED COVERAGE** **COBRA:** Available for employees who work for businesses with 20 or more employees. Have 60 days from date of termination to sign-up. **Mini-COBRA:** Available for employees who work for businesses with less than 20 employees. Must elect coverage within 31 days of termination of employment. If eligible due to layoff, must have at least 6 months of employment before layoff. **Maine Continuity Law:** Must be a Maine resident. Depending on qualifying event, you must apply for new coverage between 30–90 days of previous coverage to enroll in a plan with no pre-existing health condition exclusion. **HIPAA:** Must have had 18 months of continuous coverage and completely exhausted COBRA or state continuation coverage. Must not have lost coverage due to fraud or non-payment of premiums. You have 63 days to enroll.	**GUARANTEED COVERAGE** No medical underwriting is allowed. Elimination riders are not permitted.	**GUARANTEED COVERAGE** Must be uninsured for the last 6 months, prove having a qualified pre-existing condition, and be a U.S. citizen or legal resident. Dirigo Health Agency patients may be eligible for discounts of 20% to 80% if patients live up to 300% FPL and have an asset limit of $60,000 for one household member, or $120,000 for 2 or more household members.	**GUARANTEED COVERAGE** Must be U.S. citizen or qualified alien and resident of Maine. Pregnant Women & Infants: 200% FPL. Infants Not Born to Medicaid-Enrolled Mothers: 185% FPL if Children Ages 1-5: 133% FPL. Children Ages 6-19: 125% FPL. 19-20 year olds Living up to 150% FPL and & an asset limit of $2,000. Aged, Blind & Disabled, and medically-needy singles and couples living up to 100% FPL, with asset limit of $2,000 for singles and $3,000 for couples. Parents & Caregivers Living with Children 0–18: 150%–200% FPL and with asset limit of $2,000.
Monthly Cost	Costs depend on employer contribution and ± 20% of the modified community rate.	**COBRA/Mini-COBRA:** 100%–150% of group health rates (plus 2% administrative cost). **HIPAA/Maine Continuity Law:** Premiums depend on plan chosen.	Premiums vary by 20% above and below community rating. Annual deductibles range from $250–$1,500.	$438–$658 depending on your age and region.	**$0** or minimal share of cost.

PUBLICLY-SPONSORED PROGRAMS

Demographic	Moderate Income Individuals, Families & Employees	Children with Special Health Needs	Pregnant Women & Children	Women in Need of Cancer Screening	Seniors & Disabled
Program	**Dirigo Choice** 877-892-8391 207-287-9900(TTY) www.dirigohealth.maine.gov	**Children with Special Health Needs** 800-698-3624 TTD: 800-438-5514 www.maine.gov (Search: CSHN)	**CubCare** 800-442-6382 877-543-7669 www.maine.gov (Search: CubCare) **Women-Infants-Children (WIC)** 800-437-9300 207-287-3991 800-438-5514 (TTY) www.maine.gov (Search: WIC)	**Maine Breast & Cervical Health Program** 800-350-5180 207-287-8068 800-438-5514 (TTY) www.maine.gov (Search: MBCHP)	**Medicare** 800-633-4227 www.medicare.gov **Medicare Prescription Drug Program** 800-633-4227
Coverage	Coverage for qualified individuals, sole proprietors, and small businesses. Voucher program that pays for insurance on behalf of part-time/seasonal workers. Preventive care, Inpatient/ outpatient, Prescription drugs, Maternity and well-child care, Childhood Immunizations, Emergency care, Mental health, Smoking cessation and education programs, Domestic partner coverage, Extensive provider network and out-of-network coverage, and no referral required to see a specialist. ***Pre-Existing Health Conditions Covered***	Medical treatment, including diagnostic, medical, surgical, corrective and other therapeutic interventions for: Blood disorders, Cardiac defects, Childhood oncology Craniofacial anomalies, Gastrointestinal, Metabolic ophthalmologic, Orthopedic, neurological, Neurosensory, neuromuscular, and respiratory conditions. Assistance with coordination of care and referral services to families of infants, children, and adolescents with special health needs regardless of income. ***Pre-Existing Health Conditions Covered***	**CubCare:** Doctors visits, Hospital care, Immunizations, Prescriptions, Surgery, Lab and x-ray, Dental, Medical equipment and supplies, Chiropractic services, Therapies (speech, physical, occupational), Vision, Hearing, Ambulance, Case management, Mental health and substance abuse treatment, Family planning services, Prenatal care, and Transportation. **WIC:** Screening for growth and anemia, healthy advice for families, nutrition & healthy foods, breastfeeding support, other referrals to other services. ***Pre-Existing Health Conditions Covered***	Breast exams, Pap tests, pelvic exams, mammograms, limited diagnostic or follow-up services. Uninsured women undergoing treatment for breast or cervical cancer may qualify for MaineCare. ***Pre-Existing Health Conditions Covered***	Offers Part A, inpatient care in hospitals and rehabilitative centers; Part B, doctor and some preventive services and outpatient care; Part C allows Medicare benefits through private insurance (Medicare Advantage); Part C includes Parts A, B, and C not covered by Medicare. Part D covers prescription drugs. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** **Small Employers:** Must be Maine residents, have 2–50 employees, contribute 60% of the cost of employees' coverage. Employees' dependents not covered. **Sole Proprietors:** Must be Maine residents, pay 60% of cost for single coverage before discount is applied, are not required to give minimum contribution. **Individuals & Sole Proprietors:** Must complete a Certification Statement. **Part-Time Worker Coverage Voucher:** Must be Maine residents, work 10–35 hours a week, be uninsured for the last 90 days, living up to 300% FPL with asset of $60K (for singles) or $120K (for 2+ household members). HCTC-eligible members are qualified.	**GUARANTEED COVERAGE** Must be Maine resident. Infants, children, and adolescents who are at or below 250% FPL. Ages 21 and under.	**GUARANTEED COVERAGE** **CubCare:** Low-income children ages 0–18 and pregnant women. No citizenship requirements for pregnant women and children. Must be Maine residents. Income must be equal to or less than 180% FPL. **WIC:** Pregnant or postpartum women and children up to the age of 5 years with a family income at or below 185% FPL. Must be a state resident; and be at nutritional or medical risk, as determined by a health professional.	**GUARANTEED COVERAGE** Must be Maine resident. Ages 40 and older. Under 250% FPL. Must be uninsured or underinsured, ineligible for Medicaid, MaineCare, and Medicare Part B. Limited openings for women age 35–39 who have seen a doctor and need additional tests for a possible breast or cervical cancer or if they have not had a Pap in 5 or more years.	**GUARANTEED COVERAGE** Must be U.S. citizen or permanent U.S. resident, and: 1) If 65 years or older, you or your spouse worked for at least 10 years in Medicare-covered employment, or 2) You have a disability or end-stage renal disease (permanent kidney failure requiring dialysis or transplant) at any age.
Monthly Cost	Discounts of 10% – 80% on monthly premiums, deductibles and annual out-of-pocket expenses based on income, household size, and assets.	**$0** or nominal co-payment.	**CubCare: $0-$64** or small monthly premium. **WIC: $0**	**$0** or nominal co-payment.	**$0** and share of cost for certain services; deductibles for certain plans. Part A: $0–$451 based on length of Medicare-covered employment; Part B: $99.90-$319.70 depending on annual income; Part C: Based on provider; Part D: Varies in cost and drugs covered.

Demographic	PRIVATE HEALTH INSURANCE				
	Small Businesses (2-50 Employees)	**Individuals Recently Covered by an Employer Health Plan**	**Individuals & Families**	**Individuals with Pre-Existing, Severe, or Chronic Medical Conditions**	**Low-Income Families & Medically-Needy**
Program	**Group Plans** Maryland Association of Health Underwriters www.marylandahu.com **Comprehensive Standard Health Benefit Plan (CSHBP)** 410-764-3460 877-245-1762 mhcc.maryland.gov (Search: Health Benefit Plan) **Health Insurance Partnership (HIP)** 410-764-3460 mhcc.maryland.gov/partnership	**COBRA/Mini-COBRA** Then convert to a plan under: **HIPAA** Health Insurance Portability & Accountability Act 866-487-2365 www.dol.gov	**Individual Plans** Maryland Association of Health Underwriters www.marylandahu.com	**Maryland Health Insurance Plan (MHIP)** 888-444-9016 www.marylandhealthinsuranceplan.state.md.us **MHIP Federal Plan** 443-738-0667 www.marylandhealthinsuranceplan.net www.PCIP.gov	**Medicaid** 410-767-5800 800-492-5231 800-735-2258 (TDD) www.dhmh.state.md.us/mma/mmahome.html **Medical Assistance for Families** 800-456-8900 www.dhmh.state.md.us/ma4families/
Coverage	**CSHBP:** Insurance carriers are required by law to sell CSHBP to any small employer who applies for it. CSHBP offers comprehensive standardized benefits such as primary and specialty care, inpatient and outpatient hospital services, physician services, prescription drugs, lab and diagnostic services. Some carriers can impose 6-month look-back and 12-month exclusion periods for pre-existing conditions on new employees joining an existing non-HMO group policy. Carriers cannot impose this on enrollees under 19 years old. **HIP:** Premium subsidy program for small employers. ***Pre-Existing Health Conditions Covered***	**COBRA:** Coverage available for 18–36 months depending on qualifying events. Benefits are what you had with your previous employer. **Mini-COBRA:** Coverage lasts up to 18 months. Benefits are what you had with your previous employer. **HIPAA:** Benefits are based on program selected. There is no expiration of coverage. ***Pre-Existing Health Conditions Covered***	Assorted plans depending on medical needs There is a 12-month look-back and 12-month exclusionary period limit for pre-existing conditions. Elimination riders are permitted. ***Limits on Pre-Existing Health Conditions May Apply***	**MHIP:** Four plans offering comprehensive coverage of Doctor visits, Prescription drugs, Outpatient and in-hospital care, Maternity, Ambulance, Labs and x-rays, Skilled nursing care, Hospice, Home health visits, Transplants, Rehabilitation, Durable medical equipment, Mental health and substance abuse, Physical, Speech and occupational therapy, and Preventive care. **MHIP Federal Plan:** Covers broad range of benefits, including primary and specialty care, hospital care, and prescription drugs. ***Pre-Existing Health Conditions Covered***	**Medicaid:** Doctor visits, Prescriptions, Hospital care (including emergency care), Tests, X-rays, Family planning, Mental health services, Substance abuse services, Home health care, Dental care, Eye care, Therapy (occupational, physical and speech), and more. **Medical Assistance for Families:** Low-cost or free prescriptions, Doctor visits, Emergency room visits,Hospital stays, X-ray and lab services, and many other services. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** **CSHBP:** Must conduct business in Maryland in the preceding calendar quarter, employ 2–50 workers on at least 50% of its working days. Eligible employees (including proprietor) must work at least 30 hours per week. Carrier may deny coverage if less than 75% of eligible employees, who are not covered by spouse or another employer, sign up for CSHBP. For non-profits, groups of one currently uninsured working at least 20 hours a week are eligible. Employers do not have to offer or pay for group health benefits for their employees. **HIP:** Employers with 2–9 eligible employees and have not offered health insurance to employees in last 12 months. Eligible employees must work at least 30 hours a week, earning up to $50,000 ($75,000 for coverage for dependent). Part-time, temporary, and seasonal employees do not qualify.	**GUARANTEED COVERAGE** **COBRA:** Available for employees who work for businesses with 20 or more employees. You have 60 days from date of termination to sign up for COBRA coverage. **Mini-COBRA:** Available for employees who work for employers of any size. Must be resident of Maryland, have been covered by group insurance for 3 months before termination. Must elect coverage within 45 days of termination. In case of divorce, insured employee or his/her divorced spouse must elect coverage within 60 days after change in status. **HIPAA:** Must have had 18 months of continuous coverage and completely exhausted COBRA or state continuation coverage. Must not have lost coverage due to fraud or non-payment of premiums. You have 63 days to enroll in a HIPAA-eligible plan.	Eligibility is subject to medical underwriting. If you are denied coverage for a medical condition, you may be eligible for MHIP or MHIP Federal Plan. See next column.	**GUARANTEED COVERAGE** **MHIP:** Eligible if previous coverage was terminated for reasons other than non-payment of premium or fraud, you were denied coverage due to a medical condition, or were offered health insurance that provides limited coverage or excludes coverage for a specific medical condition. Cannot be eligible for group plan, COBRA, or government programs. Also eligible if beneficiary of Trade Adjustment Assistance (TAA). Families with incomes at or below 300% FPL can qualify for discounted premiums **(MHIP+).** **MHIP Federal Plan:** Must be a U.S. citizen or lawfully present in the U.S. and have been uninsured for at least 6 months prior to applying. Must have had a problem getting insurance due to a pre-existing condition.	**GUARANTEED COVERAGE** **Both:** Must be U.S. citizens or qualified non-citizens and Maryland residents. **Medicaid:** Income limits: Parents/caretakers living with children ages 0–18: 116% FPL. Pregnant women: 150% FPL. Aged, blind or disabled: Singles earning 75% FPL with asset limit $2,500, and couples earning up to 83% FPL with asset limit of $3,000. Medically-needy: Singles earning $350 per month with asset limit of $2,500, and couples earning $392 per month with asset limit of $3,000. Children: See" Children & Pregnant Women" column. **Medical Assistance for Families:** Must be living up to 121% FPL.
Monthly Cost	**CSHBP:** At or less than 10% of Maryland's average annual wage. Carriers must price CSHBP separate from riders. **HIP:** Subsidy per employee depends on health plan chosen and employee wage. Subsidy is up to 50% of employee premium.	**COBRA/Mini-COBRA:** Premiums range from 102%–150% of group health rates. **HIPAA:** Premiums will depend on plan chosen.	Costs for individual coverage vary.	**MHIP: 150%** or less of the standard premium rate charged by commercial carriers. **MHIP Federal Plan:** Monthly premiums range from $141 to $354 depending on your age.	**Both: $0** or minimal share of cost.

PUBLICLY-SPONSORED PROGRAMS

Demographic	Children & Pregnant Women	Women in Need of Cancer Screening & Treatment	Seniors & Disabled	Trade Dislocated Workers (TAA Recipients)	Veterans
Program	**Maryland Children's Health Program (MCHP)** 800-456-8900 800-735-2258 TTD mmcp.dhmh.maryland.gov/chp **MCHP Premium** 410-767-6883 800-456-8900 800-735-2258 (TDD) **Women-Infants-Children (WIC)** 800-242-4942 www.dhmh.state.md.us (Search: WIC)	**Breast & Cervical Cancer Screening Program** 800-477-9774 fha.dhmh.maryland.gov (Search: BCCP) **Breast & Cervical Cancer Diagnosis & Treatment Program** 410-767-6787 800-477-9774 fha.dhmh.maryland.gov (Search: BCCTD)	**Medicare** 800-633-4227 www.medicare.gov **Medicare Prescription Drug Program** 800-633-4227	**Health Coverage Tax Credit** 866-628-4282 www.irs.gov (keyword: HCTC)	**VA Medical Benefits Package** 877-222-8387 www.va.gov www.ebenefits.va.gov
Coverage	**MCHP:** Doctor Visits, Hospital Care, Lab Work and Tests, Dental, Vision, Immunizations, Prescription Drugs, Transportation, Mental Health and Substance Abuse treatment, maternity services **MCHP Premium:** Access to health coverage through Healthchoice, the Maryland Managed Care Program. **WIC:** Nutrition education, Breastfeeding Support, Free healthy food, Referral to other health and social agencies. ***Pre-Existing Health Conditions Covered***	**BCCP:** Clinical services such as Mammograms, Pap tests, Pelvic exams, Breast exams, HPV testing (when appropriate). May also receive Cervical biopsies, Colposcopies, Breast ultrasounds, and Surgical consults. **BCCDT:** Mammograms, Surgical consultations, Breast ultrasound, Biopsies, Colposcopies, Cervical biopsies, Surgery, Chemotherapy and radiation therapy, Home health, Pharmacy, Medical equipment and supplies (including prosthesis and bras),Physical therapy, Occupational therapy, Wigs, and Breast reconstruction. ***Pre-Existing Health Conditions Covered***	Offers Part A, inpatient care in hospitals and rehabilitative centers; Part B, doctor and some preventive services and outpatient care; Part C allows Medicare benefits through private insurance (Medicare Advantage); Part C includes Parts A, B, and C not covered by Medicare. Part D covers prescription drugs. ***Pre-Existing Health Conditions Covered***	Inpatient and outpatient care (lab tests, x-rays, etc.), Doctor visits, Preventive and major medical care (surgery, physical therapy, Durable medical equipment, etc.), Mental health and substance abuse care, and Prescription drugs. ***Pre-Existing Health Conditions Covered***	Comprehensive preventive and primary care, outpatient and inpatient services. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** **MCHP & MCHP Premium:** Must be U.S. citizens or qualified aliens and live in Maryland. Must be currently uninsured or not have voluntarily dropped employer-sponsored group health plan within last 6 months. Even if you are insured, apply and let the case manager determine whether your health insurance will affect your eligibility. **MCHP:** Must be children ages 0–19, with incomes up to 200% FPL, or pregnant women with incomes up to 250% FPL. Must not be eligible for Medicaid. **MCHP Premium:** Must be children ages 0–19 with incomes 200% to 300% FPL. **WIC:** Must live in Maryland, be pregnant or postpartum women, infants, or children up to 5. Income limit of 185% FPL.	**GUARANTEED COVERAGE** **BCCP:** Must be a woman, a Maryland resident, 40–64 years old, or if over 65 must be without Medicare, or with Medicare Part A only. Must either be uninsured or have health insurance which does not cover the screening procedures. Income must be at or below 250% FPL. Not eligible for this program are women on medical assistance or enrolled in Medicare Part B, HMOs or PPOs . **BCCDTP:** Must be a Maryland resident, have a breast or cervical problem, uninsured or underinsured without Medicare, have health insurance which does not cover the screening process, income must be at or below 250% FPL	**GUARANTEED COVERAGE** Must be U.S. citizen or permanent U.S. resident, and: 1) If 65 years or older, you or your spouse worked for at least 10 years in Medicare-covered employment, or 2) You have a disability or end-stage renal disease (permanent kidney failure requiring dialysis or transplant) at any age.	**GUARANTEED COVERAGE** Must be receiving TAA (Trade Adjustment Assistance), or Must be 55 years or older and receiving pension from the Pension Benefit Guaranty Corporation (PBGC). Must not be enrolled in certain state plans, or in prison, or receiving 65% COBRA premium reduction, or be claimed as a dependent in tax returns. Must be enrolled in qualified health plans where you pay more than 50% of the premiums.	**GUARANTEED COVERAGE** "Veteran status" = active duty in the U.S. military, naval, or air service and a discharge or release from active military service under other than dishonorable conditions. Certain veterans must have completed 24 continuous months of service.
Monthly Cost	**MCHP:** **$0** or monthly premium payment depending on family income. **MCHP Premium:** **$48–$60** per month per family depending on family income. **WIC:** **$0** to minimal share of cost.	**Both:** **$0**	**$0** and share of cost for certain services; deductibles for certain plans. Part A: $0–$451 based on length of Medicare-covered employment; Part B: $99.90-$319.70 depending on annual income; Part C: Based on provider; Part D: Varies in cost and drugs covered.	**27.5%** of the insurance premium including COBRA premium if employer contributes less than 50%.	**$0** and share of cost and co-pays depending on income level.

Demographic	PRIVATE HEALTH INSURANCE		PRIVATE/PUBLIC PROGRAMS
	Small Businesses (1-50 Employees)	**Individuals Recently Covered by an Employer Health Plan**	**Individuals & Families Above 300% FPL**
Program	**Group Plans** MA Association of Health Underwriters 508-634-7373 www.massahu.org Commonwealth Connector 877-623-6765 www.mahealthconnector.org MA Division of Insurance 617-521-7794 www.mass.gov/doi **The Insurance Partnership** 800-399-8285, 508-698-2070 www.insurancepartnership.org Employers can purchase health plans either directly from the insurance carrier or through the Commonwealth Connector	**COBRA/Mini-COBRA** Contact your current carrier. After 18 months continuous group/COBRA coverage, convert to a plan under: **HIPAA** Health Insurance Portability & Accountability Act 866-487-2365 www.dol.gov (Search: HIPAA) **Medical Security Program (MSP)** Premium Assistance & Direct Coverage 800-908-8801 www.mass.gov (Search: Medical Security Program)	**Individual Plans** MA Division of Insurance 617-521-7794 www.mass.gov/doi MA Association of Health Underwriters 508-634-7373 www.massahu.org Commonwealth Connector 877-623-6765 www.mahealthconnector.org Employers can purchase health plans either directly from the insurance carrier or through the Commonwealth Connector.
Coverage	Employers may choose one or more employer-sponsored plans for their eligible full-time employees among several carriers and plans including Health Savings Accounts plans. Employers may also offer non-employer sponsored plans through the Connector for their part-time and ineligible employees, and establish a Section 125 plan enabling employees to use pre-tax dollars to pay health insurance premiums. Each employee can then choose among any of the carriers and plans offered through the Connector. **The Insurance Partnership:** Offers premium assistance to employers with 50 or fewer eligible employees. ***Pre-Existing Health Conditions Covered***	**COBRA/Mini-COBRA:** Coverage available for 18–36 months depending on qualifying events. Benefits are what you had with your previous employer. **HIPAA:** Benefits are based on program selected. There is no expiration of coverage. **MSP:** Will pay some of the premiums of the employer-based health plan you are continuing, so your benefits will stay the same. If you cannot continue your employer-based health plan or have none, you will get the Network Blue Options Deductible plan from Blue Cross Blue Shield. Coverage is comprehensive (inpatient and outpatient hospital care, doctor visits, etc.), but does not include dental benefits. ***Pre-Existing Health Conditions Covered***	Commonwealth Choice plans (Gold, Silver, or Bronze) are lower-cost private plans available through Commonwealth Connector and directly through different insurance carriers. The companies offering the plans include Blue Cross Blue Shield of Massachusetts, Fallon Community Health Plan, Harvard Pilgrim Health Care, Health New England, Neighborhood Health Plan, and Tufts Health Plan. Young Adults Plans (YAP) are available and can only be purchased through the Commonwealth Connector. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Employers with one or more full-time employees may establish a group plan with employer contributions so long as the premium contribution towards full-time non-bargaining employees (defined by the state as working 30 hours or more) is not discriminatory. An employer may also establish a Section 125 plan for employees who are not eligible for their group plan and allow them to purchase insurance through the Commonwealth Connector. A full-time employee must work at least 30 hours per week in Massachusetts (even if they live in another state). Full-time employees do not include: 1) Independent contractors; 2) Seasonal employees; 3) Temporary employees; 4) Workers from temp agencies (they are the temp agency's employees). Employers with 11 or more full-time equivalent employees have four requirements: 1) Must offer a Section 125 cafeteria plan that meets Commonwealth Connector regulations. If it's not offered, employer must pay the Free Rider Surcharge if the employees or their dependents get medical care that is paid by the state's Free Care Pool (now called the Health Safety Net) for the uninsured; 2) Must make a "fair and reasonable" contribution to employees' health insurance or pay a Fair Share Contribution or fine of up to $295 per employee per year (see below); 3) Must complete an Employer Health Insurance Responsibility Disclosure (HIRD) Form/ Report which must be filed online, to report if you offer a Section 125 Plan that complies with Commonwealth Connector regulations; 4) Must collect an HIRD Employee Form from employees who decline your employer-sponsored health insurance and/or your employer-sponsored Section 125 Plan. **The Insurance Partnership:** Company size 2-50 employees or self employed. Employers must offer (or plan to offer) comprehensive health insurance to its employees and contribute (or be willing to contribute) at least 50% of the cost of the insurance purchased by the employee. Eligible employees must have incomes up to 300% FPL, and be ages of 19 to 64. In the past six months, they must not have been offered health insurance by their current employer or must not have been eligible for health insurance through their spouse's employer.	**GUARANTEED COVERAGE** **COBRA:** Available for employees who work for employers with 20 or more employees. You have 60 days from date of termination to sign-up. **Mini-COBRA:** Available for employees who work for employers with less than 20 employees. Must sign-up within 60 days from the later of either A) Date of termination of group coverage; or B) Date the notice to elect Mini-COBRA coverage is sent. **HIPAA:** Must have had 18 months of continuous coverage and completely exhausted COBRA or state continuation coverage. Must not have lost coverage due to fraud or non-payment of premiums. You have 63 days to enroll. **MSP:** Must be a Massachusetts resident, receiving unemployment benefits, have worked for a Massachusetts employer, and not have access to health insurance through spouse. **Premium assistance:** Income limit is 400% FPL. **Direct coverage:** Must earn up to 150% FPL. If you earn more than 150% FPL, you must submit proof of your high monthly expenses and a copy of your group health insurance coverage (COBRA) letter from your former employer.	**GUARANTEED COVERAGE** There is no medical underwriting. You are a resident of Massachusetts or must be employed by a Massachusetts-based employer, age 18 or older, not eligible for Commonwealth Care products because family's income before taxes is above 300% FPL. Must not be enrolled in Medicaid or Medicare Part B. Young Adults Plans (YAP) are available to people ages 18–26.
Monthly Cost	Employers must make a "fair and reasonable" contribution to employees' health insurance or pay a Fair Share Contribution or fine of up to $295 per employee per year. A "fair and reasonable" contribution by an employer is: (i) 25% of an employer's full-time employees are participating in the employer's group health plan or (ii) an employer's contribution of at least 33% toward a health plan premium for all full-time employees who are employed more than 90 days. An employer who meets either (i) OR (ii) will not be subject to the Fair Share Contribution of up to $295 per employee **The Insurance Partnership:** Program will pay up to $1,000 a year toward health insurance costs for each qualified employee. The amount depends on the tier of coverage chosen by the employee.	**COBRA/Mini-COBRA:** 102%–150% of group health rates. **HIPAA:** Premiums will depend on plan chosen. **MSP: Premium assistance:** 80% of premium will be subsidized, or up to $1,200 per month for a family plan and up to $500 per month for an individual plan. **Direct Coverage:** $0-$27 per week. Families less than 150% FPL, children 19 and under, and pregnant women are exempt from cost.	Premiums will depend on the health plan and benefit package chosen. A co-payment for each service is required. There may be a deductible amount that the member must pay for before the health plan begins paying. Deductibles vary by plan chosen.

PUBLICLY-SPONSORED PROGRAMS

Demographic	Individuals & Families	Women	Children	Seniors
Program	**MassHealth** Enrollment Center: 888-665-9993, 888-665-9997 TTY Customer Service: 800-841-2900, 800-497-4648 TTY www.ma.gov/masshealth **MassHealth offers these programs for:** **Families & Children:** MassHealth Standard, MassHealth Family Assistance, Children's Medical Security Plan **Unemployed Adults:** MassHealth Essential, Medical Security Plan, MassHealth Basic **Pregnant Women:** MassHealth Prenatal Healthy Start **Disabled:** MassHealth, CommonHealth **Commonwealth Care** 877-623-6765 www.mahealthconnector.org **Pre-Existing Condition Insurance Plan (PCIP)** 866-717-5826 www.PCIP.gov www.pciplan.com	**Breast & Cervical Cancer Treatment Program (BCCTP)** 877-414-4447 617-624-5992 TTY www.massresources.org (Search: BCCTP) **Healthy Start** 888-665-9993 (Eligibility) 800-841-2900 (Customer Service) www.massresources.org (Search: Healthy Start)	**Children's Medical Security Plan (CMSP)** 888-665-9993 800-909-2677 www.cmspkids.com **Women-Infants-Children (WIC)** 800-942-1007 www.mass.gov (Search: WIC)	**Medicare** 800-633-4227 www.medicare.gov **Medicare Prescription Drug Program** 800-633-4227
Coverage	**MassHealth** members get similar benefits depending for which MassHealth plan they qualify. Doctor visits, Hospital stays, Rehabilitation and therapeutic services, Behavioral health, Prescription drugs, Transportation services, Out-of-state emergency treatment. Retroactive benefits available at the time of application for medical services received three months prior. **CommonWealth Care:** Preventive care, Check-ups, Medical care, Prescriptions at your local pharmacy, Treatment for alcohol, drug abuse, and mental health problems, Vision care, Dental care (available to some members only). Offers four types of plans: Plan Type 1, 2, 3 or 4. A Plan Type is a list of health benefits and co-payments that are available to members based on their incomes. **PCIP:** Primary and specialty care, hospital care, and prescription drugs. Offers 3 plans: Standard, Extended and HSA Option. ***Pre-Existing Health Conditions Covered***	**BCCTP:** Screening will be done through the Women's Health Network. Insurance coverage by MassHealth Standard. Coverage includes cancer treatment and comprehensive medical care. Benefits obtained through the Primary Care Clinician (PCC) plan. Cannot get benefits through a managed care MCO plan. **Healthy Start:** Early, complete prenatal care to pregnant women and children. ***Pre-Existing Health Conditions Covered***	**CMSP:** Necessary medical, behavioral-health, dental, and pharmacy services, and only two outpatient surgical procedures. **WIC:** Nutrition education and services; breastfeeding promotion and education; monthly food prescription of nutritious foods; maternal, prenatal and pediatric health care services. ***Pre-Existing Health Conditions Covered***	Offers Part A, inpatient care in hospitals and rehabilitative centers; Part B, doctor and some preventive services and outpatient care; Part C allows Medicare benefits through private insurance (Medicare Advantage); Part C includes Parts A, B, and C not covered by Medicare. Part D covers prescription drugs. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** **Note:** Those who are self-employed, are seasonal workers and/or have income not solely from W-2 income sources with regular pay stubs, should contact an enrollment specialist to determine what their gross incomes are and to determine for what programs they are eligible. **MassHealth:** Must be a Massachusetts resident and a U.S. citizen or qualified alien, and one of the following: a parent living with your children under age 19; an adult caretaker relative living with children under age 19 to whom you are related by blood, adoption, or marriage, or are a spouse or former spouse of one of those relatives, and you are the primary caretaker of these children when neither parent is living in the home; Under age 19, pregnant, with or without children; or have been out of work for a long time; or disabled or HIV positive, are a woman under 65 with breast cancer or cervical cancer. **CommonWealth Care:** Must be at least 19 years old with an income below 300% FPL; must be uninsured and eligible as defined by the Commonwealth Connector's regulations; and must be a U.S. citizen/national or legal alien. You are considered uninsured if must be currently insured under COBRA; are paying a full premium for your health insurance in the-non group insurance commercial market; are in a waiting period prior to becoming eligible under an employer-provided health plan (where employer covers at least 20% of the cost of the premium of a family health plan or 33% of an individual plan). **PCIP:** Must have been uninsured for at least 6 months prior to applying. Must prove being a U.S. citizen or legal U.S. resident, a Massachusetts resident, and having problems getting insurance due to a pre-existing condition.	**GUARANTEED COVERAGE** **BCCTP:** Under 65 not otherwise eligible for MassHealth Standard. Have been screened for breast or cervical cancer at a Women's Health Network site and found in need of treatment. Income is up to 250% FPL. Insurance does not cover the treatment you need. Meet the residency and citizenship requirements for MassHealth. **Healthy Start:** Must be pregnant, be a resident of Massachusetts, have little or no health coverage for pregnancy, be ineligible for MassHealth (except MassHealth Limited), Income must be no greater than 200% FPL.	**GUARANTEED COVERAGE** **CMSP:** Children under 19, of any income, living in Massachusetts, unqualified for any other MassHealth coverage type (except MassHealth Limited), uninsured or whose insurance do not have physician and hospital health-care coverage. **WIC:** Must live in Massachusetts, have a nutritional need as determined by WIC staff. Must be a child under 5, a new mother, or a pregnant or breastfeeding woman. Income must be at or below 185% FPL.	**GUARANTEED COVERAGE** Must be U.S. citizen or permanent U.S. resident, and: 1) If 65 years or older, you or your spouse worked for at least 10 years in Medicare-covered employment, or 2) You have a disability or end-stage renal disease (permanent kidney failure requiring dialysis or transplant) at any age.
		Note: Massachusetts residents 18 and older are required by the Individual Mandate law to have health insurance that is deemed by the state to be affordable to them at their income level or they risk being fiscally penalized on their personal state income taxes. There is also a waiver/appeals process from the Individual Mandate. Individuals who are NOT exempt from the Individual Mandate, will have to have health insurance that is deemed affordable to them at their income level AND meets "Minimal Creditable Coverage" (MCC) standards set by the Connector.		
Monthly Cost	**MassHealth & CommonWealth Care:** Costs vary depending on which program suits you best. The costs of each plan are based on a sliding scale. **PCIP:** $181 to $778 depending on your age and plan chosen.	**BCCTP:** **$0** for those earning below 150% FPL. Monthly premium required for participants earning 150%-250% FPL. **Healthy Start:** **$0**	**CMSP:** **$0-$64** depending on income. Co-pays are up to $8, pharmacy is up to $4. **WIC:** **$0** to minimal share of cost.	**$0** and share of cost for certain services; deductibles for certain plans. Part A: $0–$451 based on length of Medicare-covered employment; Part B: $99.90-$319.70 depending on annual income; Part C: Based on provider; Part D: Varies in cost and drugs covered.

PRIVATE HEALTH INSURANCE

Demographic	Small Businesses (2-50 Employees)	Individuals Recently Covered by an Employer Health Plan	Individuals & Families	Individuals with Pre-Existing, Severe, or Chronic Medical Conditions	Low-Income Individuals & Families
Program	**Group Plans** Michigan Association of Health Underwriters www.mahu.org	**COBRA** Contact your current carrier. After 18 months continuous group/COBRA coverage, convert to a plan under: **HIPAA** Health Insurance Portability & Accountability Act 866-487-2365 www.dol.gov (Search: HIPAA)	**Individual Plans** Michigan Association of Health Underwriters www.mahu.org	**Blue Cross/ Blue Shield of Michigan (BCBSM)** 888-642-2276 877-469-2583 www.bcbsm.org **Health Insurance Program for Michigan (HIP)** Administered by Physicians Health Plan 877-459-3113 www.hipmichigan.com www.PCIP.gov	**Medicaid** 517-373-3740 DHS: 855-275-6424 www.michigan.gov/mdch (Click: Health Care Coverage)
Coverage	There is a maximum look-back period of 6 months and maximum exclusion period of 12 months for enrollees without prior creditable coverage or whose coverage lapsed for more than 63 days. Benefits will vary depending on the chosen plan. ***Pre-Existing Health Conditions Covered***	**COBRA:** Coverage available for 18–36 months depending on qualifying events. Benefits are what you had with your previous employer. **HIPAA:** Benefits are based on program selected. There is no expiration of coverage. ***Pre-Existing Health Conditions Covered***	Assorted plans depending on medical needs. There is a 6-month look-back and 12-month exclusionary period limit for pre-existing conditions. ***Limits on Pre-Existing Health Conditions May Apply***	**BCBSM:** Plans vary depending on applicant's needs. **HIP:** Covers broad range of benefits, including primary and specialty care, hospital care, and prescription drugs. ***Pre-Existing Health Conditions Covered***	Ambulance, Dental, Doctor visits, Family planning, Health checkups, Hearing and speech, Home health care, Hospice, Hospitalization, Lab and x-rays, Immunizations, Medical supplies, Nursing home care, Medicine, Mental health care, Personal care services, Prenatal care, Surgery, Vision, Substance abuse treatment, Physical therapy. Retroactive benefits available at the time of application for medical services received three months prior. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Company size 2–50 employees. Participation requirements for 10 or fewer eligible employees is 100%, for 11 to 25 employees up to 75%, for 26 to 50 employees up to 50%. An "eligible" employee is a full-time employee who works 30 or more hours. Owner can count as an employee. Owner name on business license must draw wages from the company.	**GUARANTEED COVERAGE** **COBRA:** Available for employees who work for businesses with 20 or more employees. You have 60 days from date of termination to sign-up. **HIPAA:** Must have had 18 months of continuous coverage and completely exhausted COBRA or state continuation coverage. Must not have lost coverage due to fraud or non-payment of premiums. You have 63 days to enroll.	Eligibility is subject to medical underwriting. If you are denied coverage for a medical condition, you may be eligible for BCBSM or HIP. See next column.	**GUARANTEED COVERAGE** **BCBSM:** Must be Michigan resident. Cannot be eligible for COBRA, or government programs (must have exhausted this option). HMOs in the state must offer guarantee issue coverage to residents during annual open enrollment periods. **HIP:** Must be a U.S. citizen or lawfully present in the U.S. and have been uninsured for at least 6 months prior to applying. Must have had a problem getting insurance due to a pre-existing condition.	**GUARANTEED COVERAGE** Must be U.S. citizens or qualified aliens living in Michigan. Income Limits: Pregnant Women & Infants Ages 0–1: 185% FPL. Children Ages 1–18: 150% FPL. Parents/Caretakers Living with Children Ages 0–18: 63% FPL. Childless Adults: 45% FPL. Aged, Blind & Disabled: 100% FPL with asset limit of $2,000 for singles and $3,000 for couples. Medically-Needy: Monthly income limit varies by region, from $341 to $408 for singles, and $458 to $541 for couples. Asset limit of $2,000 for singles and $3,000 for couples.
Monthly Cost	Costs depend on employer contribution and ± 45% of the insurance company's index rate.	**COBRA:**102%–150% of group health rates. **HIPAA:** Premiums will depend on plan chosen.	Costs for individual coverage vary.	**BCBSM:** Rates are not restricted and will depend on plan (BCBSM does community rating). **HIP:** $103.83 to $514.89 depending on age and plan chosen.	**$0** or minimal share of cost. **$5** for non-emergency visits in ER.

PUBLICLY-SPONSORED PROGRAMS

Demographic	Children	Women	Adults without Dependents	Seniors & Disabled	Trade Dislocated Workers (TAA Recipients)
Program	**MIChild & Healthy Kids** 888-988-6300 www.michigan.gov/mdch (Listed under "Health Care Coverage" and "Children & Teens") **Children's Special Health Care Services (CSHCS)** 800-359-3722 www.michigan.gov/mdch (Search: CSHCS Mission)	**Breast & Cervical Cancer Control Program (BCCCP)** 800-922-6266 www.michigan.gov/mdch (Search: BCCCP) **Women-Infants-Children (WIC)** 800-262-4784 www.michigan.gov/wic **Plan First!** 800-642-3195 www.michigan.gov/mdch (Search: Plan First)	**Adult Benefits Waiver** Adult Medical Program 800-642-3195 www.michigan.gov/mdch (Search: ABW) **Medicaid** 517-373-3740 DHS: 855-275-6424 www.michigan.gov/mdch (Click: Health Care Coverage)	**Medicare** 800-633-4227 www.medicare.gov **Medicare Prescription Drug Program** 800-633-4227 **Medicare/Medicaid Assistance Program (MMAP)** 800-803-7174 www.mmapinc.org	**Health Coverage Tax Credit** 866-628-4282 www.irs.gov (Search: HCTC)
Coverage	**MIChild & Healthy Kids:** Regular checkups, shots, Emergency care, Dental, Hospital, Pharmacy, Prenatal care and delivery, Vision and hearing, Mental health and substance abuse services. **Healthy Kids:** Ambulance, Doctor visits, Family planning, Speech, Home health care, Hospice, Hospitalization, Lab and x-rays, Personal care services, Surgery, Physical therapy. Some pregnancy-related services are covered even without meeting citizenship requirements. **CSHCS:** Covers medical services or treatments directly related to qualifying conditions. Hearing, Dental, Vision, Office visits, Hospital stays, Pharmacy, Counseling, Lab and x-rays, therapies, Medical supplies. ***Pre-Existing Health Conditions Covered***	**BCCP:** Clinical breast exams, Pap tests, Pelvic exams, and Screening mammograms. **WIC:** Nutrition education and services; breastfeeding promotion and education; monthly food prescription of nutritious foods; access to maternal, prenatal and pediatric health care services. **Plan First!:** Offers family planning services only. Covers physical exams, education and counseling, testing for STDs, contraceptives, sterilization, medications. Does not cover abortions or infertility treatments.	**ABW:** Offers limited medical care: Durable medical equipment and medical supplies, Mental health, diagnostic and treatment services in outpatient hospitals, Physician and nurse practitioner, Oral-maxillofacial surgery, Medical clinic, Urgent care. No inpatient hospital care. **Medicaid:** Dental, Doctor visits, Health checkups, Hearing and speech, Home health care, Hospice, Hospitalization, Immunizations, Prenatal care, Surgery, Vision, Physical therapy. **Both:** Ambulance, Family planning, Lab and x-rays, Medical supplies, Mental health, Pharmacy, Substance abuse, Nursing services. ***Pre-Existing Health Conditions Covered***	**Medicare** offers Part A, inpatient care in hospitals and rehabilitative centers; Part B, doctor and some preventive services and outpatient care; Part C allows Medicare benefits through private insurance (Medicare Advantage); Part C includes Parts A, B, and C not covered by Medicare. Part D covers prescription drugs. **MMAP** is a counseling service for seniors and disabled. ***Pre-Existing Health Conditions Covered***	Inpatient and outpatient care (lab tests, x-rays, etc.), Doctor visits, Preventive and major medical care (surgery, physical therapy, Durable medical equipment, etc.), Mental health and substance abuse care, and Prescription drugs. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** **All:** Must be Michigan residents and U.S. citizens or qualified immigrants. **MIChild:** Must be under age 19. Income must be above 150%, but below 200% FPL. Must be uninsured and ineligible for Medicaid. Families who voluntarily drop employer-based comprehensive insurance must wait six months to enroll. If families drop private insurance, they may immediately enroll in MIChild. **Healthy Kids:** Must either be pregnant women of any age, or children under age 19. Income must be at or below 150% FPL. **CSHCS:** Must be under age 21 with a qualifying medical condition or children ages 21 and older with cystic fibrosis or certain blood coagulation disorders	**GUARANTEED COVERAGE** **BCCP:** Income limit of 250% FPL. Must be uninsured or underinsured and live in Michigan. Breast/cervical cancer screening and for diagnostic follow-up of breast/cervical abnormalities for women ages 40–64, or for women ages 18–39 who have been identified with a cervical abnormality through the Family Planning program (Title X). Not eligible: Women who are enrolled in a managed care program, a health maintenance organization, or Medicare Part B. **WIC:** Must live in Michigan and have a nutritional need determined by WIC staff. Must be a child under 5, a new mom, or a pregnant or breastfeeding woman. Income limit is 185% FPL. **Plan First!:** Must be U.S. citizens or qualified aliens living in Michigan. Must be women ages 19 to 44, not Medicaid-eligible. Income limit is 185% FPL.	**GUARANTEED COVERAGE** **ABW:** Must be uninsured Michigan residents, ineligible for Medicaid. Income limit is 35% FPL. **Medicaid:** Income Limit of 45% FPL.	**GUARANTEED COVERAGE** **All:** Must be U.S. citizen or permanent U.S. resident, and: 1) If 65 years or older, you or your spouse worked for at least 10 years in Medicare-covered employment, or 2) You have a disability or end-stage renal disease (permanent kidney failure requiring dialysis or transplant) at any age.	**GUARANTEED COVERAGE** Must be receiving TAA (Trade Adjustment Assistance), or Must be 55 years or older and receiving pension from the Pension Benefit Guaranty Corporation (PBGC). Must not be enrolled in certain state plans, or in prison, or receiving 65% COBRA premium reduction, or be claimed as a dependent in tax returns. Must be enrolled in qualified health plans where you pay more than 50% of the premiums. Also see BCBSM.
Monthly Cost	**MIChild: $10** monthly premium and no co-pays. **Healthy Kids: $0.** Pregnant women over 21 years old pay small co-pays for some services. **CSHCS: $0** if child is on Medicaid. Otherwise, fees based on sliding-scale	**BCCP & Plan First!: $0** **WIC: $0** to minimal share of cost.	**$0** or minimal share of cost. **$5** for non-emergency visits in ER.	**Medicare: $0** and share of cost for certain services; deductibles for certain plans. Part A: $0–$451 based on length of Medicare-covered employment; Part B: $99.90-$319.70 depending on annual income; Part C: Based on provider; Part D: Varies in cost and drugs covered. **MMAP: $0**	**27.5%** of the insurance premium including COBRA premium if employer contributes less than 50%.

Demographic	PRIVATE HEALTH INSURANCE				
	Small Businesses (2-50 Employees)	**Individuals Recently Covered by an Employer Health Plan**	**Individuals & Families**	**Individuals with Pre-Existing, Severe, or Chronic Medical Conditions**	**Low-Income Individuals & Families**
Program	**Group Plans** Minnesota Association of Health Underwriters 651-917-6253 www.emahu.org	**COBRA/Mini-COBRA** Contact your current carrier. After 18 months continuous group/COBRA coverage, convert to a plan under: **HIPAA** Health Insurance Portability & Accountability Act 866-487-2365 www.dol.gov (Search: HIPAA)	**Individual Plans** Minnesota Association of Health Underwriters 651-917-6253 www.emahu.org	**Minnesota Comprehensive Health Association (MCHA)** 866-894-8053 www.mchamn.com **Pre-Existing Condition Insurance Plan (PCIP)** Run by the U.S. Department of Health and Human Services 866-717-5826 www.PCIP.gov www.pciplan.com	**Medical Assistance** (Medicaid) Twin-Cities Metro Area 651-431-2670 Outside Twin-Cities Metro Area 800-657-3739 mn.gov/dhs (Search: Medical Assistance)
Coverage	There is a maximum 6-month look-back/12-month exclusionary period for pre-existing conditions on enrollees that do not have prior creditable coverage or whose prior coverage lapsed for more than 63 days. Benefits will vary depending on the chosen plan. ***Pre-Existing Health Conditions Covered***	**COBRA/Mini-COBRA:** Coverage available for 18–36 months depending on qualifying events. Benefits are what you had with your previous employer. **HIPAA:** Benefits are based on program selected. There is no expiration of coverage. ***Pre-Existing Health Conditions Covered***	Options vary depending on applicant needs and plan selected. There is a maximum look-back period of 6 months and maximum exclusion period of 18 months for pre-existing condition for enrollees with no prior coverage. Elimination riders are not permitted. ***Pre-Existing Health Conditions Covered with Some Limitations***	**MCHA:** Professional service, Prescription drugs and pharmacy services, Mail service, Hospital and ambulance services, Home health care, Outpatient, Rehabilitation, Mental health substance abuse, Durable medical equipment and prosthetics, Organ and bone marrow transplant, Dental, Infertility services, Hospice, Reconstructive and restorative surgery, Skilled nursing, Emergency. **PCIP:** Primary and specialty care, hospital care, and prescription drugs. ***Pre-Existing Health Conditions Covered***	Clinic and physician, immunizations, ambulance, emergency room services when used for emergency care, inpatient and outpatient hospital care, lab, x-ray, family planning, pregnancy related services, nurse midwife, medical equipment and supplies, hearing aids, physical, occupational, speech, respiratory and rehabilitative therapy, transportation, mental health services, alcohol and drug treatment, prosthetics, nursing facilities, home health services, hospice. Retroactive benefits available at the time of application for medical services received three months prior. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Company size 2–50 employees. Owner can count as an employee. Proprietor-name on license must draw wages. Eligible employees must work at least 20 hours a week.	**GUARANTEED COVERAGE** **COBRA:** Available for employees who work for employers with 20 or more employees. You have 60 days from date of termination to sign-up. **Mini-COBRA:** Available for employees who work for employers with less than 20 employees. Must elect coverage within 60 days from date of termination or date of receiving notice of right to continue coverage, whichever is later. **HIPAA:** Must have had 18 months of continuous coverage and completely exhausted COBRA or state continuation coverage. Must not have lost coverage due to fraud or non-payment of premiums. You have 63 days to enroll.	If you are denied coverage for a medical condition, you may be eligible for an MCHA plan or PCIP. See next column	**GUARANTEED COVERAGE** **MCHA:** Live in Minnesota and are eligible for Trade Adjustment Assistance (TAA) or be HIPAA-eligible. Or you have been a Minnesota resident for the last 6 months, and are at least 65 years old and ineligible for the Federal Medicare program. Or, you can prove that you have been denied health coverage in the last 6 months due to a pre-existing condition. Or, you can prove you have been treated in the last 3 years for special medical "presumptive condition." **PCIP:** Must have been uninsured for at least 6 months prior to applying. Must prove being a U.S. citizen or legal U.S. resident, a Minnesota resident, and having problems getting insurance due to a pre-existing condition.	**GUARANTEED COVERAGE** Must be U.S. citizens or qualified aliens and live in Minnesota. Income Limits: Pregnant Women: 175% FPL. Children Ages 0–1: 280% FPL. Children Ages 2–18: 150% FPL. Children Ages 19–20: 100% FPL. Parents & Relative Caretakers with Children under 19: 100% FPL. Parents, Legal Guardians, Foster Parents & Relative Caretakers with Children under 21: 275% FPL. Adults without Children: 75% FPL. Aged, Blind & Disabled: 100% FPL. Medically-Needy: Singles with $677 monthly income with asset limit of $3,000; couples with monthly income of $911 with asset limit of $6,000. Limited assets such as cash, savings, stocks and bonds (except for pregnant women and children). Disabled are allowed to "spend down" for eligibility.
Monthly Cost	Costs depend on employer contribution and ± 25% of the insurance company's index rate.	**COBRA/Mini-COBRA:** 102%–150% of group health rates. **HIPAA:** Premiums will depend on plan chosen.	Rates are ±25% of the base individual market rate for health status, ±50% for age and ±20%for geography.	**MCHA:** $107.98 to $2,837.82 depending on your age, gender and deductible. **PCIP:** $96 to $414 depending on your age and plan chosen.	**$0** premiums. $3 co-pay per office visit. $6 per non-emergency visit in ER.

PUBLICLY-SPONSORED PROGRAMS

Demographic	Women in Need of Cancer Screening	Lower-Income Adults	Seniors & Disabled	Trade Dislocated Workers (TAA Recipients)	Veterans
Program	**Sage Screening Program** 888-643-2584 www.health.state.mn.us (Search: Sage) **Women-Infants-Children (WIC)** 800-942-4030 State offices: 651-201-4404 or 800-657-3942, www.health.state.mn.us (Search: WIC)	**MinnesotaCare** 651-297-3862 Outside Twin-Cities Metro Area 800-657-3672 TTY: 800-627-3529 mn.gov/dhs (Search: MinnesotaCare) **Healthy Minnesota Contribution Program** 651-431-2283 800-657-3629 mn.gov/dhs (Search: Minnesota Contribution Program)	**Medicare** 800-633-4227 www.medicare.gov **Medicare Prescription Drug Program** 800-633-4227 **MinnesotaHelp.info** 800-333-2433 TTD: 800-627-3529 minnesotahelp.info	**Health Coverage Tax Credit** 866-628-4282 www.irs.gov (keyword: HCTC)	**VA Medical Benefits Package** 877-222-8387 www.va.gov www.ebenefits.va.gov
Coverage	**Sage Screening Program:** Breast and cervical exams, Mammogram screenings, Pap smears and diagnostic services. **WIC:** Nutrition education and services; breastfeeding promotion and education; monthly food prescription of nutritious foods; access to maternal, prenatal and pediatric health care services.	**MinnesotaCare:** Dental services, doctor and health clinic visits for preventive and non-preventive care, emergency room visits, inpatient hospital coverage. **HMCP:** Premium assistance for private health insurance. May receive assistance for MCHA if not approved for private health insurance. ***Pre-Existing Health Conditions Covered***	**Medicare:** Part A, inpatient care in hospitals and rehabilitative centers; Part B, doctor and some preventive services and outpatient care; Part C allows Medicare benefits through private insurance (Medicare Advantage); Part C includes Parts A, B, and C not covered by Medicare. Part D covers prescription drugs. **MinnesotaHelp.info** is a Medicare counseling service. ***Pre-Existing Health Conditions Covered***	Inpatient and outpatient care (lab tests, x-rays, etc.), Doctor visits, Preventive and major medical care (surgery, physical therapy, Durable medical equipment, etc.), Mental health and substance abuse care, and Prescription drugs. ***Pre-Existing Health Conditions Covered***	Comprehensive preventive and primary care, outpatient and inpatient services. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** **Sage Screening Program:** Minnesota women with no insurance or whose insurance does not cover what Sage Screening provides. Income limit: 250% FPL. Must be age 40 or older. If younger than 40 and determined by a clinician to be at elevated risk for breast cancer, will cover office visits and mammograms. If further follow-up is needed, also covers diagnostic mammograms, breast ultrasounds, or outpatient breast biopsies. **WIC:** Must live in Minnesota, have a nutritional need as determined by WIC staff, be a child under 5, a new mom, or a pregnant or breastfeeding woman. Income limit of 185% FPL.	**GUARANTEED COVERAGE** **MinnesotaCare:** Must be U.S. citizens or qualified aliens and live in Minnesota. Must have been uninsured in the last 4 months unless the insurance was Medical Assistance or paid for more than 50% of premium of employer-based insurance. Income limits for the following: Adults without Children: 250% FPL. Parents of children under 21, pregnant women, and children under 21: 275% FPL. **HMCP:** Must be a Minnesota resident and a U.S. citizen without insurance for the last 4 months. Must be age 21 years or older without any children or be pregnant. Income must be between 200% FPL and 250% FPL with an asset limit of $10,000 for singles and $20,000 for couples.	**GUARANTEED COVERAGE** **Both:** Must be U.S. citizen or permanent U.S. resident, and: 1) If 65 years or older, you or your spouse worked for at least 10 years in Medicare-covered employment, or 2) You have a disability or end-stage renal disease (permanent kidney failure requiring dialysis or transplant) at any age.	**GUARANTEED COVERAGE** Must be receiving TAA (Trade Adjustment Assistance), or Must be 55 years or older and receiving pension from the Pension Benefit Guaranty Corporation (PBGC). Must not be enrolled in certain state plans, or in prison, or receiving 65% COBRA premium reduction, or be claimed as a dependent in tax returns. Must be enrolled in qualified health plans where you pay more than 50% of the premiums. Also see MCHA.	**GUARANTEED COVERAGE** "Veteran status" = active duty in the U.S. military, naval, or air service and a discharge or release from active military service under other than dishonorable conditions. Certain veterans must have completed 24 continuous months of service.
Monthly Cost	**Sage Screening Program: $0** **WIC: $0** to minimal share of cost.	**MinnesotaCare: $4–$179** per person, depending on income. **HMCP: $0.** HMCP will help pay private or MCHA health insurance premiums up to the monthly defined contribution amount (based on a sliding-fee scale). Enrollee must pay any additional amount over the monthly contribution amount.	**Medicare: $0** and share of cost for certain services; deductibles for certain plans. Part A: $0 - $451 based on length of Medicare-covered employment; Part B: $99.90-$319.70 depending on annual income; Part C: Based on provider; Part D: Varies in cost and drugs covered. **MinnesotaHelp.info: $0**	**27.5%** of the insurance premium including COBRA premium if employer contributes less than 50%.	**$0** and share of cost and co-pays depending on income level.

PRIVATE HEALTH INSURANCE

Demographic	Small Businesses (1-50 Employees)	Individuals Recently Covered by an Employer Health Plan	Individuals & Families	Individuals with Pre-Existing, Severe, or Chronic Medical Conditions	Low-Income Individuals & Families
Program	**Group Plans** National Association of Health Underwriters 202-552-5060 www.nahu.org	**COBRA/Mini-COBRA** Contact your current carrier. After 18 months continuous group/COBRA coverage, convert to a plan under: **HIPAA** Health Insurance Portability & Accountability Act 866-487-2365 www.dol.gov (Search: HIPAA)	**Individual Plans** National Association of Health Underwriters 202-552-5060 www.nahu.org	**Mississippi Comprehensive Health Insurance Risk Pool Association** ("The Association") 888-820 9400 www.mississippihealthpool.org **Pre-Existing Condition Insurance Plan (PCIP)** Run by the U.S. Department of Health and Human Services 866-717-5826 www.PCIP.gov www.pciplan.com	**Medicaid** 601-359-6050 800-421-2408 www.medicaid.ms.gov
Coverage	There is a maximum look-back period of 6 months and a maximum exclusion period 12 months for enrollees with no prior creditable coverage or whose prior coverage lapsed for more than 63 days. ***Pre-Existing Health Conditions Covered***	**COBRA:** Coverage available for 18–36 months depending on qualifying events. Benefits are what you had with your previous employer. **Mini-COBRA:** Coverage lasts up to 12 months. Benefits are what you had with your previous employer. **HIPAA:** Benefits are based on program selected. There is no expiration of coverage. ***Pre-Existing Health Conditions Covered***	Assorted plans depending on medical needs. There is a maximum 12-month look-back and exclusionary period limit for pre-existing conditions on enrollees with no prior coverage. Elimination riders are permitted. ***Pre-Existing Health Conditions Covered with Some Limitations***	**The Association:** Hospital services, Physician care, Limited mental health care, Prescription drugs, and other services. Benefits for nervous and mental conditions, Alcohol and drug services (and certain other treatment and services) are provided with substantial limitations. Prescription coverage does not begin until you have been enrolled for 6 months. Lifetime maximum benefit of $1,000,000. **PCIP:** Covers broad range of benefits, including primary and specialty care, hospital care, and prescription drugs. ***Pre-Existing Health Conditions Covered***	Office visits and family planning services, Hospital care, Outpatient services, Prescription drugs eyeglasses, Home health services, Long term care services, Inpatient psychiatric care, Non-emergency transportation services, Chiropractic services, Dialysis services, Dental extractions and related treatment, Durable medical equipment and medical supplies, Hospice services. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Company size 1–50 employees. Owner can count as an employee. Owner name on business license must draw wages from the company. Eligible employees must work at least 32 hours a week. Insurers are required to guarantee issue small group plans to the self-employed, except those covered by, or eligible for a health benefit plan offered by an employer. .	**GUARANTEED COVERAGE** **COBRA:** Available for employees who work for businesses with 20 or more employees. You have 60 days from date of termination to sign-up. **Mini-COBRA:** Available for employees who work for businesses with less than 20 employees. Must have been covered by group insurance for 3 months continuously before date of termination. Ex-employee must make a written election and pay premium to insurer on or before the date of termination of group insurance. In case of death of employee, divorce, or when dependent child ceases to be eligible for group coverage, beneficiary who wants Mini-COBRA coverage must sign-up within 30 days of receiving notice of right to continue coverage. **HIPAA:** Must have had 18 months of continuous coverage and completely exhausted COBRA or state continuation coverage. Must not have lost coverage due to fraud or non-payment of premiums. You have 63 days to enroll.	Eligibility is subject to medical underwriting. If you are denied coverage for a medical condition, you may be eligible for MCHIRPA or PCIP. See next column	**GUARANTEED COVERAGE** **The Association:** Must be a legal Mississippi resident under age 65 years old. Must have been turned down for coverage by an insurance company in the last 12 months or diagnosed with a health condition that causes insurance companies to automatically reject you; or you were offered coverage by an insurance company, but the policy contained a material underwriting restriction (such as an elimination rider); or offered coverage costing more than an Association policy and cannot be eligible for or have other, similar coverage from a private or government health plan (including Medicare and Medicaid) in order to get Association coverage. May be eligible with HIPAA. **PCIP:** Must have been uninsured for at least 6 months prior to applying. Must prove being a U.S. citizen or legal U.S. resident, a Mississippi resident, and having problems getting insurance due to a pre-existing condition.	**GUARANTEED COVERAGE** Must be a U.S. citizen or qualified alien and a resident of Mississippi. Income Limits: Pregnant Women & Infants 0–1: 185% FPL. Children Ages 1–5: 133% FPL. Children Ages 6–18: 100% FPL. Aged, Blind & Disabled: For singles, 80% FPL with asset limit of $4,000; for couples, 87% FPL with asset limit of $6,000. Parents/Caretakers Living with Children Ages 0–18: 44% FPL.
Monthly Cost	Costs depend on employer contribution and ± 25% of the insurance company's index rate.	**COBRA/Mini-COBRA:** 102%–150% of group health rates. **HIPAA:** Premiums will depend on plan chosen.	Costs for individual coverage vary. There are no rate caps.	**The Association:** $110 to $1,086 depending on age, gender, plan chosen, and the experience of the plan. **PCIP:** $146 to $628 depending on your age and plan chosen.	**$0 to $10** co-pays.

PUBLICLY-SPONSORED PROGRAMS

Demographic	Children in Moderate Income Families	Infants	Women in Need of Cancer Screening	Seniors & Disabled	Veterans
Program	**Children's Health Insurance Program (CHIP)** 877-543-7669 601-359-6050 www.medicaid.ms.gov/CHIP.aspx	**First Steps** 800-451-3903 601-576-7427 (Jackson Area) www.msdh.state.ms.us (Search: First Steps) **Women-Infants-Children (WIC)** 601-991-6000 www.msdh.state.ms.us (Search: WIC)	**Breast & Cervical Cancer Prevention** 601-576-7466 800-721-7222 www.msdh.state.ms.us (Search: Breast & Cervical Cancer)	**Medicare** 800-633-4227 www.medicare.gov **Medicare Prescription Drug Program** 800-633-4227 **seniorxms.org** 800-948-3090 www.seniorxms.org	**VA Medical Benefits Package** 877-222-8387 www.va.gov www.ebenefits.va.gov
Coverage	Health screenings (including vision and hearing exams); Preventive health care such as immunizations; Inpatient and outpatient hospital care; Doctor's or clinic visits for well-child check ups and sick-child care; Lab services; Prescription medications; Eyeglasses and hearing aids; Dental care; and Mental health services. ***Pre-Existing Health Conditions Covered***	**First Steps:** Family training and counseling, nursing care, Nutritional counseling and planning, Psychological services in behavior management, Learning and mental health, Physical therapy to help teach body movement, crawling, walking, Occupational therapy to help teach self-help, playing and eating skills, Speech pathologist services to help develop language skills, Transportation assistance to and from appointments. **WIC:** Nutrition education and services; breastfeeding promotion and education; monthly food prescription of nutritious foods; access to maternal, prenatal and pediatric health care services. ***Pre-Existing Health Conditions Covered***	Screening and/or diagnostic mammograms annually for women 50 years of age and older, ultrasound, fine needle aspiration of the breast and breast biopsy, colonoscopy and biopsy, if indicated. Follow-up and referral for abnormal Pap exams and/or mammograms.	**Medicare** offers Part A, inpatient care in hospitals and rehabilitative centers; Part B, doctor and some preventive services and outpatient care; Part C allows Medicare benefits through private insurance (Medicare Advantage); Part C includes Parts A, B, and C not covered by Medicare. Part D covers prescription drugs. **seniorxms.org** offers assistance and advice to seniors in need. ***Pre-Existing Health Conditions Covered***	Comprehensive preventive and primary care, outpatient and inpatient services. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Must be a Mississippi resident and a U.S. citizen or eligible immigrant. Must be children up to age 19, uninsured, ineligible for Medicaid, with family incomes up to 200% FPL. Proof of most recent full month's family income, (such as a paycheck stub) must accompany the application. Each adult or child applying must provide his or her Social Security number on the application.	**GUARANTEED COVERAGE** **First Steps:** Must be a resident of Mississippi and a child 0-3 years old who has a 25% or greater developmental delay in any one developmental area. **WIC:** Must live in Mississippi, have a nutritional need, and be child 0-5 years old, a new mom, or a pregnant or breastfeeding woman. Income must be at or below 185% FPL.	**GUARANTEED COVERAGE** Must be Mississippi women who do not have Medicaid, Medicare or other insurance or method of reimbursement. Services available depending on age: Ages 40–49: Mammograms while funds are available and only if patients have abnormal clinical breast exams. Ages 40–64: Pap exams. Ages 50–64: Mammograms. Ages 19–39: May be specially approved for enrollment in the BCCP at the discretion of the program director if patient meets all other program criteria other than the age category, has an abnormality of the breast and/or cervix.	**GUARANTEED COVERAGE** **Both:** Must be U.S. citizen or permanent U.S. resident, and: 1) If 65 years or older, you or your spouse worked for at least 10 years in Medicare-covered employment, or 2) You have a disability or end-stage renal disease (permanent kidney failure requiring dialysis or transplant) at any age.	**GUARANTEED COVERAGE** "Veteran status" = active duty in the U.S. military, naval, or air service and a discharge or release from active military service under other than dishonorable conditions. Certain veterans must have completed 24 continuous months of service.
Monthly Cost	**$0** premiums or deductibles, although there may be a small co-payment for some services for higher-income families.	**First Steps & WIC: $0** or minimal share of cost.	**$0** or minimal share of cost.	**Medicare: $0** and share of cost for certain services; deductibles for certain plans. Part A: $0–$451 based on length of Medicare-covered employment; Part B: $99.90-$319.70 depending on annual income; Part C: Based on provider; Part D: Varies in cost and drugs covered. **seniorxms.org: $0**	**$0** and share of cost and co-pays depending on income level.

Demographic	PRIVATE HEALTH INSURANCE				
	Small Businesses (2-50 Employees)	**Individuals Recently Covered by an Employer Health Plan**	**Individuals & Families**	**Individuals with Pre-Existing, Severe, or Chronic Medical Conditions**	**Low-Income Individuals & Families**
Program	**Group Plans** National Association of Health Underwriters 202-552-5060 www.nahu.org	**COBRA/Mini-COBRA** Contact your current carrier. After 18 months continuous group/ COBRA coverage, convert to a plan under: **HIPAA** Health Insurance Portability & Accountability Act 866-487-2365 www.dol.gov (Search: HIPAA) **HIPP** Health Insurance Premium Payment 573-751-2005 www.dss.mo.gov (Search: HIPP)	**Individual Plans** National Association of Health Underwriters 202-552-5060 www.nahu.org	**Missouri Health Insurance Pool (MHIP)** 800-821-2231 www.mhip.org **Pre-Existing Condition Insurance Plan (PCIP)** Federal program run by MHIP 800-821-2231 www.mhip.org www.PCIP.gov	**MO Healthnet** (Medicaid) 888-275-5908 573-731-3425 www.dss.mo.gov/mhd
Coverage	There is a maximum 6-month look-back/12-month exclusionary period for pre-existing conditions on enrollees that do not have prior coverage. Benefits will vary depending on the chosen plan. ***Pre-Existing Health Conditions Covered***	**COBRA:** Coverage available for 18–36 months depending on qualifying events. Benefits are what you had with your previous employer. If beneficiary is 55 years or older, then beneficiary can continue COBRA until he or she is eligible for other group health insurance or Medicare. **Mini-COBRA:** Coverage available for 18–36 months depending on qualifying events. Benefits are what you had with your previous employer. **HIPAA:** Benefits are based on program selected. There is no expiration of coverage. **HIPP:** Premium assistance that pays employer-sponsored health insurance or COBRA premiums. The assistance amount depends on the most cost-effective premium available. ***Pre-Existing Health Conditions Covered***	Covers certain state-mandated services. There is a maximum 12-month look-back period and a maximum 24-month exclusionary period for pre-existing conditions on enrollees with no prior coverage. Coverage options vary by carrier, but most offer plans that are HSA (Health Savings Account) compatible. ***Pre-Existing Health Conditions Covered with Some Limitations***	**MHIP & PCIP:** Hospital, physician care, maternity, prescription drugs, some limitations on alcohol and drug abuse care. For most services, plan will pay for 80% of covered charges after you satisfy your annual deductible if you receive care in-network. After paying maximum amount of coinsurance charges for covered in-network services, MHIP will pay 100% of your covered charges for the rest of the calendar year. ***Pre-Existing Health Conditions Covered***	Inpatient and outpatient hospital care, Laboratory and x-rays, Physician's services, Emergency ambulance, Audiology, Podiatry, Ambulatory surgical services, Durable medical equipment, Prosthetics and orthotics, Vision care, Family planning, Rehabilitative services and therapies, Midwife services, Federally qualified health centers or rural health clinics, Psychiatry, Transplants, Home and community based services, Waivers to person 65 and older, Persons with AIDS, or developmentally disabled individuals, Early and periodic screening, diagnosis and treatment (EPSDT) for children under 21 years old. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Company size 2–50 employees. Owner can count as an employee. Proprietor-name on license must draw wages. Small group health plans are required to treat all of eligible employees (generally employees who work at least 30 hours a week) equally and may not discriminate against those who are ill or become ill.	**GUARANTEED COVERAGE** **COBRA:** Available for employees who work for businesses with 20 or more employees. You have 60 days from date of termination to sign-up. **Mini-COBRA:** Available for employees who work for employers with less than 20 employees. Must elect coverage within 31 days of termination of group insurance. **HIPAA:** Must have had 18 months of continuous coverage and completely exhausted COBRA or state continuation coverage. Must not have lost coverage due to fraud or non-payment of premiums. You have 63 days to enroll. **HIPP:** Must qualify for Medicaid and have access to Employer-Sponsored Insurance or COBRA.	Eligibility is based on medical underwriting. Must be resident of state or documented immigrant. If you are denied coverage for a medical condition, you may be eligible for MHIP or PCIP. See next column.	**GUARANTEED COVERAGE** **MHIP:** Must be a Missouri resident with a qualifying health condition and show proof of one of the following: 1) Rejection for health coverage by an insurers for pre-existing condition; 2) Offer of coverage similar to but at rates higher than MHIP's coverage; 3) Involuntary loss of coverage for a reason other than non-payment of premium or fraud; 4) Being a dependent of a person eligible for MHIP; 4) Eligibility for HIPAA or Trade Adjustment Assistance. **PCIP:** Must be a Missouri resident, be uninsured for at least six months, and show proof of the following: 1) Lawful presence in the United States; 2) Having a pre-existing health condition.	**GUARANTEED COVERAGE** Must be U.S. citizen or an eligible qualified non-citizen living in Missouri. Income Limits: Infants Ages 0–1: 185% FPL. Children Ages 1–5: 133% FPL. Children Ages 6 –18: 100% FPL. Parents/Caretakers Living with Children ages 0–18: 25% FPL. Pregnant Women: 185% FPL. Aged, Blind & Disabled: 85% FPL with asset limit of $1,000 for singles and $2,000 for couples. Limited assets such as cash, savings, stocks and bonds.
Monthly Cost	Costs depend on employer contribution and ± 25% of the insurance company's index rate.	**COBRA/Mini-COBRA:** 102%–150% of group health rates. **HIPAA:** Premiums will depend on plan chosen. **HIPP:** Reimburses the full employer-sponsored insurance premium amount by check monthly. Pays the insurance company directly for people on COBRA or eligible small businesses.	Various price ranges depending on deductible and what plan you buy. There are no rate caps .	**MHIP:** $133 to $3,615 depending on age, gender, and plan chosen. **PCIP:** $137 to $601 depending on your age and plan chosen.	**$0** or minimal share of cost.

PUBLICLY-SPONSORED PROGRAMS

Demographic	Children with Special Health Needs	Pregnant Women & Children	Women with Chronic Illnesses	Seniors & Disabled	Veterans
Program	**Children and Youth with Special Health Care Needs (CYSHCN)** 573-751-6246 800-451-0669 health.mo.gov (Search: Children Special Health Care Needs)	**MO HealthNet for Kids (MHK)** 888-275-5908 www.dss.mo.gov (Search: MHK) **Women-Infants-Children (WIC)** 573-751-6204 800-392-8209 health.mo.gov/living/families/wic	**Show Me Healthy Women (SMHW)** 573-522-2845 www.dhss.mo.gov (Search: Show Me Healthy Women) **WISEWOMAN** 573-522-2845 health.mo.gov (WISEWOMAN)	**Medicare** 800-633-4227 www.medicare.gov **Medicare Prescription Drug Program** 800-633-4227 **MO Senior Rx** 800-375-1406 www.morx.mo.gov **Missouri CLAIM** 800-390-3330 www.missouriclaim.org	**VA Medical Benefits Package** 877-222-8387 www.va.gov www.ebenefits.va.gov
Coverage	Limited coverage includes Tests and evaluations, Inpatient care, Surgery, Therapy (physical, occupational, speech, language), Prescription medicines, Equipment, and supplies. Covered conditions include but are not limited to arthritis, Burns, Cerebral palsy, Cleft lip and palate, Cystic fibrosis, Digestive disorders, Ear infections (chronic), Hearing disorders, Heart disorders, Hemophilia, Hydrocephalus, Neuromuscular disorders, Orthopedic disorders, Paraplegia, Quadriplegia, Seizures, Sickle cell disease, Spina bifida, Spinal cord deformities, Traumatic brain injury, Urinary disorders. ***Pre-Existing Health Conditions Covered***	**MHK:** Comprehensive care, doctor visits, mental, dental, prescriptions, hospitalization and more. **WIC:** Nutrition education and services, breastfeeding promotion and education, monthly food prescription of nutritious foods, and access to maternal, prenatal and pediatric health care services. ***Pre-Existing Health Conditions Covered***	**SMHW:** Screenings for breast and cervical cancer. Pelvic exams, Pap tests, clinical breast examinations (CBE), diagnostic breast and cervical exams, and mammograms. **WISEWOMAN:** Health screenings and lifestyle education that can reduce the risk of heart disease and stroke. ***Pre-Existing Health Conditions Covered***	**Medicare** offers Part A, inpatient care in hospitals and rehabilitative centers; Part B, doctor and some preventive services and outpatient care; Part C allows Medicare benefits through private insurance (Medicare Advantage); Part C includes Parts A, B, and C not covered by Medicare. Part D covers prescription drugs. **Senior Rx** is a prescription discount program. **Missouri CLAIM** is a Medicare counseling service. ***Pre-Existing Health Conditions Covered***	Comprehensive preventive and primary care, outpatient and inpatient services. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Must be age 0–21, and reside in Missouri, with income limit of 185% FPL and an eligible special health care need.	**GUARANTEED COVERAGE** **MHK:** Must be a U.S. citizen or an eligible qualified non-citizen living in Missouri. Income Limits: Infants Ages 0–1: 185% FPL. Children Ages 1–5: 133% FPL. Children Ages 6–18: 100% FPL. Children Ages 0–18 with no prior health insurance in the last 6 months: 300 % FPL. **WIC:** Pregnant women, non-breastfeeding postpartum women (up to 6 months after delivery or termination of the pregnancy), breastfeeding women (up to 1 year after delivery as long as they are breastfeeding the baby), children age 0 to 5, and individually determined to be at "nutritional risk" by a health professional. Income must be at or below 185% FPL and live in Missouri.	**GUARANTEED COVERAGE** **SMHW:** Must be U.S. citizens or legal permanent residents and live in Missouri. Income limit of 200% FPL. Must be women ages 50–64, or older without Medicare Part B. Women ages 35–49 are eligible for pelvic exams, Pap tests, clinical breast examinations (CBE), diagnostic breast services if CBE results are suspicious for cancer, and diagnostic cervical services if their initial/follow-up Pap test was abnormal. Women ages 50 and older get all benefits above plus mammograms. Cervical cancer screenings are offered to women who have had a hysterectomies. Treatment is available for U.S. citizens diagnosed with cancer. Women with MO HealthNet, Medicare Part B or HMO health coverage are not eligible. **WISEWOMAN:** Must participate in the Show Me Healthy Women breast and cervical cancer control project and be 35–64 years old.	**GUARANTEED COVERAGE** **Medicare & Missouri CLAIM:** Must be U.S. citizen or permanent U.S. resident, and: 1) If 65 years or older, you or your spouse worked for at least 10 years in Medicare-covered employment, or 2) You have a disability or end-stage renal disease (permanent kidney failure requiring dialysis or transplant) at any age. **Senior Rx:** Must have Medicare Part D. If you are single your income must be at or below $21,660 and if you are a married your income must be below $29,140.	**GUARANTEED COVERAGE** "Veteran status" = active duty in the U.S. military, naval, or air service and a discharge or release from active military service under other than dishonorable conditions. Certain veterans must have completed 24 continuous months of service.
Monthly Cost	**$0** or share of cost.	**MHK: $0**, if family income is up to 150% FPL. If above 150% FPL, required monthly premium will be less than 5% of their annual income. If out-of-pocket expenses reach the 5% limit, then no premiums required. **WIC: $0** or minimal share of cost.	**Both: $0**	**Medicare: $0** and share of cost for certain services; deductibles for certain plans. Part A: $0–$451 based on length of Medicare-covered employment; Part B: $99.90-$319.70 depending on annual income; Part C: Based on provider; Part D: Varies in cost and drugs covered. **Senior Rx & Missouri CLAIM: $0**	**$0** and share of cost and co-pays depending on income level.

PRIVATE HEALTH INSURANCE

Demographic	Small Businesses (2-50 Employees)	Already Insured Small Businesses (2-9 Employees)	Individuals Recently Covered by an Employer Health Plan	Individuals & Families	Individuals with Pre-Existing, Severe, or Chronic Medical Conditions
Program	**Group Plans** National Association of Health Underwriters 202-552-5060 www.nahu.org **Insure Montana Purchasing Pool** State Auditor's Office 800-332-6148 406-444-2040 www.sao.mt.gov/InsureMontana/index.asp	**Insure Montana Purchasing Pool & Tax Credit Program** State Auditor's Office 800-332-6148 406-444-2040 www.sao.mt.gov/InsureMontana/index.asp	**COBRA** Contact your current carrier. After 18 months continuous group/COBRA coverage, convert to a plan under: **HIPAA** Health Insurance Portability & Accountability Act 866-487-2365 www.dol.gov (Search: HIPAA)	**Individual Plans** National Association of Health Underwriters 202-552-5060 www.nahu.org	**Montana Comprehensive Health Association (MCHA)** 800-447-7828 www.mthealth.org **Montana Affordable Care Plan (MACP)** Federal program run by MCHA 800-447-7828 www.mthealth.org www.PCIP.gov NOTE: In Helena, add extension 2128 to the 800 number.
Coverage	There is a maximum look-back period of 6 months and a maximum exclusion period of 12 months for pre-existing conditions on enrollees with no prior coverage or whose prior coverage had a break of more than 63 days. ***Pre-Existing Health Conditions Covered***	1) Employers receive subsidies that pay a portion of an employee's health insurance cost. The net of employer payment is 25% of the employee's premium. Employees will get discounts of 20%-90% on their premiums depending on family annual income. 2) Employers get refundable tax credit when they pay some or all the cost of the group health insurance plan of their employees and their spouse or dependents. Business will be enrolled on a first-come first-serve basis. ***Pre-Existing Health Conditions Covered***	**COBRA:** Coverage available for 18–36 months depending on qualifying events. Benefits are what you had with your previous employer. **HIPAA:** Benefits are based on program selected. There is no expiration of coverage. ***Pre-Existing Health Conditions Covered***	Assorted plans depending on medical needs. Elimination riders are permitted. There is a maximum 36-month look-back and a maximum 12-month exclusionary period limit for pre-existing conditions on enrollees with no prior coverage. ***Pre-Existing Health Conditions Covered with Some Limitations***	**MCHA:** Comprehensive plans to choose from, the primary difference is the annual deductible. Lifetime maximum of $2,000,000. Waiting periods for certain pre-existing conditions may apply. **MACP:** Primary and specialty care, hospital care, and prescription drugs. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Company size 2–50 employees. Owner can count as an employee. Owner name on business license must draw wages from the company. "Eligible employee" means an employee who works at least 30 hours a week, or at the discretion of employer, one who works 20–40 hours as long as this eligibility criteria is applied uniformly among all of the employer's employees.	**GUARANTEED COVERAGE** Employers with or without group health insurance for employees. Must offer coverage to all employees working at least 30 hours per week. May also count employees working at least 20 hours per week as long this criterion is applied uniformly on all of the employees. Have 2–9 employees that meet the eligibility criteria established by the State Auditor. All employees must be paid less than $75,000 per year (owner excluded). Employers who belong to a Multi Employer Welfare Arrangement (MEWA) are not eligible. The tax credit cannot be more than 50% of premiums paid.	**GUARANTEED COVERAGE** **COBRA:** Available for employees who work for businesses with 20 or more employees. You have 60 days from date of termination to sign-up. **HIPAA:** Must have had 18 months of continuous coverage and completely exhausted COBRA or state continuation coverage. Must not have lost coverage due to fraud or non-payment of premiums. You have 63 days to enroll.	Eligibility is subject to medical underwriting. If you are denied coverage for a medical condition, you may be eligible for MCHA or MACP. See next column	**GUARANTEED COVERAGE** **MCHA:** Must have lived in Montana for at least 30 days, cannot be eligible for COBRA or any other government programs (except "endstage renal disease" covered under Medicare), must prove denial of coverage by 2 insurance companies due to qualified pre-existing conditions or proof of offer paying 150% higher premium than MCHA. Trade Adjust Assistance (TAA) beneficiaries have same requirements but must have at least 3 months prior coverage, else a 12-month pre-existing waiting period may apply. HIPAA-eligible also qualified. **MACP:** Must be a U.S. citizen or lawfully present in the U.S. and have been uninsured for at least 6 months prior to applying. Must be a Montana resident. Must have had a problem getting insurance due to a pre-existing condition.
Monthly Cost	Costs depend on employer contribution and ±25% of the insurance company's index rate.	Costs depend on employer contribution.	**COBRA:** 102%–150% of group health rates. **HIPAA:** Premiums will depend on plan chosen.	Costs for individual coverage vary. There are no rate caps.	**MCHA:** Premiums vary based on plans chosen. Plans have deductibles of $1K–$10K, 70/30 co-payments, with annual maximum member liability of $5K–$15K. **MACP:** $186 to $339 depending on your age and plan chosen.

PUBLICLY-SPONSORED PROGRAMS

Demographic	Low-Income Individuals & Families	Children in Moderate Income Families	Women in Need of Cancer Screening	Seniors & Disabled	Trade Dislocated Workers (TAA Recipients)
Program	**Medicaid** 800-362-8312 www.dphhs.mt.gov (Search: Medicaid)	**Healthy Montana Kids (HMK)** 877-543-7669 406-444-6971 hmk.mt.gov **Women-Infants-Children (WIC)** 800-433-4298 406-444-5533 wic.mt.gov	**Montana Cancer Screening Program (MCSP)** 888-803-9343 406-444-0063 www.dphhs.mt.gov (Search: Cancer Screening)	**Medicare** (Age 65 and up) 800-633-4227 www.medicare.gov **Medicare Prescription Drug Program** 800-633-4227 **State Health Insurance Assistance Program (SHIP)** 800-551-3191 www.dphhs.mt.gov (Search: SHIP)	**Health Coverage Tax Credit** 866-628-4282 www.irs.gov (Search: HCTC)
Coverage	Treatment by physicians, Nurse practitioners, Nurse midwives, Dentists, Denturists, Podiatrists, Lab services and x-rays, Inpatient hospital visits, Outpatient hospital visits, Family planning, Nursing facilities, Home health care, Durable medical equipment; Outpatient drugs, Mental health, Ambulance, and Eyeglasses. Retroactive benefits available at the time of application for medical services received three months prior. ***Pre-Existing Health Conditions Covered***	**HMK:** Physician, Inpatient and outpatient hospital services, Routine sports or employment physicals, General anesthesia services, Surgical services clinic and ambulatory health care services, Prescriptions, Laboratory and radiological services, Inpatient, outpatient, and residential mental health and substance abuse services, Dental, Vision exams, Eyeglasses, Hearing exams. **WIC:** Nutrition education and services, breastfeeding promotion and education, monthly food prescription of nutritious foods, and access to maternal, prenatal and pediatric health care services. ***Pre-Existing Health Conditions Covered***	Mammograms, clinical breast exams, Pap tests and pelvic exams for the early detection of breast and cervical cancer.	**Medicare** offers Part A, inpatient care in hospitals and rehabilitative centers; Part B, doctor and some preventive services and outpatient care; Part C allows Medicare benefits through private insurance (Medicare Advantage); Part C includes Parts A, B, and C not covered by Medicare. Part D covers prescription drugs. **SHIP** is a Medicare counseling service. ***Pre-Existing Health Conditions Covered***	Inpatient and outpatient care (lab tests, x-rays, etc.), Doctor visits, Preventive and major medical care (surgery, physical therapy, Durable medical equipment, etc.), Mental health and substance abuse care, and Prescription drugs. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Must be a Montana resident and U.S. citizen or qualified legal alien. Income Limits: Pregnant Women: 150% FPL with asset limit of $3,000. Newborns: No income limit. Children under Age 19: 133% FPL. Parents/Caretakers Living with Children Ages 0–18: 56% FPL Aged, Blind & Disabled: 75% FPL with asset limit of $2,000 for singles; 83% FPL of with asset limit of $3,000 for couples Medically-Needy: $625 per month, with asset limit of $2,000 for singles and $3,000 for couples.	**GUARANTEED COVERAGE** **HMK:** Must be U.S. citizen or legal qualified alien and resident of Montana. Must be children under age 19. Must not be eligible for Medicaid, or currently insured, or covered by health insurance in the past 3 months (some employment-related exceptions apply). Parents must not employed by the state of Montana. Income limit of 250% FPL. **WIC:** Must be a Montana resident, and a pregnant woman, a breastfeeding woman, or a woman who recently had a baby, or child 0–5 years old. Must be determined by a health professional to be at nutritional or medical risk. Income must be at or below 185% FPL	**GUARANTEED COVERAGE** Must be a Montana resident, uninsured or underinsured. Income must be at or below 200% FPL. Women 50–64 years old, or 65 and older that do not have Medicare part B, are eligible for breast cancer screening. Women ages 40–49 are eligible also if funds are available. Women age 39 and younger can be eligible if referred by a surgeon or consulting breast specialist. Women ages 30–64 are eligible for cervical cancer screening.	**GUARANTEED COVERAGE** **Both:** Must be U.S. citizen or permanent U.S. resident, and: 1) If 65 years or older, you or your spouse worked for at least 10 years in Medicare-covered employment, or 2) You have a disability or end-stage renal disease (permanent kidney failure requiring dialysis or transplant) at any age.	**GUARANTEED COVERAGE** Must be receiving TAA (Trade Adjustment Assistance), or Must be 55 years or older and receiving pension from the Pension Benefit Guaranty Corporation (PBGC). Must not be enrolled in certain state plans, or in prison, or receiving 65% COBRA premium reduction, or be claimed as a dependent in tax returns. Must be enrolled in qualified health plans where you pay more than 50% of the premiums.
Monthly Cost	**$0–$5** for some co-pays Prescription drugs: $25 maximum per month. $100 per admission in hospital except in mental institutions.	**HMK: $0** to low cost. Maximum co-payment is $215 per year. **WIC: $0** or minimal share of cost.	**$0** or minimal share of cost.	**Medicare: $0** and share of cost for certain services; deductibles for certain plans. Part A: $0–$451 based on length of Medicare-covered employment; Part B: $99.90-$319.70 depending on annual income; Part C: Based on provider; Part D: Varies in cost and drugs covered. **SHIP: $0**	**27.5%** of the insurance premium including COBRA premium if employer contributes less than 50%.

Demographic	PRIVATE HEALTH INSURANCE				
	Small Businesses (2-50 Employees)	**Individuals Recently Covered by an Employer Health Plan**	**Individuals & Families**	**Individuals with Pre-Existing, Severe, or Chronic Medical Conditions**	**Low-Income Families & Medically-Needy**
Program	**Group Plans** Nebraska Association of Health Underwriters 402-397-0280 www.neahu.org	**COBRA/Mini-COBRA** Then convert to a plan under: **HIPAA** Health Insurance Portability & Accountability Act 866-487-2365 www.dol.gov **Nebraska Medical Assistance Program (NMAP)** (Similar to HIPP) Premium Payment 800-383-4278 www.dhhs.ne.gov/reg/t471.htm (Chapter 30 Payment for Health Insurance Premiums)	**Individual Plans** Nebraska Association of Health Underwriters 402-397-0280 www.neahu.org	**Nebraska Comprehensive Health Insurance Pool (NECHIP)** 402-343-3574 877-348-4304 www.nechip.com **Pre-Existing Condition Insurance Plan (PCIP)** Run by U.S. Department of Health and Human Services 866-717-5826 www.PCIP.gov	**Medicaid** 402-471-3121 877-255-3092 TTD: 402-471-9570 www.hhs.state.ne.us (Search: Medicaid)
Coverage	There is a maximum 6-month look-back and a maximum 12-month exclusionary period for pre-existing conditions on enrollees that do not have prior creditable coverage. ***Pre-Existing Health Conditions Covered*** **GUARANTEED COVERAGE**	**COBRA:** Coverage available for 18–36 months depending on qualifying events. Benefits are what you had with your previous employer. **Mini-COBRA:** Coverage available for 6–12 months depending on qualifying events. Benefits are what you had with your previous employer. **HIPAA:** Benefits are based on program selected. There is no expiration of coverage. **NMAP:** Benefits are the same as what you had with your previous employer. HIPP is a premium assistance program. ***Pre-Existing Health Conditions Covered*** **GUARANTEED COVERAGE**	There is no limit to the look-back and exclusionary periods for pre-existing conditions on enrollees with no prior coverage. ***Pre-Existing Health Conditions Covered with Some Limitations*** Eligibility is subject to medical underwriting. If you are denied coverage for a medical condition, you may be eligible for NECHIP or PCIP. See next column.	**NECHIP:** Hospital room and board, Physician services, Office visits, Therapies (physical, speech, occupational, home infusion), Anesthetics, X-ray and lab, Mammograms, Ambulance services, Nursing, Cardiac and pulmonary rehab, Medical equipment, Renal dialysis, Hospice, Home health, Mental health and substance abuse, Surgery, Prescription drugs, and more. There are 8 different deductible options to choose from. Waiting period may apply. **PCIP:** Covers broad range of benefits, including primary and specialty care, hospital care, and prescription drugs. ***Pre-Existing Health Conditions Covered*** **GUARANTEED COVERAGE**	Hospital, Physician, Laboratory and x-ray, Nurse midwife and practitioner services, Clinic services and family planning, Home health agency and personal care aide, Medical transportation, Ambulance, and chiropractic, Durable medical equipment, Orthotics, Prosthetics, and medical supplies, Prescription drugs and hearing aid services, Therapies (physical, occupational, speech pathology, audiology) and podiatry, Adult day treatment, Mental health and substance abuse, Vision and dental, Preventive care (e.g. mammograms). ***Pre-Existing Health Conditions Covered*** **GUARANTEED COVERAGE**
Eligibility	Company size 2–50 employees. Owner can count as an employee; proprietor name on license must draw wages. Eligible employees must work at least 30 hours a week.	**COBRA:** Available for employees who work for businesses with 20 or more employees. You have 60 days from date of termination to sign up for COBRA coverage. **Mini-COBRA:** Available for employees who work for employers with less than 20 employees. Ex-employee must elect Mini-COBRA within 10 days after date of receiving notice of right to continue coverage. In case of employee's death, the surviving covered spouse and dependent children must elect Mini-COBRA within 31 days after date of employee's death. **HIPAA:** Must have had 18 months of continuous coverage and completely exhausted COBRA or state continuation coverage. Must not have lost coverage due to fraud or non-payment of premiums. You have 63 days to enroll in a HIPAA-eligible plan. **NMAP:** You may be eligible for HIPP if you have a high-cost health condition (e.g., pregnancy, HIV/AIDS), and are on Medicaid.		**NECHIP:** Must be a legal Nebraska resident for at least 6 months prior to application, uninsured or ineligible for Medicaid or Medicare and exhausted COBRA continuation. Previous coverage terminated for reasons other than non-payment of premium or fraud, or within last 6 months was rejected for coverage due to pre-existing conditions, or offered coverage with restricted benefits or premiums higher than NECHIP's. You have a qualified pre-existing condition. Those eligible for HIPAA plans or Trade Adjustment Assistance are also qualified. **PCIP:** Must have been uninsured for at least 6 months prior to applying. Must prove being a U.S. citizen or legal U.S. resident, a Nebraska resident, and having problems getting insurance due to a pre-existing condition.	Must be a Nebraska resident and U.S. citizen or legal qualified alien. Income limits: Pregnant woman and infants 0-1: 185% FPL. Children ages 1-5: 133% FPL. Children ages 6–18: 100% FPL. Aged, blind, and disabled: For singles, 74% FPL with asset limit of $2,000; for couples not on SSI, 82% FPL with asset limit of $3,000. Parents/caretakers living with children ages 0–18: 58% FPL. Medically-needy: Singles and couples earning $392 a month, with asset limit of $4,000 for singles and $6,000 for couples.
Monthly Cost	Costs depend on employer contribution and ± 25% of the insurance company's index rate.	**COBRA/Mini-COBRA:** Premiums range from 102%–150% of group health rates. **HIPAA**: Premiums will depend on plan chosen. **NMAP:** **$0** or minimal share of cost.	Costs depend on age and county/zone. If you are self-employed and buy your own insurance you are eligible to deduct 100% of the cost of the premium from your federal income tax.	**NECHIP:** Monthly premiums range from $131.65 to $2,956.98 depending on age, gender, tobacco use, and deductible. **PCIP:** Monthly premiums range from $132 to $568 depending on your age and plan chosen.	**$1–$3** co-pays and may share in some costs.

PUBLICLY-SPONSORED PROGRAMS

Demographic	Low-Income Children	Cancer Screening for Men & Women	Native Americans	Seniors & Disabled	Trade Dislocated Workers (TAA Recipients)
Program	**Kids Connection Program (KCP)** 402-323-7455 (Lincoln) 800-383-4278 dhhs.ne.gov (Search: Kids Connection) **Women-infants-children (WIC)** 800-942-1171 402-471-2781 www.dhhs.ne.gov/wic	**Every Woman Matters (EWM)** dhhs.ne.gov (Search: Every Woman Matters) **Nebraska Colon Cancer Screening Program (NCCSP)** dhhs.ne.gov (Search: Cancer Screening) **For both:** 800-532-2227 402-471-0929 TTD: 800-833-7352	**Indian Health Services** 605-226-7582 www.ihs.gov (Search: Aberdeen)	**Medicare** 800-633-4227 www.medicare.gov **Medicare Prescription Drug Program** 800-633-4227	**Health Coverage Tax Credit** 866-628-HCTC 866-628-4282 www.irs.gov (keyword: HCTC)
Coverage	**KCP:** Hospital services, Physician services, Laboratory and x-ray, Family planning, Health checks, Home health agency, Medical transportation, Ambulance, Chiropractic, Dental, Durable medical equipment, Orthotics, Prosthetics and medical supplies, Prescribed drugs, Hearing aids, Therapy (physical, occupational, speech, pathology, and audiology), Podiatry, Mental health and substance abuse, and Vision. **WIC:** Nutrition education and services, breastfeeding promotion and education, monthly food prescription of nutritious foods, and maternal, prenatal and pediatric health care services. ***Pre-Existing Health Conditions Covered***	**EWM:** Breast exams, Mammograms, Pap test every 2 years, Pelvic exams, various checkups. **NCCSP:** Fecal occult blood test (FOBT) kits for at home testing, colonoscopies, and education about healthy living.	Inpatient and outpatient services, Physical therapy, Pediatric, Optometry, Diabetes, Emergency rooms, Specialty care, Medical supplies, Lab & x-ray, Ambulance. ***Pre-Existing Health Conditions Covered***	Offers Part A, inpatient care in hospitals and rehabilitative centers; Part B, doctor and some preventive services and outpatient care; Part C allows Medicare benefits through private insurance (Medicare Advantage); Part C includes Parts A, B, and C not covered by Medicare. Part D covers prescription drugs. ***Pre-Existing Health Conditions Covered***	Inpatient and outpatient care (lab tests, x-rays, etc.), Doctor visits, Preventive and major medical care (surgery, physical therapy, Durable medical equipment, etc.), Mental health and substance abuse care, and Prescription drugs. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** **KCP:** Must be a Nebraska resident under 19 years of age or be a primary care giver with a child under the age of 19, and a U.S. citizen or legal alien and with household income of 200% FPL. Must not be covered by health insurance (including Medicaid). **WIC:** Must reside in Nebraska. Must either be a pregnant woman, a breastfeeding woman, a woman who recently had a baby, or a child up to age 5 years. Must be determined by a health professional to be at nutritional or medical risk. Income limit is 185% FPL.	**GUARANTEED COVERAGE** **Both:** Must be a Nebraska resident and U.S. citizen or a qualified alien. Income limit of 225% FPL. **EWM:** Must be ages 40–74. Must not belong to an HMO (Health Maintenance Organization), or have Medicaid or Medicare. **NCCSP:** Men and women who are at least 50 years old.	**GUARANTEED COVERAGE** Must exhaust all private, state, and other federal programs. Must be regarded by the local community as an Indian; is a member of an Indian or Group under Federal supervision; resides on tax-exempt land or owns restricted property; actively participates in tribal affairs; any other reasonable factor indicative of Indian descent; is a non-Indian woman pregnant with an eligible Indian's child for the duration of her pregnancy through postpartum (usually 6 weeks); is a non-Indian member of an eligible Indian's household and the medical officer in charge determines that services are necessary to control a public health hazard or an acute infectious disease which constitutes a public health hazard.	**GUARANTEED COVERAGE** Must be U.S. citizen or permanent U.S. resident, and: 1) If 65 years or older, you or your spouse worked for at least 10 years in Medicare-covered employment, or 2) You have a disability or end-stage renal disease (permanent kidney failure requiring dialysis or transplant) at any age.	**GUARANTEED COVERAGE** Must be receiving TAA (Trade Adjustment Assistance), or Must be 55 years or older and receiving pension from the Pension Benefit Guaranty Corporation (PBGC). Must not be enrolled in certain state plans, or in prison, or receiving 65% COBRA premium reduction, or be claimed as a dependent in tax returns. Must be enrolled in qualified health plans where you pay more than 50% of the premiums. Also see NECHIP.
Monthly Cost	**KCP:** **$0** for most members. **WIC:** **$0** to minimal share of cost.	**EWM:** **$0** Suggested donation of $5 for patients earning 100% to 225% FPL. **NCCSP:** **$0** to minimal share of cost. Colonoscopy requires 10% co-payment.	**$0** or minimal share of cost.	**$0** and share of cost for certain services; deductibles for certain plans. Part A: $0–$451 based on length of Medicare-covered employment; Part B: $99.90-$319.70 depending on annual income; Part C: Based on provider; Part D: Varies in cost and drugs covered.	**27.5%** of the insurance premium including COBRA premium if employer contributes less than 50%.

PRIVATE HEALTH INSURANCE

Demographic	Small Businesses (2-50 Employees)	Individuals Recently Covered by an Employer Health Plan	Individuals & Families	Individuals with Pre-Existing, Severe, or Chronic Medical Conditions	Low-Income Individuals & Families
Program	**Group Plans** National Association of Health Underwriters 202-552-5060 www.nahu.org	**COBRA/Mini-COBRA** Contact your current carrier. After 18 months continuous group/ COBRA coverage, convert to a plan under: **HIPAA** Health Insurance Portability & Accountability Act 866-487-2365 www.dol.gov **HIPP** Health Insurance Premium Payment 775-335-1040, 800-856-8839 www.hms.com/our_services/services_hipp.asp	**Individual Plans** National Association of Health Underwriters 202-552-5060 www.nahu.org	**Pre-Existing Condition Insurance Plan (PCIP)** Run by U.S. Department of Health and Human Services 866-717-5826 www.PCIP.gov www.pciplan.com	**Medicaid** 775-684-3600 800-992-0900 dwss.nv.gov To find address and phone number of welfare office near you: dwss.nv.gov (Under: DWSS Offices Telephone and Fax Numbers) **Access to Health Care Network (AHN)** 877-385-2345 775-284-8989 www.accesstohealthcare.org
Coverage	Carriers can impose a maximum 6-month look-back and a maximum 12-month exclusionary period for pre-existing conditions on enrollees who do not have prior or whose coverage had a break of more than 63 days. ***Pre-Existing Health Conditions Covered***	**COBRA/ Mini-COBRA:** Coverage available for 18–36 months depending on qualifying events. Benefits are what you had with your previous employer. **HIPAA:** Benefits are based on program selected. There is no expiration of coverage. **HIPP:** Premium assistance that pays employer-sponsored health insurance or COBRA premiums. The assistance amount depends on the most cost-effective premium available. ***Pre-Existing Health Conditions Covered***	Elimination riders are permitted. There is a maximum look-back period of 6 months and no limit to the maximum exclusion period for pre-existing conditions on enrollees with no prior coverage. ***Limits on Pre-Existing Health Conditions May Apply***	Covers broad range of benefits, including primary and specialty care, hospital care, and prescription drugs. ***Pre-Existing Health Conditions Covered***	**Medicaid:** Diagnosis (services to find out what is wrong), Physician services, Check-ups (medical and dental), Family planning, Maternity, Prenatal and newborn care, Prescriptions, Hospital services, Comfort care, Hospice, Dental services, Drug and alcohol treatment, Mental health services. Retroactive benefits available at the time of application for medical services received three months prior. **AHN:** Hospitals, Family doctors, Cancer care, Care from Specialists, X-ray & labs, Diagnostics, Children's health services, Maternity care, Women's health services, Prescription drug assistance ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Company size 2–50. Owner can count as an employee. Proprietor-name on license must draw wages. Eligible employees must work at least 30 hours a week.	**GUARANTEED COVERAGE** **COBRA:** Available for employees who work for businesses with 20 or more employees. You have 60 days from date of termination to sign-up. **Mini-COBRA:** Available for employees who work for employers with less than 20 employees. Must have been covered by group insurance for 12 consecutive months before date of termination. Must sign-up within 60 days after date of receiving notice of right to continue coverage. **HIPAA:** Must have had 18 months of continuous coverage and completely exhausted COBRA or state continuation coverage. Must not have lost coverage due to fraud or non-payment of premiums. You have 63 days to enroll. **HIPP:** Must qualify for Medicaid and have access to Employer-Sponsored Insurance or COBRA.	Eligibility is subject to medical underwriting. HIPAA-eligible must be offered two standard policies. If you are denied coverage for a medical condition, you may be eligible for PCIP. See next column.	**GUARANTEED COVERAGE** Must have been uninsured for at least 6 months prior to applying. Must prove being a U.S. citizen or legal U.S. resident, a Nevada resident, and having problems getting insurance due to a pre-existing condition.	**GUARANTEED COVERAGE** **Medicaid:** Must be a U.S. citizen or qualified alien and live in Nevada. Income Limits: Pregnant Women: 185% FPL. Infants Ages 0–1: 133% FPL. Children Ages 1–5: 133% FPL. Children Ages 6–18: 100% FPL Aged, Blind, & Disabled Singles: Asset limit of $2,000 for all; aged, living independently up to 86% FPL; blind, living independently up to 87% FPL; disabled, up to 75% FPL. Aged, Blind, & Disabled Couples: Aged, living independently, up to 89% FPL; blind, living independently, up to 114% FPL; disabled up to 83% FPL. Parents/Caretakers Living with Children Ages 0–18: Non-working, 25% FPL; working, 86% FPL. **AHN:** Must be uninsured and live in Nevada. Must have income between 100% to 250% FPL.
Monthly Cost	Costs depend on employer contribution and ± 25% of the insurance company's index rate.	**COBRA/Mini-COBRA:** 102%–150% of group health rates. **HIPAA:** Premiums will depend on plan chosen. **HIPP:** Reimburses the full employer-sponsored insurance premium amount by check monthly. Pays the insurance company directly for people on COBRA or eligible small businesses.	Rates are ±50% of the base individual market rate. If you are self-employed and buy your own insurance you are eligible to deduct 100% of the cost of the premium from your federal income tax.	$113 to $487 depending on your age and plan chosen.	**Medicaid: $0** or may share in some costs. **AHN:** $120 to $770 depending on number of dependents and plan chosen.

PUBLICLY-SPONSORED PROGRAMS

Demographic	Children	Children with Developmental Delays	Women	Seniors & Disabled	Trade Dislocated Workers (TAA Recipients)
Program	**Nevada Check Up** 877-543-7669 775-684-3777 www.nevadacheckup.state.nv.us **Women-Infants-Children (WIC)** 800-863-8942 775-684-5942 health.nv.gov/WIC.htm	**Nevada Early Intervention Services (NEIS)** 800-522-0066 health.nv.gov/BEIS.htm NEIS is the payer of last resort. Private insurance and Medicaid will be billed first.	**Women's Health Connection (WHC)** 877-385-2345 health.nv.gov (Search: Women's Health Connection) **Maternal Child Health (MCH) Line** 800-429-2669 775-684-4285 health.nv.gov (Search: MCH) **Women-Infants-Children (WIC)** 800-863-8942 775-684-5942 health.nv.gov/WIC.htm	**Medicare** 800-633-4227 www.medicare.gov **Medicare Prescription Drug Program** 800-633-4227 **Senior Rx** 866-303-6323 www.dhhs.nv.gov/SeniorRx.htm	**Health Coverage Tax Credit** 866-628-4282 www.irs.gov (keyword: HCTC)
Coverage	**NV Check Up:** Physician, Chiropractor, Dental, Vision, Medical Equipment, Hospital Inpatient and Outpatient hospital, Laboratory and X-Ray, Prescription Drugs, Ambulance, Non-Emergency Transportation, Mental Health, Home Health, Well-Child, Well-Baby Visits, and Immunizations. **WIC:** Nutrition education and services, breastfeeding promotion and education, monthly food prescription of nutritious foods, and maternal, prenatal and pediatric health care services. ***Pre-Existing Health Conditions Covered***	Audiology (hearing) services Family training, Counseling and home visits, Health services, Medical services for diagnostic or evaluation purposes, Nutrition counseling, Occupational therapy, Physical therapy, Psychological services, Service coordination, Social work services, Special instruction, Speech and language services, Transportation services, Vision and more. ***Pre-Existing Health Conditions Covered***	**WHC:** Breast and cervical cancer screening services. Pelvic exams, Pap smears, clinical breast exams, mammograms. **MCH:** Provides prenatal care and other maternity services. **WIC:** Nutrition education and services, breastfeeding promotion and education, monthly food prescription of nutritious foods, and maternal, prenatal and pediatric health care services.	**Medicare** offers Part A, inpatient care in hospitals and rehabilitative centers; Part B, doctor and some preventive services and outpatient care; Part C allows Medicare benefits through private insurance (Medicare Advantage); Part C includes Parts A, B, and C not covered by Medicare. Part D covers prescription drugs. **Senior Rx:** Extra coverage for medication. There are plans for seniors with Medicare Part D and for seniors without Medicare Part D. ***Pre-Existing Health Conditions Covered***	Inpatient and outpatient care (lab tests, x-rays, etc.), Doctor visits, Preventive and major medical care (surgery, physical therapy, Durable medical equipment, etc.), Mental health and substance abuse care, and Prescription drugs. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** **NV Check Up:** Must be a Nevada resident and a U.S. citizen or "qualified alien" (legal residents need to have 5 years residency). Must be a child age 0–18. Income limit of 200% FPL. Must not be insured within the last 6 months before enrolling or lost insurance beyond parents' control, and must not be eligible for Medicaid. Eligibility is determined for one year unless child moves out of state, is enrolled in Medicaid, has other coverage, or becomes financially ineligible. **WIC:** Must reside in Nevada, and be a pregnant or recently pregnant woman, or a child up to age 5, and be determined to have a nutritional risk. Income must be at or below 185% FPL.	**GUARANTEED COVERAGE** Must be a child 0–3 years old of a Nevada resident. Patient must have been diagnosed with a condition such as Down syndrome, spina bifida, autism, blindness, deafness, or other diagnosed condition that has a high probability of resulting in a developmental delay, or shows significant delays in development, such as talking or walking.	**GUARANTEED COVERAGE** **WHC:** Nevada women 40 years or older who do not have health insurance, Medicaid, Medicare Part B, HMO coverage, or whose health insurance does not pay for the program's services. Income limit of 250% FPL. Women ages 40 or older get annual pelvic exams and annual clinical breast exams, and Pap tests. Those age 50 or older get the above benefits plus annual mammograms. **MCH:** Must be parents of children up to age 5 who are Medicaid-eligible. **WIC:** Must reside in Nevada, and be a pregnant or recently pregnant woman, or a child up to age 5, and be determined to have a nutritional risk. Income must be at or below 185% FPL.	**GUARANTEED COVERAGE** **Medicare:** Must be U.S. citizen or permanent U.S. resident, and: 1) If 65 years or older, you or your spouse worked for at least 10 years in Medicare-covered employment, or 2) You have a disability or end-stage renal disease (permanent kidney failure requiring dialysis or transplant) at any age. **Senior Rx:** Must be age 62 or older Income limit of $25,477 if you are single and $33,963 if you are a married couple.	**GUARANTEED COVERAGE** Must be receiving TAA (Trade Adjustment Assistance), or Must be 55 years or older and receiving pension from the Pension Benefit Guaranty Corporation (PBGC). Must not be enrolled in certain state plans, or in prison, or receiving 65% COBRA premium reduction, or be claimed as a dependent in tax returns. Must be enrolled in qualified health plans where you pay more than 50% of the premiums.
Monthly Cost	**NV Check Up:** **$0** or **$25–$80** every 3 months. Premiums are based on income. No co-payments or deductibles. Federally recognized Native Americans who can prove their tribal affiliations pay no premiums. **WIC:** **$0** or minimal share of cost.	**$0** or minimal share of cost.	**All:** **$0** and share of cost sliding scale.	**Medicare:** **$0** and share of cost for certain services; deductibles for certain plans. Part A: $0–$451 based on length of Medicare-covered employment; Part B: $99.90-$319.70 depending on annual income; Part C: Based on provider; Part D: Varies in cost and drugs covered. **Senior Rx:** **$0** or minimal share of cost.	**27.5%** of the insurance premium including COBRA premium if employer contributes less than 50%.

PRIVATE HEALTH INSURANCE

Demographic	Small Businesses (1-50 Employees)	Individuals Recently Covered by an Employer Health Plan	Individuals & Families	Individuals with Pre-Existing, Severe, or Chronic Medical Conditions	Low-Income Individuals & Families
Program	**Group Plans** New Hampshire Association of Health Underwriters www.nhahu.org	**COBRA/New Hampshire (NH) State Continuation** Contact your current carrier. After 18 months continuous group/COBRA coverage, convert to a plan under: **HIPAA** Health Insurance Portability & Accountability Act 866-487-2365 www.dol.gov (Search: HIPAA) **HIPP** Health Insurance Premium Payment 603-271-5218 800-852-3345 ext. 5218 www.dhhs.nh.gov/oii/hipp.htm	**Individual Plans** New Hampshire Association of Health Underwriters www.nhahu.org	**New Hampshire Health Plan(NHHP)** 877-888-6447 www.nhhealthplan.org **NHHP-FED** Federal program run by Benefit Management Inc. 877-505-0508 www.nhhealthplan.org www.PCIP.gov	**Medicaid** 603-271-9700 800-852-3345, ext. 9700 www.dhhs.nh.gov (Search: Medicaid)
Coverage	There is a maximum look-back period of 3 months and a maximum exclusionary period of 9 months on pre-existing health conditions for enrollees who have no prior health coverage. ***Pre-Existing Health Conditions Covered***	**COBRA:** Coverage available for 18–36 months depending on qualifying events. Benefits are what you had with your previous employer. **NH State Continuation:** Benefits are what you had with your previous employer. Coverage available for 18–36 months depending on qualifying events. When the surviving/divorced spouse is at least age 55 at time of death of/divorce from covered employee, then the surviving/divorced spouse can continue coverage until he or she is eligible for another employer-based group plan or Medicare. **HIPAA:** Benefits are based on program selected. There is no expiration of coverage. **HIPP:** Premium assistance that pays employer-sponsored health insurance or COBRA premiums. The assistance amount depends on the most cost-effective premium available. ***Pre-Existing Health Conditions Covered***	There is a maximum look-back period of 3 months and a maximum exclusionary period of 9 months on pre-existing health conditions for enrollees who have no prior health coverage. ***Limits on Pre-Existing Health Conditions May Apply***	**NHHP:** Seven plans each with a different deductible. Offers hospitalization, physician care, diagnostic tests, x-rays, prescription drugs, and some mental health care services. **NHHP-FED:** Broad range of benefits, including primary and specialty care, hospital care, and prescription drugs. ***Pre-Existing Health Conditions Covered***	Hospital, Physician, Nursing, Home health, Lab and x-ray, Family planning, Rural health clinics, Prescription drugs, Therapies (speech, physical, occupational), Adult medical day care, Medical transportation, Durable medical equipment, Dental, Chiropractor, Psychotherapy, Podiatry, Interpreter, Midwife, EPSDT (early, periodic, screening and diagnostic testing), Newborn home visits, Maternity, Vision and hearing. Retroactive benefits available at the time of application for medical services received three months prior. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Company size 1–50. Owner can count as an employee. Proprietor name on license must draw wages. Eligible employees must work at least 15 hours a week for coverage. Insurers are required to give guaranteed issue small group plans to the self-employed during open enrollment periods twice a year. Limited guarantee issue to sole-proprietors. Carrier may not require more than 75% when the health carrier's plan is the only one offered to the employer and 37.5% when the employer is offered more than one plan.	**GUARANTEED COVERAGE** **COBRA:** Available for employees who work for businesses with 20 or more employees. You have 60 days from date of termination to sign-up. **NH State Continuation:** Available for any New Hampshire resident who is an eligible employee, or qualified beneficiary of a fully insured group or blanket policy of health insurance. Must sign up for NH State Continuation within 45 days of date of receiving notice of right to continue coverage. **HIPAA:** Must have had 18 months of continuous coverage and completely exhausted COBRA or state continuation coverage. Must not have lost coverage due to fraud or non-payment of premiums. You have 63 days to enroll. **HIPP:** Must qualify for Medicaid and have access to Employer-Sponsored Insurance or COBRA.	Eligibility is subject to medical underwriting. If you are denied coverage for a medical condition, you may be eligible for NHHP or NHHP-FED. See next column.	**GUARANTEED COVERAGE** **NHHP:** Must be a New Hampshire resident and have a pre-qualifying medical condition. Must have been denied coverage due to a health condition, or offered coverage similar to NHHP's but with higher premiums. Had your previous coverage terminated for reasons other than non-payment of premium or fraud. Also qualified: Federally eligible or certified as eligible for TAA or PBGC assistance. Must not be eligible for COBRA or government programs. **NHHP-FED:** Must be a U.S. citizen or lawfully present in the U.S. and have been uninsured for at least 6 months prior to applying. Must have had a problem getting insurance due to a pre-existing condition.	**GUARANTEED COVERAGE** Must be a New Hampshire resident and a U.S. citizen or an eligible qualified alien. Income Limits: Infants Ages 0–1: 185% FPL. Children Ages 1–19: 185% FPL. Pregnant Women: 185% FPL. Parents/Caretakers Living with Children ages 0–18: 49% FPL. Aged, Blind & Disabled: 79% FPL with asset limit of $1,500 for singles; 87% FPL with asset limit of $2,250 for couples. Medically-Needy: Singles with monthly income of $591 and asset limit of $2,500; couples with monthly income of $675 and asset limit of $4,000.
Monthly Cost	Rates vary ± 25% based on age, industry, heath status and geography. Rate increases capped at 15%	**COBRA/NH State Continuation:** 102%–150% of group health rates. **HIPAA:** Premiums will depend on plan chosen. **HIPP:** Reimburses the full employer-sponsored insurance premium amount by check monthly. Pays the insurance company directly for people on COBRA or eligible small businesses.	Costs depend on age and county/zone. If you are self-employed and buy your own insurance, you are eligible to deduct 100% of the cost of the premium from your federal income tax.	**NHHP:** $125 to $1,835 based on tobacco use, age and plan chosen. Enrollees living up to 250% FPL may be eligible for premium discounts of up to 20% and enrollees living up to 400% FPL may be eligible for premium discounts up to 10%. **NHHP-FED:** $152 to $1,535 depending on your age, tobacco use, and plan chosen.	**$0** to minimal share of cost.

PUBLICLY-SPONSORED PROGRAMS

Demographic	Children in Moderate Income Families	Women in Need of Cancer Screening	Seniors & Disabled	Trade Dislocated Workers (TAA Recipients)	Veterans
Program	**Healthy Kids** 877-464-2447 603-228-2925 www.nhhealthykids.com or www.dhhs.nh.gov (Search: Healthy Kids) Offers 3 programs: Gold, Silver, and Buy-In **Women-Infants-Children (WIC)** 800-942-4321 www.dhhs.nh.gov (Search: WIC)	**Let No Woman Be Overlooked Program** 800-852-3345 x4931 603-271-4931 www.dhhs.nh.gov (Search: BCCP)	**Medicare** 800-633-4227 www.medicare.gov **Medicare Prescription Drug Program** 800-633-4227 www.expressscript.com **New Hampshire (NH) Senior Prescription Discount Program** 888-580-8902	**Health Coverage Tax Credit** 866-628-4282 www.irs.gov (Search: HCTC)	**VA Medical Benefits Package** 877-222-8387 www.va.gov www.ebenefits.va.gov
Coverage	**Healthy Kids:** Physician services, Office and specialist visits, Check-ups and physical exams, Immunizations, Prescription drugs, Emergency room, Inpatient hospital services, Outpatient services, Lab and x-ray, Home health services, Physical, speech and occupational therapy, Outpatient and inpatient mental health care, Hearing aids, Early intervention services, Regular dental check-ups and cleanings, Fluoride treatments. **WIC:** Nutrition education and services; breastfeeding promotion and education; monthly food prescription of nutritious foods, and access to maternal, prenatal and pediatric health care services. ***Pre-Existing Health Conditions Covered***	Women's health exams, Mammograms, Pap tests, and Pelvic exams.	**Medicare** offers Part A, inpatient care in hospitals and rehabilitative centers; Part B, doctor and some preventive services and outpatient care; Part C allows Medicare benefits through private insurance (Medicare Advantage); Part C includes Parts A, B, and C not covered by Medicare. Part D covers prescription drugs. **NH Senior Prescription Discount Program** offers discounts on drugs at participating pharmacies. ***Pre-Existing Health Conditions Covered***	Inpatient and outpatient care (lab tests, x-rays, etc.), Doctor visits, Preventive and major medical care (surgery, physical therapy, Durable medical equipment, etc.), Mental health and substance abuse care, and Prescription drugs. ***Pre-Existing Health Conditions Covered***	Comprehensive preventive and primary care, outpatient and inpatient services. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** **Healthy Kids (All)**: Must be New Hampshire resident and a U.S. citizen or a legal permanent resident or qualified alien. **Gold:** Must be pregnant women living up to 185% FPL, or children ages 0–1 living up to 300% FPL. **Silver**: Must be children ages 1-19 living 185%–300% FPL. Must be uninsured for 6 consecutive months prior to enrolling. **Buy-In:** Must be children ages 1–19 living between 300%–400% FPL. Must be uninsured for 3 consecutive months prior to enrolling. Rule may be waived for certain reasons (e.g. child loses coverage due parent being laid off). **WIC:** Must reside in New Hampshire. Must be a pregnant or recently pregnant woman, or child up to age 5, and determined to have a nutritional risk. Income limit of 185% FPL.	**GUARANTEED COVERAGE** Must be New Hampshire women ages 18–64, with incomes at or less than 250% FPL, and must have no insurance or have insurance that does not pay for breast or cervical cancer screening tests. Women ages 40 and older get mammograms every 1–2 years and annual breast check. Women ages 18–39 get annual breast check and medical assessment to determine mammogram. Women ages 18 and older get Pap tests every 1–2 years.	**GUARANTEED COVERAGE** **Medicare:** Must be U.S. citizen or permanent U.S. resident, and: 1) If 65 years or older, you or your spouse worked for at least 10 years in Medicare-covered employment, or 2) You have a disability or end-stage renal disease (permanent kidney failure requiring dialysis or transplant) at any age. **NH Senior Prescription Discount Program:** Must be New Hampshire residents ages 65 or older. No income test.	**GUARANTEED COVERAGE** Must be receiving TAA (Trade Adjustment Assistance), or Must be 55 years or older and receiving pension from the Pension Benefit Guaranty Corporation (PBGC). Must not be enrolled in certain state plans, or in prison, or receiving 65% COBRA premium reduction, or be claimed as a dependent in tax returns. Must be enrolled in qualified health plans where you pay more than 50% of the premiums.	**GUARANTEED COVERAGE** "Veteran status" = active duty in the U.S. military, naval, or air service and a discharge or release from active military service under other than dishonorable conditions. Certain veterans must have completed 24 continuous months of service.
Monthly Cost	**Healthy Kids: $0** for Gold Program. Monthly premium for Silver and Buy-In programs range from $32 to $237 per child based on family size and income. **WIC: $0** to minimal share of cost	**$0** or nominal co-payment.	**Medicare: $0** and share of cost for certain services; deductibles for certain plans. Part A: $0–$451 based on length of Medicare-covered employment; Part B: $99.90-$319.70 depending on annual income; Part C: Based on provider; Part D: Varies in cost and drugs covered. **NH Senior Prescription Discount Program: $0** enrollment fee.	**27.5%** of the insurance premium including COBRA premium if employer contributes less than 50%.	**$0** and share of cost and co-pays depending on income level.

Demographic	PRIVATE HEALTH INSURANCE				
	Small Businesses (2-50 Employees)	**Individuals Recently Covered by an Employer Health Plan**	**Individuals & Families**	**Individuals with Pre-Existing, Severe, or Chronic Medical Conditions**	**Low-Income Individuals & Families**
Program	**Group Plans** New Jersey Association of Health Underwriters www.njahu.org	**COBRA/Mini-COBRA** Contact your current carrier. After 18 months continuous group/ COBRA coverage, convert to a plan under: **HIPAA** Health Insurance Portability & Accountability Act 866-487-2365 www.dol.gov (Search: HIPAA)	**Individual Plans** New Jersey Association of Health Underwriters www.njahu.org	**Individual Health Coverage (IHC) Program** 800-838-0935 609-633-1882 www.state.nj.us (Search: Individual Health Coverage) **NJ Protect** Federal program run by the state of New Jersey 888-551-2130 www.state.nj.us (Search: NJ Protect)	**Medicaid** 800-356-1561 www.state.nj.us/humanservices/dmahs/clients/medicaid/
Coverage	Groups of 2–5 individuals: There is a maximum look-back and exclusion period of 6 months for pre-existing conditions for enrollees with no prior coverage. Groups of 6–50 individuals: Insurers may not impose an exclusion period for pre-existing conditions on enrollees with no prior coverage. Benefits will vary depending on the chosen plan. ***Pre-Existing Health Conditions Covered***	**COBRA/ Mini-COBRA:** Coverage available for 18–36 months depending on qualifying events. Benefits are what you had with your previous employer. **HIPAA:** Benefits are based on program selected. There is no expiration of coverage. ***Pre-Existing Health Conditions Covered***	Assorted plans depending on medical needs . All carriers must guarantee issue coverage to all individuals. There is a maximum 6-month look-back and a maximum 12-month exclusionary period limit for pre-existing conditions on enrollees with no prior coverage. ***Pre-Existing Health Conditions Covered with Some Limitations***	**IHC:** Office visits, Hospital care, Prenatal and maternity care, Immunizations, Well-child care, Screenings (including mammographies, Pap smears and prostate examinations), X-ray and laboratory services, Certain mental health and substance abuse services, Prescription drugs. Individuals may be subject to a 12-month waiting period. **NJ Protect:** Broad range of benefits, including primary and specialty care, hospital care, and prescription drugs. ***Pre-Existing Health Conditions Covered***	Inpatient and outpatient hospital treatment, Laboratory tests and x-rays, Early and periodic screening, diagnostic and treatment services, Home health care, Physician services, Nurse-midwife services, Assistance with family planning and any necessary supplies, Nursing facilities for people over 21. Retroactive benefits available at the time of application for medical services received three months prior. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Company size 2–50 employees (including owner). An "eligible employee" is one who works at least 25 hours a week. Eligible employees do not include union employees who have collectively bargained for their health plan, independent contractors, employees hired on a temporary or substitute basis, or seasonal employees even though they work at least 25 hours a week. Most carriers require the most recent copy of New Jersey's quarterly wage and tax filing form.	**GUARANTEED COVERAGE** **COBRA:** Available for employees who work for businesses with 20 or more employees. You have 60 days from date of termination to sign-up. **Mini-COBRA:** Available for employees who work for employers with less than 20 employees. Must sign-up within 30 days of qualifying event. **HIPAA:** Must have had 18 months of continuous coverage and completely exhausted COBRA or state continuation coverage. Must not have lost coverage due to fraud or non-payment of premiums. You have 63 days to enroll.	**GUARANTEED COVERAGE** Must be New Jersey resident. Medical underwriting is not allowed. If you are denied coverage for a medical condition, you may be eligible for IHC or NJ Protect. See next column.	**GUARANTEED COVERAGE** **IHC:** Must have been a resident of New Jersey for at least 6 months. Not eligible for coverage under a group health plan, governmental plan or church plan. Not eligible for coverage under Medicare. HIPAA-eligible patients are also qualified (no length of residency requirement). **NJ Protect:** Must be a U.S. citizen or national or lawfully present in the United States and a New Jersey resident. Must have been without any creditable coverage for at least 6 months and you must have a pre-existing condition.	**GUARANTEED COVERAGE** Must be a New Jersey resident and a U.S. citizen or legal permanent resident. Income Limits: Pregnant Women & Infants Ages 0–1: 185% FPL. Children Ages 1–5: 133% FPL. Children Ages 6–19: 100% FPL. Parents/Caretakers Living with Children Ages 0–18: 133% FPL. Aged, Blind & Disabled: Singles and couples up to 100% FPL, with asset limit of $4,000 for singles and $6,000 for couples. Medically-Needy: Singles with income of $367 a month and asset limit of $4,000, couples with monthly income of $434 and asset limit of $6,000.
Monthly Cost	Costs depend on employer contribution and the modified community rate.	**COBRA/Mini-COBRA:** 102%–150% of group health rates. **HIPAA:** Premiums will depend on plan chosen.	Costs for individual coverage vary and are based on purely community rate.	**IHC:** Costs vary based on age, gender and/or geographic location, and plans chosen. Renewal increase limited to 15%. **NJ Protect:** $245.18 to $946.60 depending on your age and plan chosen.	**$0** or small share of cost.

PUBLICLY-SPONSORED PROGRAMS

Demographic	Moderate Income Families	Cancer Screening for Men & Women	Seniors & Disabled	Trade Dislocated Workers (TAA Recipients)	Veterans
Program	**NJ Family Care** 800-701-0710 www.njfamilycare.org **Women-Infants-Children (WIC)** 866-446-5942 609-292-9560 www.state.nj.us/health/fhs/wic	**Cancer Education & Early Detection (CEED)** 609-292-8540 800-328-3838 www.state.nj.us (Search: Cancer Education)	**Medicare** 800-633-4227 www.medicare.gov **Medicare Prescription Drug Program** 800-633-4227 **Senior Gold Program** 800-792-9745 www.nj.gov/health/seniorbenefits/seniorgold.shtml	**Health Coverage Tax Credit** 866-628-4282 www.irs.gov (Search: HCTC)	**VA Medical Benefits Package** 877-222-8387 www.va.gov www.ebenefits.va.gov
Coverage	**NJ Family Care:** Doctor visits, Eyeglasses, Hospitalization, X-rays & lab tests, Prescriptions, Check-ups, Mental health, and Dental (for children). **WIC:** Nutrition education and services, breastfeeding promotion and education, monthly food prescription of nutritious foods, immunization screenings, and maternal, prenatal and pediatric health care services. ***Pre-Existing Health Conditions Covered***	Education about and screening services for breast, cervical, colorectal and prostate cancers, and case management, tracking, follow-up.	**Medicare** offers Part A, inpatient care in hospitals and rehabilitative centers; Part B, doctor and some preventive services and outpatient care; Part C allows Medicare benefits through private insurance (Medicare Advantage); Part C includes Parts A, B, and C not covered by Medicare. Part D covers prescription drugs. **Senior Gold** is a state funded prescription discount program. ***Pre-Existing Health Conditions Covered***	Inpatient and outpatient care (lab tests, x-rays, etc.), Doctor visits, Preventive and major medical care (surgery, physical therapy, Durable medical equipment, etc.), Mental health and substance abuse care, and Prescription drugs. ***Pre-Existing Health Conditions Covered***	Comprehensive preventive and primary care, outpatient and inpatient services. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** **NJ Family Care:** Must be New Jersey resident, not covered by health insurance (including Medicaid), and be a U.S. citizen or legal permanent resident for at least 5 years. Eligible children must be under 19 and have family income of up to 350% FPL. Eligible parents/guardians and their children under 19 must have income of up to 133% FPL. **WIC:** Must be New Jersey resident, be a pregnant or recently pregnant woman, or a child up to age 5, and be determined to have a nutritional risk. Must live at or below 185% FPL.	**GUARANTEED COVERAGE** Must be a New Jersey resident with income at or below 250% FPL. Must have no insurance or have insurance that does not cover the services offered by CEED.	**GUARANTEED COVERAGE** **Medicare:** Must be U.S. citizen or permanent U.S. resident, and: 1) If 65 years or older, you or your spouse worked for at least 10 years in Medicare-covered employment, or 2) You have a disability or end-stage renal disease (permanent kidney failure requiring dialysis or transplant) at any age. **Senior Gold:** Must be New Jersey resident and be at least 65 years old, or at least 18 years old and receiving Social Security Disability Title II benefits. Must be participating in Medicare Part D. Income limits of $24,432–$34,432 for singles, and $29,956–$39,956 for couples.	**GUARANTEED COVERAGE** Must be receiving TAA (Trade Adjustment Assistance), or Must be 55 years or older and receiving pension from the Pension Benefit Guaranty Corporation (PBGC). Must not be enrolled in certain state plans, or in prison, or receiving 65% COBRA premium reduction, or be claimed as a dependent in tax returns. Must be enrolled in qualified health plans where you pay more than 50% of the premiums. Also contact Aetna of New Jersey.	**GUARANTEED COVERAGE** "Veteran status" = active duty in the U.S. military, naval, or air service and a discharge or release from active military service under other than dishonorable conditions. Certain veterans must have completed 24 continuous months of service.
Monthly Cost	**NJ Family Care:** **$0-$138.50** monthly premium per child or parent/guardian and $5-$35 co-pays, depending on income. **WIC:** **$0** to minimal share of cost.	**$0** or minimal share of cost.	**Medicare:** **$0** and share of cost for certain services; deductibles for certain plans. Part A: $0–$451 based on length of Medicare-covered employment; Part B: $99.90-$319.70 depending on annual income; Part C: Based on provider; Part D: Varies in cost and drugs covered. **Senior Gold:** Premiums depend on chosen Medicare Part D plan.	**27.5%** of the insurance premium including COBRA premium if employer contributes less than 50%.	**$0** and share of cost and co-pays depending on income level.

Demographic	PRIVATE HEALTH INSURANCE			PRIVATE/PUBLIC PROGRAM
	Small Businesses (1-50 Employees)	**Individuals Recently Covered by an Employer Health Plan**	**Individuals & Families**	**Individuals Below 200% FPL**
Program	**Group Plans** New Mexico State Association of Health Underwriters www.nmsahu.org **Small Employer Insurance Program (SEIP)** 866-773-9939 866-901-4538 www.gsd.state.nm.us/rmd/seip.html **New Mexico Health Insurance Alliance** ("The Alliance") 800-204-4700 888-997-2583 www.nmhia.com	**COBRA/New Mexico (NM) Continuation Coverage** Contact your current carrier. After 18 months continuous group/COBRA coverage, convert to a plan under: **HIPAA** Health Insurance Portability & Accountability Act 866-487-2365 www.dol.gov (Search: HIPAA)	**Individual Plans** New Mexico State Association of Health Underwriters www.nmsahu.org	**State Coverage Insurance (SCI)** 888-997-2583 www.insurenewmexico.state.nm.us/SCIHome.htm There is a waiting list for individual applicants, but not for SCI applications submitted as part of employer groups.
Coverage	There is a maximum 6-month look-back and a maximum 6-month exclusionary period for pre-existing conditions on enrollees that do not have prior coverage. **SEIP:** Annual claims limit of $100,000 per enrollee. Offers comprehensive health insurance. **The Alliance:** Offers comprehensive PPO and HMO plans. Waiting period of 30–180 days for all employees. ***Pre-Existing Health Conditions Covered***	**COBRA:** Coverage available for 18–36 months depending on qualifying events. Benefits are what you had with your previous employer. **NM Continuation Coverage:** Coverage lasts up to 6 months. Benefits are what you had with your previous employer. **HIPAA:** Benefits are based on program selected. There is no expiration of coverage. ***Pre-Existing Health Conditions Covered***	There is a maximum 6-month look-back and exclusionary period limit on pre-existing health conditions. ***Pre-Existing Health Conditions Covered with Some Limitations***	Benefits are limited to $100,000 payable per member per benefit year. Benefits include doctor visits; pre/post natal care; preventive services; inpatient and outpatient hospital care; home health; physical, occupational and speech therapies; medical supplies; emergency and urgent services; prescription drugs; diabetes treatment; and behavioral health and substance abuse. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** **SEIP & The Alliance:** Company size is 2–50 employees (including owner). Eligible employees must work 20 hours per week. **SEIP:** Self-employed people may qualify. Must have come from a group health plan, church plan or government plan and have completed either state continuation or COBRA option, if available. Must have no more than 95 days lapse from prior coverage. Must have lost coverage involuntarily and have had 18 months of creditable coverage prior. **The Alliance:** 50% of employees must be New Mexico residents. Also eligible are self-employed people with at least one dependent. 50% of eligible employees must participate in plan. Employer must not participate in other health plans, including paying for their employees' individual policies.	**GUARANTEED COVERAGE** **COBRA:** Available for employees who work for businesses with 20 or more employees. You have 60 days from date of termination to sign-up. **NM Continuation Coverage:** Must have been continuously covered under an Alliance plan (see "Small Business 1–50 Employees" column) for at least 6 months, even if employer ceases to do business or terminates its group coverage under The Alliance. Employee must apply for continuation coverage through The Alliance within 31 days of the loss of his or her eligibility for group coverage. **HIPAA:** Must have had 18 months of continuous coverage and completely exhausted COBRA or state continuation coverage. Must not have lost coverage due to fraud or non-payment of premiums. You have 63 days to enroll.	Eligibility is subject to medical underwriting. If you are denied coverage for a medical condition, you may be eligible for NMMIP or PCIP. See the "Individuals with Pre-Existing, Severe, or Chronic Medical Conditions" column.	**GUARANTEED COVERAGE** **Employers:** Must do business in New Mexico, have 50 or fewer eligible employees, and not currently offer health insurance. **Individuals:** Must be a U.S. citizen or legal permanent resident with at least 5 years residency in the U.S. and an uninsured adult the ages of 19–64, and live in New Mexico. Must not have voluntarily cancelled one's health insurance within last 6 months, and not be eligible for certain government health insurance benefits (i.e. Medicaid, Medicare) or private health insurance. Income limit of 200% FPL. No asset test for eligibility.
Monthly Cost	**SEIP:** Premiums are determined by age, gender, and geographic location. Employers pay at least 50% of employees' monthly premiums. **The Alliance:** Costs depend on employer contribution and ± 25% of the insurance company's index rate.	**COBRA:** 102%-150% of group health rates. **NM Continuation Coverage:** Premiums are calculated at individual coverage rates. Premiums are about 9% higher than what is charged for similar plans. **HIPAA:** Premiums will depend on plan chosen.	Costs for individual coverage vary according to age, gender, smoking and geographic location. There are no rate caps.	Employer pays $0 to $75 and employee pays $0 to $35 of the monthly premium. If you make less than 100% FPL, the state contributes to the premium payment. Self-employed individuals pay both employer and employee premiums from $0 to $110 depending on income.

PUBLICLY-SPONSORED PROGRAMS

Demographic	Individuals with Pre-Existing, Severe, or Chronic Medical Conditions	Low-Income Individuals & Families	Children in Moderate Income Families	Adults in Need of Cancer Screening	Native Americans
Program	**New Mexico Medical Insurance Pool (NMMIP)** 866-622-4711 505-424-7105 www.nmmip.org **Pre-Existing Condition Insurance Plan (PCIP)** Federal program run by NMMIP 877-573-3676 www.nmmip.org www.PCIP.gov **New Mexico Health Insurance Alliance** (The "Alliance") 800-204-4700 888-997-2583 www.nmhia.com	**Medicaid** 888-997-2583 505-827-3100 www.hsd.state.nm.us/mad	**New Mexikids** 888-997-2583 www.insurenewmexico.state.nm.us/NewMexiKidsandTeens.htm or newmexicokids.org	**Breast & Cervical Cancer Early Detection Program (BCC)** www.cancernm.org/bcc **Colorectal Cancer Program (CCP)** www.cancernm.org/crc **Both:** 877-852-2585	**Indian Health Services** 505-248-4500 www.ihs.gov (Search: Albuquerque or Navajo)
Coverage	**NMMIP:** Hospital and physician care, Prescription drugs and other services, Limited home health visits and organ transplant coverage are available. No lifetime maximum per member except for certain benefits (e.g., $5 million lifetime maximum per member for organ transplant), and optional coverage for maternity. **PCIP:** Covers broad range of benefits, including primary and specialty care, hospital care, and prescription drugs. **The Alliance:** Offers HMO and PPO plans. ***Pre-Existing Health Conditions Covered***	Hospital care (inpatient and outpatient), Nursing home care, Physician services, Laboratory and x-ray services, Immunizations, Early and periodic screening, diagnostic, and treatment (EPSDT) services for children, Family planning, Health centers (FQHC) and rural health clinics (RHC), Nurse midwife and nurse practitioner services. Retroactive benefits available at the time of application for medical services received three months prior. ***Pre-Existing Health Conditions Covered***	Check-ups, doctor visits, dental visits, hospital care, prescriptions, glasses, and hearing and vision exams, and other services, if medically-necessary. ***Pre-Existing Health Conditions Covered***	**BCC:** Clinical breast exams, Pelvic exams, Mammograms, Pap tests, ultrasounds and biopsies if needed. If diagnosed with a cancerous or precancerous condition through the BCC Program, you may be eligible for full Medicaid services which include the cost of cancer treatment. **CCP:** Colorectal cancer screening, surveillance, and diagnostic services. ***Pre-Existing Health Conditions Covered***	Health care team includes, Clinical psychologists, Dental assistants, Dental hygienists, Dental officers, Dieticians, Environmental health staff, Health educators, Medical officers, Medical records staff, Medical technologists, Mental health technicians, Nurses, Nutritionists, Pharmacists, Radiology technologists, Social workers. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** **NMMIP:** Must be a permanent resident of New Mexico, and HIPAA-eligible, or if your previous coverage was terminated for reasons other than non-payment or fraud, or if you have a qualifying medical condition, or have reached the maximum allowable coverage limit of your current health insurance, or prove that you were denied coverage due to pre-existing conditions, or offered coverage with restrictive benefits (e.g. elimination rider), or with premiums higher than NMMIP's . **PCIP:** Must be a U.S. citizen or lawfully present in the U.S. Must have been uninsured for at least 6 months prior to applying. Must have had a problem getting insurance due to a pre-existing condition. **The Alliance:** Must be HIPAA-eligible. Must not have any other available health plans, but have had 18 months of creditable coverage. If you have a policy from the Alliance, you can transfer into NMMIP.	**GUARANTEED COVERAGE** Must be a New Mexico resident and U.S. citizen or legal qualified alien. Income Limits: Children Ages 0–18: 185% FPL. Parents/Caretakers Living with Children Ages 0-18: 85% FPL. Aged, Blind & Disabled: 75% FPL and asset limit of $2,000 for singles; 83% FPL and asset limit of $3,000 for couples. Pregnant Women: 235% FPL.	**GUARANTEED COVERAGE** Must be a New Mexico resident, under age 19, not covered by health insurance (including Medicaid), and be U.S. citizen or legal qualified alien. Must have income below 235% FPL, and be ineligible for no-cost Medicaid.	**GUARANTEED COVERAGE** **BCC:** Must be a New Mexico woman age 30 and over. Must live at or below 250% FPL. Must have no health insurance or have health insurance with deductibles or co-pays that are too high. **CCP:** Must be a uninsured or underinsured New Mexico man or woman age 50 with income limit of 200% FPL. Must not have symptoms of colorectal cancer.	**GUARANTEED COVERAGE** Must exhaust all private, state, and other federal programs. Must be regarded by the local community as an Indian; is a member of an Indian or Group under Federal supervision; resides on tax-exempt land or owns restricted property; actively participates in tribal affairs; any other reasonable factor indicative of Indian descent; is a non-Indian woman pregnant with an eligible Indian's child for the duration of her pregnancy through postpartum (usually 6 weeks); is a non-Indian member of an eligible Indian's household and the medical officer in charge determines that services are necessary to control a public health hazard or an acute infectious disease which constitutes a public health hazard.
Monthly Cost	**NMMIP:** $67 to $720 depending on age, gender, and plan chosen. Incomes below 400% FPL may qualify for premium assistance. **PCIP:** $116-$618 based on age. **The Alliance:** Depends on age, deductible, region, and plan chosen.	**$0** or minimal share of cost.	**$0**. $2-$25 co-payments if income falls between 185% - 235% FPL. Federally recognized Native Americans are not required to pay.	**Both: $0** or minimal share of cost.	**$0** or minimal share of cost.

PRIVATE HEALTH INSURANCE

Demographic	Small Businesses (2-50 Employees)	Individuals Recently Covered by an Employer Health Plan	Small Businesses & Working Individuals	Individuals & Families	Individuals with Pre-Existing, Severe, or Chronic Medical Conditions
Program	**Group Plans** New York Association of Health Underwriters www.nysahu.org	**COBRA/Mini-COBRA** Contact your current carrier. After 18 months continuous group/ COBRA coverage, convert to a plan under: **HIPAA** Health Insurance Portability & Accountability Act 866-487-2365 www.dol.gov (Search: HIPAA)	**Healthy NY** 866-432-5849 www.healthyny.com	**Individual Plans** New York Association of Health Underwriters www.nysahu.org	**NY Bridge Plan** Federal program run by Group Health Incorporated 866-693-9277 www.ghi.com/nybridgeplan www.PCIP.gov
Coverage	There is a maximum 6-month look-back and a maximum 12-month exclusionary period for pre-existing conditions on enrollees that do not have prior creditable coverage. Benefits will vary depending on the chosen plan. ***Pre-Existing Health Conditions Covered***	**COBRA:** Coverage available for 18–36 months depending on qualifying events. Benefits are what you had with your previous employer. **Mini-COBRA:** Coverage available up to 36 months depending on qualifying events. Benefits are what you had with your previous employer. **HIPAA:** Benefits are based on program selected. There is no expiration of coverage. ***Pre-Existing Health Conditions Covered***	Inpatient/outpatient hospital services, Physician services; Maternity care, Preventive health services, Diagnostic and x-ray services, and Emergency services. Applicants may choose a benefit package with or without a limited prescription benefit. High deductible plans available Pregnancy is treated as a pre-existing condition, but only in individual contracts. ***Pre-Existing Health Conditions Covered with Some Limitations***	Assorted plans depending on medical needs. All carriers must guarantee coverage to all individuals. There is a maximum 6-month look-back and a maximum 12-month exclusionary period limit for pre-existing conditions on enrollees with no prior coverage. Elimination riders are not allowed. ***Pre-Existing Health Conditions Covered***	Inpatient Hospital Coverage, Nursing, Rehabilitation, Hospice, Pre-admission testing, Ambulatory surgery, Home health care, X-ray and lab, Screenings, Specialists, Maternity care, Check-ups, Chiropractic care, Therapy, Surgery, Durable medical equipment immunizations, Child care, Emergency room care and transportation, Mental health, eye exams, and prescription drugs.
Eligibility	**GUARANTEED COVERAGE** Company size 2–50 employees (including owner). Eligible employees must work at least 20 hours a week.	**GUARANTEED COVERAGE** **COBRA:** Available for employees who work for employers with 20 or more employees. You have 60 days from date of termination to sign-up. **Mini-COBRA:** Available for employees who work for employers with less than 20 employees. Must sign-up within 60 days from date of termination or date of receiving notice of right to continue coverage (whichever is later). **HIPAA:** Must have had 18 months of continuous coverage and completely exhausted COBRA or state continuation coverage. Must not have lost coverage due to fraud or non-payment of premiums. You have 63 days to enroll.	**GUARANTEED COVERAGE** Must be a New York resident. **Sole Proprietors & Individuals:** You or your spouse must be employed or have been employed within the last 12 months, uninsured in the last 12 months, ineligible for Medicare, and living up to 250% FPL. **Small Businesses:** Must have 1–50 eligible employees, 30% of which must earn $40,000 or less. The business must not have provided group health insurance to its employees within the last 12 months. A small employer is considered to have provided health insurance if the employer has BOTH arranged for and contributed more than $50 or $75 (in certain counties) per employee per month toward health insurance.	**GUARANTEED COVERAGE** Must be a New York resident. Medical underwriting is not allowed.	**GUARANTEED COVERAGE** Must be a U.S. citizen, or legal U.S. resident, and a resident of New York State. Must have a qualified pre-existing medical condition, and be uninsured for the last 6 months. No minimum age. Patient 65 years and older and have Medicare coverage are not eligible. Applicants who transfer from another state's PCIP program will be eligible if they are a resident of New York with no more than a 180-day break in coverage from their prior PCIP coverage.
Monthly Cost	Costs depend on employer contribution and based on pure community rate.	**COBRA/Mini-COBRA:** 102%–150% of group health rates. **HIPAA:** Premiums will depend on plan chosen.	Premiums vary based on the month of enrollment, county of residence, and plan chosen.	Costs for individual coverage vary.	$362–$421 depending on county.

PUBLICLY-SPONSORED PROGRAMS

Demographic	Low-Income Individuals & Families	Individuals, Children, & Families	Adults in Need of Cancer Screening	Adults	Seniors & Disabled
Program	**Medicaid** 800-541-2831 877-472-8411 718-557-1399 www.health.ny.gov/health_care/medicaid	**Child Health Plus (CHP)** 800-698-4543 www.health.ny.gov (Search: Child Health Plus) **Family Health Plus (FHP)** 877-934-7587 518-457-2977 www.health.ny.gov (Search: Family Health Plus)	**Medicaid Cancer Treatment Program (MCTP)** Run by the New York State Department of Health Cancer Services Program (CSP) 800-422-2262 www.nyhealth.gov (Search: MCTP)	**Family Planning Benefit Program (FPBP)** 800-541-2831 www.health.ny.gov (Search: Family Planning Benefit Program) **Family Health Plus (FHP)** 877-934-7587 518-457-2977 www.health.ny.gov (Search: Family Health Plus)	**Medicare** 800-633-4227 www.medicare.gov **Medicare Prescription Drug Program** 800-633-4227 **New York Elderly Pharmaceutical Insurance Coverage (EPIC) Program** 800-332-3742 www.health.ny.gov (Search: EPIC)
Coverage	Smoking cessation agents, Treatment and preventive health and dental care, Hospital inpatient and outpatient services, Laboratory and x-ray, nursing home, Home health agencies and personal care, Treatment in psychiatric hospitals and mental health facilities, Family planning, Early periodic screening, Diagnosis, and treatment for children, medical equipment, and appliances, transportation to medical appointments, emergency ambulance, prenatal care, clinical services. Retroactive benefits available at the time of application for medical services received three months prior. ***Pre-Existing Health Conditions Covered***	Well-child care, Physical exams, Immunizations, Diagnosis and treatment of illness and injury, X-ray and lab tests, Outpatient surgery, Emergency care, Prescription and non-prescription drugs if ordered, Inpatient hospital medical or surgical care, Short-term therapeutic outpatient services (chemotherapy, hemodialysis), Limited inpatient and outpatient treatment for alcoholism and substance abuse and mental health, Dental, Vision, Speech and hearing, Durable medical equipment, Hospice, Emergency ambulance transportation to a hospital. ***Pre-Existing Health Conditions Covered***	Breast, cervical, colorectal and prostate cancer screening, treatment and comprehensive health care through Medicaid. ***Pre-Existing Health Conditions Covered***	**FPBP:** Birth control, Emergency contraception services and follow-up care, Sterilization, Preconception counseling, Various screenings, Bone density scans, and Ultrasounds. **FHP:** Physician services, Inpatient & outpatient hospital care, Prescription drugs, Smoking cessation products, Lab tests & x-rays, Vision, Speech, Hearing services, Rehab, Durable medical equipment, Emergency room, Ambulance, Behavioral health & chemical dependence services, Diabetes, Hospice, Radiation, Chemotherapy & hemodialysis, Dental, Family planning. ***Pre-Existing Health Conditions Covered***	**Medicare** offers Part A, inpatient care in hospitals and rehabilitative centers; Part B, doctor and some preventive services and outpatient care; Part C allows Medicare benefits through private insurance (Medicare Advantage); Part C includes Parts A, B, and C not covered by Medicare. Part D covers prescription drugs. **EPIC** is a prescription discount program. Seniors with other prescription coverage through Medicare or most other plans can join EPIC to cover drug costs not covered by that other coverage. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Must be U.S. citizens or legal immigrants, and residents of New York State. Undocumented immigrants are eligible for emergency medical services, if pregnant or require emergency medical treatment. Income Limits: Pregnant Women & Infants Ages 0–1: 200% FPL Children Ages 1–5: 133% FPL Children Ages 6–18: 100% FPL. Singles, Couples without Children & Low-Income Families: 79% FPL for singles and 73% FPL for couples. Aged, Blind & Disabled: 85% FPL with asset limit of $14,250 for singles; 92% FPL with asset limit of $20,850 for couples. Individuals may also own a home, a car, and personal property and still be eligible. The income and resources of legally-responsible relatives in the household will be counted. There are limits on cash resources. Children ages 1-18 with incomes of 133% FPL may be eligible for the Medicaid Excess Income program (must have medical bills equal to income over Medicaid level).	**GUARANTEED COVERAGE** **Both:** Must be residents of New York State and U.S. citizens or qualified aliens. **CHP:** Must be uninsured children ages 0–18, with incomes up to 400% FPL. Families with incomes above 400% FPL can pay the full premium. **FHP:** Must be ages 19–64, with no private or employer-based insurance, but with incomes or resources too high to qualify for Medicaid. Parents/Guardians Living with at Least 1 Child under age 21: Income limit of 150% FPL.	**GUARANTEED COVERAGE** Must be uninsured, ineligible for Medicaid under other eligibility groups. Must be a New York State resident, and a U.S. citizen or an alien with satisfactory immigration status. For breast/cervical cancer screenings: Must be screened for and need treatment for breast and/or cervical cancer or have a pre-cancerous condition. For colorectal/prostate cancer screenings: Must be screened and/or diagnosed through a Cancer Services Program (CSP) partnership or CSP provider. Must be under 65 years of age and need treatment for colorectal and/or prostate cancer or have a pre-cancerous condition. Income limit of 250% FPL.	**GUARANTEED COVERAGE** **FPBP:** Must be male or female of childbearing age and a resident of New York State and a U.S. citizen (or satisfactory immigration status). Income must be below 200% FPL and not already enrolled in Medicaid or Family Health Plus. **FHP:** Must be residents of New York State and U.S. citizens or qualified aliens. Single Adults & Couples with No Children: Income limit of 100% FPL.	**GUARANTEED COVERAGE** **Medicare:** Must be U.S. citizen or permanent U.S. resident, and: 1) If 65 years or older, you or your spouse worked for at least 10 years in Medicare-covered employment, or 2) You have a disability or end-stage renal disease (permanent kidney failure requiring dialysis or transplant) at any age. **EPIC:** Must be a New York State resident age 65 or older with annual income under $35,000 (for singles) or $50,000 or less (for couples), and must join a Medicare Part D. Seniors with a Medicaid spend-down are eligible, but those with full Medicaid benefits are not.
Monthly Cost	**$0** or small share of cost. $200 maximum co-pay per year.	**CHP: $0–$60** premiums and no co-pays. Must pay full premium charged by health plan if income is greater than 400% FPL. **FHP: $0** or minimal share of cost. May have co-pays.	**$0** or minimal share of cost.	**$0** or minimal share of cost. **FHP: $0** or minimal share of cost. May have co-pays.	**Medicare: $0** and share of cost for certain services; deductibles for certain plans. Part A: $0–$451 based on length of Medicare-covered employment; Part B: $99.90-$319.70 depending on annual income; Part C: Based on provider; Part D: Varies in cost and drugs covered. **EPIC:** Co-pays up to $20. Medicare Part D members pay their Medicare premium if their income exceeds $23,000 for singles and $29,000 for couples.

Demographic	PRIVATE HEALTH INSURANCE				
	Small Businesses (1-50 Employees)	**Individuals Recently Covered by an Employer Health Plan**	**Individuals & Families**	**Individuals with Pre-Existing, Severe, or Chronic Medical Conditions**	**Low-Income Individuals & Families**
Program	**Group Plans** North Carolina Association of Health Underwriters www.ncahu.org	**COBRA/Mini-COBRA** Contact your current carrier. After 18 months continuous group/ COBRA coverage, convert to a plan under: **HIPAA** Health Insurance Portability & Accountability Act 866-487-2365 www.dol.gov (Search: HIPAA) **HIPP** Health Insurance Premium Payment 855-696-2447 www.mynchipp.com	**Individual Plans** North Carolina Association of Health Underwriters www.ncahu.org	**Inclusive Health** North Carolina Health Insurance Risk Pool 866-665-2117 www.inclusivehealth.org **Inclusive Health-Federal Option** Federal program run by North Carolina Health Insurance Risk Pool 866-665-2117 www.inclusivehealth.org www.PCIP.gov	**Medicaid** 800-662-7030 919-855-4400 (for Wake County) TTY: 919-733-4851 www.ncdhhs.gov/dma/medicaid
Coverage	There is a maximum 6-month look-back and a maximum 12-month exclusionary period for pre-existing conditions on enrollees that do not have prior creditable coverage. Benefits will vary depending on the chosen plan. ***Pre-Existing Health Conditions Covered***	**COBRA:** Coverage available for 18–36 months depending on qualifying events. Benefits are what you had with your previous employer. **Mini-COBRA:** Coverage lasts up to 18 months. Benefits are what you had with your previous employer. **HIPAA:** Benefits are based on program selected. There is no expiration of coverage. **HIPP:** Premium assistance that pays employer-sponsored health insurance or COBRA premiums. The assistance amount depends on the most cost-effective premium available. ***Pre-Existing Health Conditions Covered***	Assorted plans depending on medical needs. There is a maximum 12-month look-back and exclusionary period limit for pre-existing conditions on enrollees that do not have prior creditable coverage. ***Pre-Existing Health Conditions Covered with Some Limitations***	**InclusiveHealth:** Preventive care, Urgent care, Outpatient services, Prescription drug benefits and other common health care services. May have a 6 to 12-month waiting period for pre-existing conditions. Lifetime benefit maximum of $1,000,000. **InclusiveHealth-Fed:** Primary and specialty care, hospital care, and prescription drugs. ***Pre-Existing Health Conditions Covered***	Doctor visits, Hospital visits, Prescriptions, Dental, Vision, Medicare premiums, Nursing home care, In-home care, Mental health care, Most medically-necessary services for children under age 21, Personal care services, Medical equipment, and other home health services. Retroactive benefits available at the time of application for medical services received three months prior. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Company size 1–50 employees (including owner). Owner name on business license must draw wages from the company. Eligible employees must work at least 30 hours a week.	**GUARANTEED COVERAGE** **COBRA:** Available for employees who work for businesses with 20 or more employees. You have 60 days from date of termination to sign-up. **Mini-COBRA:** Available for employees who work for employers with less than 20 employees. Must have been covered by group policy continuously for 3 months. Must elect coverage within 60 days of termination. **HIPAA:** Must have had 18 months of continuous coverage and completely exhausted COBRA or state continuation coverage. Must not have lost coverage due to fraud or non-payment of premiums. You have 63 days to enroll. **HIPP:** Must qualify for Medicaid and have access to Employer-Sponsored Insurance or COBRA.	Eligibility is subject to medical underwriting. If you are denied coverage for a medical condition, you may be eligible for guarantee issue through Inclusive Health. See next column.	**GUARANTEED COVERAGE** **InclusiveHealth:** Must not be eligible for Medicaid, Medicare, or any group insurance. Must be a legal resident of the U.S. and have been a continuous resident of North Carolina for at least 30 days. Must have been denied health insurance due to pre-existing medical reasons, offered coverage by an insurer but with a conditional rider limiting coverage, exhausted 18 months of COBRA, or with higher premiums, or you were diagnosed with a qualifying medical condition. Also qualified to enroll are HIPAA or HCTC-eligibles who do not need to fulfill 30-day North Carolina residency requirement. **InclusiveHealth-Fed:** Must be a U.S. citizen or lawfully present in the U.S. Must have been uninsured for at least 6 months prior to applying. Must have had a problem getting insurance due to a pre-existing condition.	**GUARANTEED COVERAGE** Must be a U.S. citizen or legal permanent resident and live in North Carolina. Income Limits: Children Ages 1–5: 200% FPL. Children Ages 6–18: 100% FPL. Aged, Blind & Disabled: Singles and couples living up to 100% FPL with asset limit of $2,000 for singles and $3,000 for couples. Parents/Caretakers Living with Children Ages 0–18, and children under age 21: $362/month for 1 household member; $472/month for 2; $544/month for 3; $594/month for 4; $648/month for 5. Asset limit of $3,000. Medically-Needy: $242/month with asset limit of $2,000 for singles; $317/ month with asset limit of $3,000 for couples. Working Disabled: 200% FPL and must be ages 16–64 and disabled by Social Security standards. Asset limit of $21,192.
Monthly Cost	Costs depend on employer contribution and ± 20% of the insurance company's index rate.	**COBRA/Mini-COBRA:** 102%–150% of group health rates. **HIPAA:** Premiums will depend on plan chosen. **HIPP:** Reimburses the full employer-sponsored insurance premium amount by check monthly. Pays the insurance company directly for people on COBRA or eligible small businesses.	Costs for individual coverage vary. There are no rate caps.	**InclusiveHealth:** $85 to $3,558 depending on age, gender, tobacco use, deductible, and plan chosen. Income level under 300% FPL may be eligible for premium assistance. **InclusiveHealth-Fed:** $71 to $724 depending on age and region.	**$0** or minimal share of cost.

PUBLICLY-SPONSORED PROGRAMS

Demographic	Children in Moderate Income Families	Pregnant Women & Infants	Women with Chronic Illnesses	Seniors & Disabled	Trade Dislocated Workers (TAA Recipients)
Program	**North Carolina's Health Choice** 800-662-7030 919-855-4440 (for Wake County) www.ncdhhs.gov/dma/healthchoice	**Medicaid for Pregnant Women** 919-707-5700 TTD: 877-452-2514 www.dhhs.state.nc.us/dma/medicaid **Baby Love** 919-855-4260 www.ncdhhs.gov/dma/services/babylove.htm **Women-Infants-Children (WIC)** 919-707-5800 www.nutritionnc.com/wic	**Breast & Cervical Cancer Control Program** 919-707-5300 bcccp.ncdhhs.gov **WISEWOMAN** 919-707-5300 bcccp.ncdhhs.gov/wisewoman.htm	**Medicare** 800-633-4227 www.medicare.gov **Medicare Prescription Drug Program** 800-633-4227 **Senior Insurance Counseling (SHIIP)** 919-807-6900 800-443-9354 www.ncdoi.com/SHIIP	**Health Coverage Tax Credit** 866-628-4282 www.irs.gov (Search: HCTC)
Coverage	**NCHC:** Physician and clinic services, X-ray & lab, Surgical services, Prescription drugs, Dental, Vision & hearing, Durable medical equipment, Therapies (physical, speech, hearing, occupational) Hospice care, Home health care, Inpatient/outpatient mental health services and substance abuse treatment. ***Pre-Existing Health Conditions Covered***	**Medicaid for Pregnant Women:** Maternity services only. Prenatal care, delivery and 60 days postpartum care, treating medical conditions which may complicate the pregnancy (approval for some services needed), childbirth and parenting classes, family planning, Maternity Care Coordination services. **Baby Love:** Maternity care coordination, childbirth education classes, counseling and emotional support, medical home visits, and referral to other programs. **WIC:** Nutrition education and services, breastfeeding promotion and education, monthly food prescription of nutritious foods, and access to maternal, prenatal and pediatric health care services. ***Pre-Existing Health Conditions Covered***	**BCCCP:** Clinical breast exams, Screening mammograms, Pap tests, Diagnostic procedures as indicated (diagnostic mammograms, ultrasounds, colposcopies, breast and cervical biopsies), Medical consultations. **WISEWOMAN:** Heart disease risk factor testing, Blood pressure, Cholesterol, Blood sugar, Height and weight (BMI), Lifestyle intervention (classes, counseling, activities), Referrals to health care providers and sources of low-cost medications.	**Medicare** offers Part A, inpatient care in hospitals and rehabilitative centers; Part B, doctor and some preventive services and outpatient care; Part C allows Medicare benefits through private insurance (Medicare Advantage); Part C includes Parts A, B, and C not covered by Medicare. Part D covers prescription drugs. **SHIIP** answers questions and counsels Medicare beneficiaries and caregivers about Medicare, Medicare supplements, Medicare Advantage, Medicare prescription drug plans, long-term care insurance and other health insurance concerns. ***Pre-Existing Health Conditions Covered***	Inpatient and outpatient care (lab tests, x-rays, etc.), Doctor visits, Preventive and major medical care (surgery, physical therapy, Durable medical equipment, etc.), Mental health and substance abuse care, and Prescription drugs. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** **NCHC:** Income limit of 200% FPL. Must not be eligible for Medicaid or have any other health insurance. Must be under age 19, and be a U.S. citizen or lawful alien and North Carolina resident.	**GUARANTEED COVERAGE** **Medicaid for Pregnant Women & Baby Love:** Must be a resident of North Carolina and a U.S. citizen or legal permanent resident. Income of mother and infant age 0–1 must be at or less than 185% FPL. No asset limit. **WIC:** Must reside in North Carolina, be a pregnant or recently pregnant woman, or child up to age 5, and have been determined to be at nutritional risk. Income must be at or below 185% FPL.	**BCCCP:** Must be a woman between ages living in North Carolina. Uninsured or underinsured, without Medicare Part B or Medicaid. Between ages 40-64 for breast screening services and 18-64 for cervical screening services. Must have a household income at or below 250% FPL. **WISEWOMAN:** Women who are enrolled in NCBCCCP and reside in counties that have a participating WISEWOMAN provider are also eligible for WISEWOMAN services.	**GUARANTEED COVERAGE** **Medicare & SHIIP:** Must be U.S. citizen or permanent U.S. resident, and: 1) If 65 years or older, you or your spouse worked for at least 10 years in Medicare-covered employment, or 2) You have a disability or end-stage renal disease (permanent kidney failure requiring dialysis or transplant) at any age.	**GUARANTEED COVERAGE** Must be receiving TAA (Trade Adjustment Assistance), or Must be 55 years or older and receiving pension from the Pension Benefit Guaranty Corporation (PBGC). Must not be enrolled in certain state plans, or in prison, or receiving 65% COBRA premium reduction, or be claimed as a dependent in tax returns. Must be enrolled in qualified health plans where you pay more than 50% of the premiums.
Monthly Cost	**NCHC:** **$0** enrollment fee for incomes under 150% FPL. $50 enrollment fee per child (Fee no more than $100) for incomes over 150% FPL. **$1–$25** co-pays depending on service.	**Medicaid for Pregnant Women & Baby Love:** **$0** or minimal share of cost. **WIC:** **$0** to minimal share of cost.	**Both:** **$0** or minimal share of cost.	**Medicare:** **$0** and share of cost for certain services; deductibles for certain plans. Part A: $0–$451 based on length of Medicare-covered employment; Part B: $99.90-$319.70 depending on annual income; Part C: Based on provider; Part D: Varies in cost and drugs covered. **SHIIP:** **$0**	**27.5%** of the insurance premium including COBRA premium if employer contributes less than 50%.

PRIVATE HEALTH INSURANCE

Demographic	Small Businesses (2-50 Employees)	Individuals Recently covered by an Employer Health Plan	Individuals & Families	Individuals with Pre-Existing, Severe, or Chronic Medical Conditions	Low-Income Individuals & Families
Program	**Group Plans** National Association of Health Underwriters 202-552-5060 www.nahu.org	**COBRA/Mini-COBRA** Contact your current carrier. After 18 months continuous group/ COBRA coverage, convert to a plan under: **HIPAA** Health Insurance Portability & Accountability Act 866-487-2365 www.dol.gov (Search: HIPAA)	**Individual Plans** National Association of Health Underwriters 202-552-5060 www.nahu.org	**Comprehensive Health Association of North Dakota (CHAND)** 800-737-0016 701-277-2271 www.chand.org **Pre-Existing Condition Insurance Plan (PCIP)** Run by the U.S. Department of Health and Human Services 866-717-5826 www.PCIP.gov www.pciplan.com	**Medicaid** 800-755-2604 701-328-2321 TTY: 701-328-8950 www.nd.gov/dhs/services/medicalserv/medicaid
Coverage	There is a maximum 6-month look-back and a 12-month exclusionary period for pre-existing conditions on enrollees with no prior creditable coverage. ***Pre-Existing Health Conditions Covered***	**COBRA:** Coverage available for 18–36 months depending on qualifying events. Benefits are what you had with your previous employer. **Mini-COBRA:** Coverage available for 39 weeks to 36 months depending on qualifying events. Benefits are what you had with your previous employer. **HIPAA:** Benefits are based on program selected. There is no expiration of coverage. ***Pre-Existing Health Conditions Covered***	Elimination riders are not allowed. There is a maximum 6-month look-back and a 12-month exclusionary period for pre-existing conditions on enrollees with no prior creditable coverage. ***Pre-Existing Health Conditions Covered with Some Limitations***	**CHAND:** Two comprehensive coverage options with $500 or $1,000 deductibles including: Doctor visits, Prescription drugs, Outpatient and in-hospital care, Maternity, Ambulance, Labs and x-rays, Skilled nursing care, Hospice, Home health visits, Rehabilitation, Durable medical equipment, Mental health and substance abuse, Physical, speech and occupational therapy, Preventive care, and other services. Covered services have a lifetime limit of $1,000,000. **PCIP:** Covers broad range of benefits, including primary and specialty care, hospital care, and prescription drugs. ***Pre-Existing Health Conditions Covered***	Hospital, Nursing facility, clinics, Rural health clinics, Hospice, physicians, Prescription drugs, Chiropractor, EPDST, Home health, Durable medical equipment and supplies, Dental, Family planning, Sterilization, Podiatry, Mental health, Ambulance, Transportation, Vision, Therapies, Waivers for certain services, Home and community based services, Traumatic brain injury, out-of-state services. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Company size 2–50 employees. Owner can count as an employee. Owner name on business license must draw wages from the company. Eligible employees must work at least 30 hours a week.	**GUARANTEED COVERAGE** **COBRA:** Available for employees who work for businesses with 20 or more employees. You have 60 days from date of termination to sign-up. **Mini-COBRA:** Available for employees who work for employers with less than 20 employees. Must have been continuously covered for 3 months under group insurance. Must elect continuation coverage within 10 days after date of termination, or date of receiving notice of right to continue coverage (whichever is later). However, if more than 31 days passed after date of termination, you cannot elect continuation. **HIPAA:** Must have had 18 months of continuous coverage and completely exhausted COBRA or state continuation coverage. Must not have lost coverage due to fraud or non-payment of premiums. You have 63 days to enroll.	Eligibility is subject to medical underwriting. If you are denied coverage for a medical condition, you may be eligible for CHAND or PCIP. See next column.	**GUARANTEED COVERAGE** **CHAND:** Must have resided in North Dakota for at least 183 days. Must have written evidence of denial of coverage from at least one carrier due to health reasons, or offered coverage with substantially restricts benefits for specific conditions, or with rates exceeding the CHAND rate. Must have written evidence from a medical professional of the existence of a qualifying condition and proof of exhausting most recent coverage within 90 days of application. Must be ineligible for health benefits under North Dakota's medical assistance program, COBRA or other government programs. Medicare supplement plan is also available. **PCIP:** Must have been uninsured for at least 6 months prior to applying. Must prove being a U.S. citizen or legal U.S. resident, a North Dakota resident, and having problems getting insurance due to a pre-existing condition.	**GUARANTEED COVERAGE** Must be a North Dakota resident and a U.S. citizen or legal permanent resident. Some legal permanent residents may have to wait for 5 years for full Medicaid benefits, but there is no waiting period for emergency services. Income Limits: Pregnant Women & Children Ages 0–6: 133% FPL. Children Ages 6–19: 100% FPL. Parents/Caretakers Living with Children Ages 0–18: 33% FPL. Aged, Blind & Disabled: 75% FPL for singles and 83% FPL couples, with asset limit of $3,000 for singles and for $6,000 couples. Medically-Needy: 83% FPL for singles and couples. People with high medical expenses after subtracting income.
Monthly Cost	Costs depend on employer contribution and ± 35% of the insurance company's index rate.	**COBRA/Mini-COBRA:** 102%–150% of group health rates. **HIPAA:** Premiums will depend on plan chosen.	Costs for individual coverage vary.	**CHAND:** $246.20 to $1,128.60 depending age, deductible and plan chosen. **PCIP:** $133 to $571 depending on your age and plan chosen.	**$1-$3** co-pay for office visit. $75 per admission in hospital except institution for mental diseases.

PUBLICLY-SPONSORED PROGRAMS

Demographic	Children in Low-Income Families	Children in Moderate Income Families	Women in Need of Cancer Screening	Native Americans	Trade Dislocated Workers (TAA Recipients)
Program	**Healthy Steps** 877-543-7669 www.nd.gov (Search: Healthy Steps) **Women-Infants-Children (WIC)** 800-472-2286 www.health.state.nd.us/wic	**Caring for Children** 800-342-4718 701-277-2227 www.ndcaring.org **Children's Special Health Services** 800-755-2714 701-328-2436 www.ndhealth.gov/CSHS	**Women's Way** 800-449-6636 www.womensway.net	**Indian Health Services** 605-226-7582 www.ihs.gov (Search: Aberdeen)	**Health Coverage Tax Credit** 866-628-4282 www.irs.gov (Search: HCTC)
Coverage	**Healthy Steps:** Inpatient/ outpatient hospital services, clinic, Mental health and substance abuse, Prescription drugs, Preventive services, Dental and vision, Prenatal, and Orthodontia. **WIC:** Nutrition education and services, breastfeeding promotion and education, monthly food prescription of nutritious foods, and maternal, prenatal and pediatric health care services. ***Pre-Existing Health Conditions Covered***	**Caring for Children:** Well-child visits, Physician office visits and routine physicals, Immunizations, Emergency accident care, Inpatient and outpatient hospital care, Diagnostic tests, Dental services, Mental health and chemical dependency. **CSHS:** Covers specialty care needed to treat an eligible condition. Care coordination, Dental, Equipment, Testing, Counseling, Hearing, Home health, Inpatient and outpatient services, Lab and x-rays, Pharmacy, Therapies, vision, physician and nurse practitioner services. ***Pre-Existing Health Conditions Covered***	Provides clinical breast exams, Pap tests, pelvic exams for breast and cervical cancer.	Inpatient and outpatient services, Physical therapy, Pediatric, Optometry, Diabetes, Emergency rooms, Specialty care, Medical supplies, Lab & x-ray, Ambulance. ***Pre-Existing Health Conditions Covered***	Inpatient and outpatient care (lab tests, x-rays, etc.), Doctor visits, Preventive and major medical care (surgery, physical therapy, Durable medical equipment, etc.), Mental health and substance abuse care, and Prescription drugs. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** **Healthy Steps:** Must be a North Dakota resident and U.S. citizen or legal permanent resident. Must not be covered by health insurance (including Medicaid). Must be under 19 years old with income of 160% FPL. Single 18 year olds with eligible incomes may also apply. **WIC:** Must reside in North Dakota. Must be a pregnant or recently pregnant woman, or a child up to age 5 and be at nutritional risk. Income must be at or below 185% FPL.	**GUARANTEED COVERAGE** **Caring for Children:** Must be a U.S. citizen or legal permanent resident and resident of North Dakota. Must be without comprehensive medical coverage through Medicaid, Healthy Steps or a private insurance carrier. Must be 0–18 years old with income between 161% and 200% FPL. Enrollees who have voluntarily cancelled medical insurance are not eligible to participate in Caring for Children for 6 months after the date the coverage was cancelled. **CSHS:** Must be a North Dakota resident ages 0-21 with a qualifying disability or chronic health condition. Must have an income at or below 185% to receive services at no cost. FPL for treatment services. Diagnostic services have no income limit.	**GUARANTEED COVERAGE** Must be a woman, age 40–64, and a U.S. citizen and North Dakota resident with an income of up to 200% FPL. Must be uninsured or have insurance that doesn't cover Pap tests and/or mammograms or can't afford to pay her deductible or co-payments. Must not be enrolled in or eligible for Medicaid or Medicare Part B. Women ages 65 or older can be eligible for the program, but they must not be eligible for Medicare or cannot afford Medicare Part B.	**GUARANTEED COVERAGE** Must exhaust all private, state, and other federal programs. Must be regarded by the local community as an Indian; is a member of an Indian or Group under Federal supervision; resides on tax-exempt land or owns restricted property; actively participates in tribal affairs; any other reasonable factor indicative of Indian descent; is a non-Indian woman pregnant with an eligible Indian's child for the duration of her pregnancy through postpartum (usually 6 weeks); is a non-Indian member of an eligible Indian's household and the medical officer in charge determines that services are necessary to control a public health hazard or an acute infectious disease which constitutes a public health hazard.	**GUARANTEED COVERAGE** Must be receiving TAA (Trade Adjustment Assistance), or Must be 55 years or older and receiving pension from the Pension Benefit Guaranty Corporation (PBGC). Must not be enrolled in certain state plans, or in prison, or receiving 65% COBRA premium reduction, or be claimed as a dependent in tax returns. Must be enrolled in qualified health plans where you pay more than 50% of the premiums.
Monthly Cost	**Healthy Steps:** **$0–$50** co-payments depending on service. No payments required from federally-recognized Native Americans. **WIC:** **$0** or minimal share of cost.	**Caring for Children:** **$0** **CSHS:** **$0** or minimal share of cost if at or below 185% FPL. Families above 185% FPL must spend a designated amount for out-of-pocket medical expenses.	**$0** or minimal share of cost.	**$0** or minimal share of cost.	**27.5%** of the insurance premium including COBRA premium if employer contributes less than 50%.

Demographic	PRIVATE HEALTH INSURANCE				
	Small Businesses (2-50 Employees)	**Individuals Recently Covered by an Employer Health Plan**	**Individuals & Families**	**Individuals with Pre-Existing, Severe, or Chronic Medical Conditions**	**Low-Income Individuals, Families & Children**
Program	**Group Plans** Ohio Association of Health Underwriters 330-273-5756 www.ohioahu.org	**COBRA/Mini-COBRA** Contact your current carrier. After 18 months continuous group/ COBRA coverage, convert to a plan under: **HIPAA** Health Insurance Portability & Accountability Act 866-487-2365 www.dol.gov (Search: HIPAA)	**Individual Plans** Ohio Association of Health Underwriters 330-273-5756 www.ohioahu.org	**Ohio High Risk Pool** Federal program run by Medical Mutual through the Ohio Dept. of Insurance 877-730-1117 www.ohiohighriskpool.com www.PCIP.gov	**Medicaid** 800-324-8680 TDD: 800-292-3572 jfs.ohio.gov (Search: Medicaid) **Healthy Families** 800-324-8680 TDD: 800-292-3572 jfs.ohio.gov (Search: Healthy Families)
Coverage	There is a maximum 6-month look-back and maximum 12-month exclusion for pre-existing conditions on enrollees that do not have prior creditable coverage. Benefits will vary depending on the chosen plan. Annual open enrollment regardless of pre-existing conditions. ***Pre-Existing Health Conditions Covered***	**COBRA:** Coverage available for 18–36 months depending on qualifying events. Benefits are what you had with your previous employer. **Mini-COBRA:** Coverage lasts up to 12 months depending on qualifying events. Benefits are what you had with your previous employer. **HIPAA:** Benefits are based on program selected. There is no expiration of coverage. ***Pre-Existing Health Conditions Covered***	Covers certain state mandated items. Annual open enrollment regardless of pre-existing conditions. Coverage options vary by carrier, but most offer plans that are HSA (Health Savings Account) compatible. There is a maximum 6-month look-back and maximum 12-month exclusionary period on pre-existing health conditions on individual policies except for HMO basic health service plans.	Primary and specialty care, hospital care, and prescription drugs. ***Pre-Existing Health Conditions Covered***	**Both:** Ambulatory Surgery Centers, Nursing, Family planning, EPSDT, Home health services, Inpatient hospital, Lab & X-ray, Dental & vision, Medicare Premium Assistance, Non-Emergency transportation, Outpatient services, and Physician services. **Medicaid:** Retroactive benefits available at the time of application for medical services received three months prior. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Company size 2–50 employees. Owner can count as an employee Proprietor-name on license must draw wages. Eligible employees must work at least 25 hours a week.	**GUARANTEED COVERAGE** **COBRA:** Available for employees who work for employers with 20 or more employees. You have 60 days from date of termination to sign-up. **Mini-COBRA:** Available for employees who work for employers with less than 20 employees. Employee must have been under group coverage for 3 months prior to termination and entitled to unemployment benefits. Ex-employee must sign up for continuation on the earlier of the following: A) In 31 days after the date of termination of coverage, or B) If employer has notified employee of right of continuation prior to date of termination of coverage, then employee must sign-up in 10 days after date of termination of coverage. **HIPAA:** Must have had 18 months of continuous coverage and completely exhausted COBRA or state continuation coverage. Must not have lost coverage due to fraud or non-payment of premiums. You have 63 days to enroll.	Eligibility is based on medical underwriting. Elimination riders are allowed. Must be resident of Ohio and U.S. citizen or documented immigrant.	**GUARANTEED COVERAGE** Must be a U.S. citizen or lawfully present in the U.S with a qualifying pre-existing condition. Must have been uninsured for at least 6 months prior to applying. Must have had a problem getting insurance due to a pre-existing condition.	**GUARANTEED COVERAGE** **Medicaid:** Must be an Ohio resident and a U.S. citizen or qualified alien. Income Limits: Children Ages 0-18: 150% FPL Aged, Blind & Disabled: 65% FPL with asset limit of $1,500 for singles; 83% FPL with asset limit of $2,250 for couples. Workers with Disabilities: 250% FPL, with asset limit of $10,580. Must be 16–64 years old, disabled (as determined by the Social Security Administration, Medicaid or eligible under the Medicaid Buy-In for Workers with Disability medically improved category), and employed (part-time or full-time). **Healthy Families:** Families with Children Ages 0–18: 90% FPL. **Both:** Pregnant Women: 200% FPL
Monthly Cost	Costs depend on employer contribution and ± 35% of the insurance company's index rate.	**COBRA/Mini-COBRA:** 102%–150% of group health rates. **HIPAA:** Premiums will depend on plan chosen.	Various price ranges depending on deductible and what plan you buy. No rate caps, except on standardized products.	$95 to $706 depending on your age, region, and tobacco use.	**Both:** **$0** or minimal share of cost. Workers with disabilities who earn more than 150% FPL must pay premiums which are based on income, family size, and certain standard deductions.

PUBLICLY-SPONSORED PROGRAMS

Demographic	Children	Women with Cancer	Individuals with Genetic Disorders	Seniors & Disabled	Trade Dislocated Workers (TAA Recipients)
Program	**Healthy Start** 800-324-8680 TDD: 800-292-3572 jfs.ohio.gov (Search: Healthy Start) **Women-Infants-Children (WIC)** 614-644-8006 www.odh.ohio.gov (Search: WIC)	**Breast & Cervical Cancer Project (BCCP)** 614-728-2177 (Ohio Department of Health) www.odh.ohio.gov (Search: BCCP)	**Ohio Genetics Program** 614-466-1549 www.odh.ohio.gov (Search: Genetics)	**Medicare** 800-633-4227 www.medicare.gov **Medicare Prescription Drug Program** 800-633-4227	**Health Coverage Tax Credit** 866-628-4282 www.irs.gov (Search: HCTC)
Coverage	**Healthy Start:** Comprehensive care including but not limited to Doctor visits, Prescriptions, Hospital care, Immunizations, Vision and dental care, Substance abuse, Mental health services and more. **WIC:** Nutrition education and services, breastfeeding promotion and education, monthly food prescription of nutritious foods, and maternal, prenatal and pediatric health care services. ***Pre-Existing Health Conditions Covered***	Mammograms, Pap tests, office visits, clinical breast exams, colposcopies, breast ultrasounds, biopsies and other diagnostic procedures. If screened and diagnosed for breast or cervical cancer, patient may be eligible for complete health coverage through Medicaid. ***Pre-Existing Health Conditions Covered***	Ohio Genetics Program is not insurance, but a system of clinics for individuals with genetic illnesses. Genetic services include, but are not limited to, genetic counseling, education, diagnosis and treatment for all genetic conditions and congenital abnormalities.	Offers Part A, inpatient care in hospitals and rehabilitative centers; Part B, doctor and some preventive services and outpatient care; Part C allows Medicare benefits through private insurance (Medicare Advantage); Part C includes Parts A, B, and C not covered by Medicare. Part D covers prescription drugs. ***Pre-Existing Health Conditions Covered***	Inpatient and outpatient care (lab tests, x-rays, etc.), Doctor visits, Preventive and major medical care (surgery, physical therapy, Durable medical equipment, etc.), Mental health and substance abuse care, and Prescription drugs. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** **Healthy Start:** Must be an Ohio resident and a U.S. citizen, qualified alien or lawful permanent resident. Must be one of the following: A) Pregnant women living up to 200% FPL. Babies born to mothers enrolled in Healthy Start become eligible for free health coverage for one full year from the date of birth. B) Children under 19 with family income below 200% FPL. Children with family income between 150% and 200% FPL must be without insurance to become eligible for Healthy Start. C) Certain children 21 years old and younger aging out of the foster care system. **WIC:** Must reside in Ohio. Must be a pregnant or recently pregnant woman, or child up to age 5. Must be determined to be at nutritional risk. Income must be at or below 185% FPL.	**GUARANTEED COVERAGE** Must be an Ohio resident. Must be uninsured with income limit of 200% FPL. For mammograms, must be 50–64 years old. For pelvic and Pap test must be 40–64 years old. Women ages 40–49 can also receive mammograms if indicated by a clinical breast exam, family history or other factors.	Anyone can call and get information regarding genetic disorders. No one is turned away from the genetics clinics for not having insurance. Individuals/families might benefit from genetic services if they have questions about the cause of a medical condition or developmental problem, the chance of the same condition showing up in their children or other relatives, how to prepare for and have a healthy pregnancy, and where to find medical specialists, community resources and parent support groups in their area or nationally.	**GUARANTEED COVERAGE** Must be U.S. citizen or permanent U.S. resident, and: 1) If 65 years or older, you or your spouse worked for at least 10 years in Medicare-covered employment, or 2) You have a disability or end-stage renal disease (permanent kidney failure requiring dialysis or transplant) at any age.	**GUARANTEED COVERAGE** Must be receiving TAA (Trade Adjustment Assistance), or Must be 55 years or older and receiving pension from the Pension Benefit Guaranty Corporation (PBGC). Must not be enrolled in certain state plans, or in prison, or receiving 65% COBRA premium reduction, or be claimed as a dependent in tax returns. Must be enrolled in qualified health plans where you pay more than 50% of the premiums.
Monthly Cost	**Healthy Start: & WIC: $0** or minimal share of cost.	**$0**	There are different costs for the various services at genetics clinics. Most insurance companies and third party payers cover the costs of most services. Those who do not have medical coverage are billed based on their income level.	**$0** and share of cost for certain services; deductibles for certain plans. Part A: $0–$451 based on length of Medicare-covered employment; Part B: $99.90-$319.70 depending on annual income; Part C: Based on provider; Part D: Varies in cost and drugs covered.	**27.5%** of the insurance premium including COBRA premium if employer contributes less than 50%.

PRIVATE HEALTH INSURANCE

Demographic	Small Businesses (2-50 Employees)	Individuals Recently Covered by an Employer Health Plan	Individuals & Families	Individuals with Pre-Existing, Severe, or Chronic Medical Conditions	Low-Income Individuals & Families
Program	**Group Plans** Oklahoma Association of Health Underwriters www.osahu.org **Insure Oklahoma (IO)** 888-365-3742 www.insureoklahoma.org	**COBRA/Mini-COBRA** Contact your current carrier. After 18 months continuous group/COBRA coverage, convert to a plan under: **HIPAA** Health Insurance Portability & Accountability Act 866-487-2365 www.dol.gov (Search: HIPAA)	**Individual Plans** Oklahoma Association of Health Underwriters www.osahu.org **Insure Oklahoma (IO)** 888-365-3742 www.insureoklahoma.org	**Oklahoma Health Insurance High Risk Pool (OKHRP)** 877-885-3717 www.okhrp.org www.bcbsok.com/ohrp **Temporary High Risk Pool** Federal program run by OKHRP 877-885-3717 www.bcbsok.com/ohrp/temp_pool www.PCIP.gov	**SoonerCare** (Medicaid) www.okdhs.org (Search: SoonerCare) **SoonerPlan** www.okhca.org/individuals.aspx?id=176 **Both:** 800-987-7767
Coverage	HMOs cannot look-back at or issue exclusions for pre-existing conditions. Otherwise, there is a maximum 6-month look-back/12-month exclusionary period for pre-existing conditions on enrollees that do not have prior coverage. Benefits will vary depending on the chosen plan. **Insure Oklahoma:** Premium assistance program. Up to 60% of premium costs are paid by the state of Oklahoma. ***Pre-Existing Health Conditions Covered***	**COBRA:** Coverage available for 18–36 months depending on qualifying events. Benefits are what you had with your previous employer. **Mini-COBRA:** Coverage lasts from 63 days to 6 months depending on qualifying events and type of health plan you have. Benefits are what you had with your previous employer. **HIPAA:** Benefits are based on program selected. There is no expiration of coverage. ***Pre-Existing Health Conditions Covered***	There is no limit to look-back/exclusionary periods for pre-existing conditions for other individual coverage products. Benefits will vary depending on the chosen plan. **Insure Oklahoma:** Limited health services subject to medical necessity, such as inpatient hospital services (acute care only), outpatient hospital services, prescription drugs, physician services, etc. ***Pre-Existing Health Conditions Covered with Some Limitations***	**OKHRP:** Lifetime maximum of $1,000,000. Comprehensive coverage of doctor visits, Prescription drugs, Outpatient and in-hospital care, Maternity, Ambulance, Labs and x-rays, Skilled nursing care, Home health visits, Transplants, Rehabilitation, Durable medical equipment, and Mental health and substance abuse, among other services. Applicants are subject to a 12-month pre-existing condition exclusion. **TemporaryHRP:** Primary and specialty care, hospital care, and prescription drugs. ***Pre-Existing Health Conditions Covered***	**SoonerCare:** Family planning, Home health inpatient, Laboratory and x-ray, Nurse-midwife, Nursing facility outpatient, Physician, Ambulatory surgical center, Hearing, Durable medical equipment, Prescription drugs, Prosthetics, Mental health, Rehabilitative services, Transportation services, Dental and vision for some people, and more. Retroactive benefits available at the time of application for medical services received three months prior. **SoonerPlan:** Office visits and physical exams related to family planning. Pregnancy tests, birth control education and supplies, Pap smears, STD screening. For patients age 21 and older, tubal ligations for women and vasectomies for men are offered. Fertility services are not covered. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Company size 2–50 employees (including owner). Eligible employees must work at least 24 hours/week. Eligible employees do not include temporary or substitute employees. **Insure Oklahoma:** Employers must operate in Oklahoma, no more than 99 employees, and be enrolled, or in the process of, enrolling in a qualified health plan. Employees must work for employers participating in Insure Oklahoma, have incomes of 186%–200% FPL, be Oklahoma residents and U.S. citizens or legal permanent residents for at least 5 years, be 19–64 years old, and not in any other state health program. Spouses may be eligible if he or she is unemployed, works full-time for an employer that is eligible for but is not participating in Insure Oklahoma, or works less than 24 hours/week for any size employer.	**GUARANTEED COVERAGE** **COBRA:** Available for employees who work for employers with 20 or more employees. You have 60 days from date of termination to sign-up. **Mini-COBRA:** Available for employees who work for employers with less than 20 employees. Must have been covered under group policy for 6 months prior to termination. Must sign-up and pay for continuation coverage within 63 days after date of termination. **HIPAA:** Must have had 18 months of continuous coverage and completely exhausted COBRA or state continuation coverage. Must not have lost coverage due to fraud or non-payment of premiums. You have 63 days to enroll.	Eligibility is subject to medical underwriting, except for HMO plans. If you are denied coverage for a medical condition, you may be eligible for an Oklahoma Health Insurance High Risk Pool plan or the Temporary High Risk Pool. See next column. **Insure Oklahoma:** Depending on number of employed or self-employed in family, income limit may be 200%–240% FPL. Must be an Oklahoma resident, age 19–64, a U.S. citizen or legal permanent resident for at least 5 years, not be in any state health program, and be employed by an employer that has less than 99 employees and does not participate in the Insure Oklahoma program; or be unemployed and eligible to collect unemployment benefits; or be a disabled adult with a Federal Ticket to Work certificate. Spouses may be eligible if he or she is unemployed, works full-time for an employer that is eligible for but is not participating in Insure Oklahoma, or works less than 24 hours/week for any size employer.	**GUARANTEED COVERAGE** **OKHRP:** Must be a resident of Oklahoma for at least one year and denied coverage by at least two insurance carriers due to pre-existing conditions, or have a qualified medical condition. Must not be eligible for group coverage, COBRA, or government programs (must have exhausted this option). Also qualified, with no requirement for length of residency in Oklahoma, are those eligible for Trade Adjustment Assistance (TAA) or HIPAA plans. **TemporaryHRP:** Must have been uninsured for at least 6 months prior to applying. Must prove being a U.S. citizen or legal U.S. resident, an Oklahoma resident, and having problems getting insurance due to a pre-existing condition.	**GUARANTEED COVERAGE** **Both:** Must be an Oklahoma resident and a U.S. citizen or legal alien who has been in the U.S. at least five years. **SoonerCare:** Aged, Blind & Disabled: Singles earning $739/month with asset limit of $2,000. Couples earning $1,089/month for an eligible individual with an ineligible spouse; couples with both individuals eligible earning $1,093/month. Asset limit of $3,000 for both kinds of couples. Parents/Caretakers Living with Children Ages 0–18: 32% FPL. Pregnant Women & Children Ages 0–18: 185% FPL **SoonerPlan:** Must be over 18 years old, uninsured, not enrolled in SoonerCare, and did not already have surgery that prevents pregnancy. Income limit of 185% FPL.
Monthly Cost	Costs depend on employer contribution and ± 25% of the insurance company's index rate. **Insure Oklahoma:** Employer must pay 25% and employee must pay 15% of the premium costs.	**COBRA/Mini-COBRA:** 102%–150% of group health rates. **HIPAA:** Premiums will depend on plan chosen.	Costs for individual coverage vary. **Insure Oklahoma:** $0-192.42	**OKHRP:** $89 to $2,542 based on age, gender, tobacco use and plan chosen. **TemporaryHRP:** $121 to $704 depending on age and tobacco use.	**Both:** **$0** or share of cost.

PUBLICLY-SPONSORED PROGRAMS

Demographic	Children	Native Americans	Seniors & Disabled	Trade Dislocated Workers (TAA Recipients)	Veterans
Program	**Child & Adolescent Health Clinical Services (CAHCS)** 405-271-4471 cah.health.ok.gov (Search: Clinical Services) **Women-Infants-Children (WIC)** 405-271-4676 888-655-2942 www.ok.gov (Search: WIC)	**Indian Health Services** 405-951-3820 www.ihs.gov/oklahoma	**Medicare** 800-633-4227 www.medicare.gov **Medicare Prescription Drug Program** 800-633-4227 **Senior's Health Insurance Counseling Program (SHIP)** 800-763-2828 405-521-6628 www.ok.gov/oid (Search: SHIP)	**Health Coverage Tax Credit** 866-628-4282 www.irs.gov (Search: HCTC)	**VA Medical Benefits Package** 877-222-8387 www.va.gov www.ebenefits.va.gov
Coverage	**CAHCS:** Well-child care and treatment for minor acute illnesses for children and adolescents ages 0–21. **WIC:** Nutrition education and services, breastfeeding promotion and education, monthly food prescription of nutritious foods, and maternal, prenatal and pediatric health care services. ***Pre-Existing Health Conditions Covered***	The Oklahoma City Area Indian Health Services serves Oklahoma, Kansas, and portions of Texas. Tribes operate their own health programs (such as preventive and behavioral health) and hospitals. There are 8 service units with federally-operated and qualified hospitals, clinics and smaller health stations, providing ambulatory outpatient health care. ***Pre-Existing Health Conditions Covered***	**Medicare** offers Part A, inpatient care in hospitals and rehabilitative centers; Part B, doctor and some preventive services and outpatient care; Part C allows Medicare benefits through private insurance (Medicare Advantage); Part C includes Parts A, B, and C not covered by Medicare. Part D covers prescription drugs. **SHIP** is a Medicare counseling service. ***Pre-Existing Health Conditions Covered***	Inpatient and outpatient care (lab tests, x-rays, etc.), Doctor visits, Preventive and major medical care (surgery, physical therapy, Durable medical equipment, etc.), Mental health and substance abuse care, and Prescription drugs. ***Pre-Existing Health Conditions Covered***	Comprehensive preventive and primary care, outpatient and inpatient services. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** **CAHCS:** Must be age 0–21 years old, uninsured or underinsured for health care services. Income limit of 185% FPL. Services will not be refused based on patient's inability to pay. **WIC:** Must reside in Oklahoma. Must be a pregnant or recently pregnant woman, or child up to age 5, and determined to be at nutritional risk. Income limit of 185% FPL.	**GUARANTEED COVERAGE** Must exhaust all private, state, and other federal programs. Must be regarded by the local community as an Indian; is a member of an Indian or Group under Federal supervision; resides on tax-exempt land or owns restricted property; actively participates in tribal affairs; any other reasonable factor indicative of Indian descent; is a non-Indian woman pregnant with an eligible Indian's child for the duration of her pregnancy through postpartum (usually 6 weeks); is a non-Indian member of an eligible Indian's household and the medical officer in charge determines that services are necessary to control a public health hazard or an acute infectious disease which constitutes a public health hazard.	**GUARANTEED COVERAGE** **Both:** Must be U.S. citizen or permanent U.S. resident, and: 1) If 65 years or older, you or your spouse worked for at least 10 years in Medicare-covered employment, or 2) You have a disability or end-stage renal disease (permanent kidney failure requiring dialysis or transplant) at any age.	**GUARANTEED COVERAGE** Must be receiving TAA (Trade Adjustment Assistance), or Must be 55 years or older and receiving pension from the Pension Benefit Guaranty Corporation (PBGC). Must not be enrolled in certain state plans, or in prison, or receiving 65% COBRA premium reduction, or be claimed as a dependent in tax returns. Must be enrolled in qualified health plans where you pay more than 50% of the premiums. See OKHRP.	**GUARANTEED COVERAGE** "Veteran status" = active duty in the U.S. military, naval, or air service and a discharge or release from active military service under other than dishonorable conditions. Certain veterans must have completed 24 continuous months of service.
Monthly Cost	**CAHCS: $0** for families earning up to 100% FPL. Families with incomes 101%–185% FPL pay fees on a sliding-scale based on family size and income. **WIC: $0** or minimal share of cost.	**$0** or minimal share of cost.	**Medicare: $0** and share of cost for certain services; deductibles for certain plans. Part A: $0–$451 based on length of Medicare-covered employment; Part B: $99.90-$319.70 depending on annual income; Part C: Based on provider; Part D: Varies in cost and drugs covered. **SHIP: $0**	**27.5%** of the insurance premium including COBRA premium if employer contributes less than 50%.	**$0** and share of cost and co-pays depending on income level.

PRIVATE HEALTH INSURANCE

Demographic	Small Businesses (2-50 Employees)	Individuals Recently Covered by an Employer Health Plan	Individuals & Families	Individuals with Pre-Existing, Severe, or Chronic Medical Conditions	Low-Income Adults, Children, & Families
Program	**Group Plans** Oregon Association of Health Underwriters 877-412-6248 www.orahu.org	**COBRA/Mini-COBRA** Contact your current carrier. After 18 months continuous group/COBRA coverage, convert to a plan under: **HIPAA** Health Insurance Portability & Accountability Act 866-487-2365 www.dol.gov (Search: HIPAA) **HIPP** Health Insurance Premium Payment 503-947-7980 www.oregon.gov (Search: Health Insurance Premium Payment) Effective January 1, 2012, the policyholder does not have to be in the same household.	**Individual Plans** Oregon Association of Health Underwriters 877-412-6248 www.orahu.org **Children's Reinsurance Pool** Oregon Association of Health Underwriters 877-412-6248 www.orahu.org	**Oregon Medical Insurance Pool (OMIP)** 503-225-6620 800-848-7280 www.omip.state.or.us **Federal Medical Insurance Pool (FMIP)** Federal program run by OMIP 503-225-6620 800-848-7280 www.PCIP.gov www.oregon.gov (Search: FMIP)	**Oregon Health Plan (OHP)** 503-945-5772 800-527-5772 TTY: 800-375-2863 www.oregon.gov (Search: OHP) **Programs: OHP Standard, OHP Plus, OHP with Limited Drug Benefit**
Coverage	There is a maximum 6-month look-back/12-month exclusionary period for pre-existing conditions on enrollees that do not have prior creditable coverage. Under Oregon law, newborns and adopted children are automatically covered under parents' health plan for the first 31 days, if the plan provides dependent coverage. ***Pre-Existing Health Conditions Covered***	**COBRA:** Benefits are what you had with your previous employer. Coverage available for 18–36 months depending on qualifying events. **Mini-COBRA:** Benefits are what you had with your previous employer. Coverage lasts up to 9 months. **HIPAA:** Benefits are based on program selected. There is no expiration of coverage. **HIPP:** Premium assistance that pays employer-sponsored health insurance or COBRA premiums. The assistance amount depends on the most cost-effective premium available. ***Pre-Existing Health Conditions Covered***	Carriers must guarantee issue portability products to residents with 6 months of prior coverage, and elimination riders are not allowed. Pre-existing conditions may not be considered for portability products. Otherwise, there is no look-back or exclusionary period limit for pre-existing conditions on other kinds of individual policies. **CRP:** Open enrollment anytime for individual plans throughout the year, and no waiting periods for pre-existing conditions.	**OMIP:** Max lifetime benefit is $2 million per covered person. Choose from 4 policy options. In some cases benefits will not be provided during the first six months of enrollment for expenses resulting from a pre-existing condition. **FMIP:** Primary and specialty care, hospital care, and prescription drugs. ***Pre-Existing Health Conditions Covered***	**OHP Standard:** Acupuncture, Chemical dependency, Dental, Emergency/urgent hospital care, Hospice and hospital care, Immunizations, Labor and delivery, Laboratory and x-ray, medical equipment and supplies, Medical transportation, Mental health, Physician care, Podiatry, Prescription drugs, Vision care. Retroactive benefits available at the time of application for medical services received three months prior. **OHP Plus:** Includes OHP Standard benefits, plus hearing aids and hearing aid exams, home health, naturopathy, therapy (occupational, physical and speech) and private duty nursing. **OHP with Limited Drug:** Same benefits as OHP Plus, but no coverage for prescription drugs that Medicare Part D covers. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Company size 2–50 employees. Owner can count as an employee. Proprietor-name on license must draw wages. Eligible employees must work at least 17.5 hours a week for coverage.	**GUARANTEED COVERAGE** **COBRA:** Available for employees who work for businesses with 20 or more employees. You have 60 days from date of termination to sign-up. **Mini-COBRA:** Available for employees who work for employers with less than 20 employees. Must have been continuously covered for 3 months by group insurance prior to termination. Ex-employees must sign up for continuation on the later of the following: A) In 10 days after the date of termination of coverage; or B) In 10 days after date when notice of the right to continue coverage was sent. Ex-employees cannot elect continuation more than 31 days after date of termination of coverage. Surviving/divorced spouses must elect continuation within 60 days after the date of mailing of the notice of the right to continue coverage. **HIPAA:** Must have had 18 months of continuous coverage and completely exhausted COBRA or state continuation coverage. Must not have lost coverage due to fraud or non-payment of premiums. You have 63 days to enroll. **HIPP:** Must qualify for Medicaid and have access to Employer-Sponsored Insurance or COBRA.	Eligibility is subject to medical underwriting. If you are denied coverage for a medical condition, you may be eligible for OMIP or FMIP. See next column. CRP: Must be a child under 19 years old.	**GUARANTEED COVERAGE** **OMIP:** Must be an Oregon resident and have a qualifying medical condition, or denied coverage due to pre-existing conditions, or offered coverage with substantially reduced benefits (e.g. elimination rider). May be eligible if previous coverage was terminated for reasons other than non-payment of premium or fraud. Cannot be eligible for COBRA, or government programs. **FMIP:** Must be a U.S. citizen or lawfully present in the U.S. Must have been uninsured for at least 6 months prior to applying. Must have had a problem getting insurance due to a pre-existing condition.	**GUARANTEED COVERAGE** Must be an Oregon resident and a U.S. citizen or a qualified non-citizen. **OHP Standard:** Parents and childless adults 19 years or older with asset limit of $2,000, earning up to 100% FPL, and not getting Medicare. Must be uninsured for 6 months prior to enrollment (the six-month waiting period is waived in some cases), and paid all previously billed OHP premiums. **OHP Plus:** Aged and disabled singles earning 75% FPL, blind singles earning 78% FPL. Aged and disabled couples earning 83% FPL, blind couples earning 85% FPL. Asset limit for aged, blind and disabled singles is $4,000, and for couples $6,000. Pregnant women earning 185% FPL. Patients receiving TANF or Extended Medical Assistance. **OHP with Limited Drug Benefit:** Must be eligible for both Medicaid and Medicare Part D.
Monthly Cost	Costs depend on plan choice and the modified community rate.	**COBRA/Mini-COBRA:**102%–150% of group health rates. **HIPAA:** Premiums will depend on plan chosen. **HIPP:** Reimburses the full employer-sponsored insurance premium amount by check monthly. Pays the insurance company directly for people on COBRA or eligible small businesses.	Costs depend on age and county. If you are self-employed and buy your own insurance you can deduct 100% of the cost of the premium from your federal income tax.	**OMIP:** $203 to $1,811 for individuals depending on age and plan chosen. **FMIP:** $262 to $826 depending on your age and family size.	**OHP Standard: $9–$20** per month premiums. No co-payments. **OHP Plus & OHP with Limited Drug Benefit: $0** No premiums required from Native Americans and those earning up to 10% FPL.

PUBLICLY-SPONSORED PROGRAMS

Demographic	Women & Children	Families	Cancer Screening for Men & Women	Native American Indians	Trade Dislocated Workers (TAA Recipients)
Program	**Oregon Health Plan Plus (OHP Plus)** 503-378-2666 www.oregon.gov (Search: OHP) OHP Plus includes the no-cost option of Healthy Kids **Healthy Kids** 503-378-2666 800-359-9517 www.oregonhealthykids.gov **Women-infants-children (WIC)** 971-673-0040 www.oregon.gov (Search: WIC)	**Family Health Insurance Assistance Program (FHIAP)** 503-373-1692 888-564-9669 www.fhiap.oregon.gov Program is full for adults, due to budget. Reservation list remains open.	**Oregon Breast and Cervical Cancer Program (BCCP)** 877-255-7070 www.oregon.gov (Search: BCCP)	**Indian Health Services** 503-414-5555 www.ihs.gov (Search: Portland)	**Health Coverage Tax Credit** 866-628-4282 www.irs.gov (Search: HCTC)
Coverage	**OHP Plus/Healthy Kids:** Acupuncture, Chemical dependency, Dental, Emergency/urgent hospital care, Hospice and hospital care, Immunizations, Labor and delivery, Laboratory and x-ray, Medical equipment and supplies, Medical transportation, Mental health, Physician care, Podiatry prescription drugs, Vision care, Hearing aids and Hearing aid exams, Home health, Naturopathy, Occupational therapy, physical therapy, Private duty nursing, and speech therapy. **WIC:** Nutrition education and services, breastfeeding promotion and education, monthly food prescription of nutritious foods, and maternal, prenatal and pediatric health-care services. ***Pre-Existing Health Conditions Covered***	Use FHIAP to buy the private health insurance plan you choose. If an employer-sponsored plan is available then you must use FHIAP assistance to enroll in that plan. Applicants have 75 days to fill out the forms and return them with supporting documents.	Screening for breast and cervical cancer: ultrasounds, breast biopsies, surgical consultations, colonoscopies. Cancer treatment for some women qualified through Medicaid.	The Portland Area Indian Health Service operates six Federal health facilities in five Tribal communities and one at Chemawa Indian School. They operate health centers and stations, preventative health programs and urban programs for the 43 Federally Recognized Tribes in Idaho, Oregon and Washington. Health centers are open 40 hours per week offering a wide range of clinical services. Health stations are open less than 40 hours a week and provide a limited range of clinical services. Preventive programs offer counselor and referral services. ***Pre-Existing Health Conditions Covered***	Inpatient and outpatient care (lab tests, x-rays, etc.), Doctor visits, Preventive and major medical care (surgery, physical therapy, Durable medical equipment, etc.), Mental health and substance abuse care, and Prescription drugs. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** **OHP Plus/Healthy Kids:** Must be an Oregon resident and a U.S. citizen or qualified non-citizen, and 0–18 years old. Must have been uninsured for 2 months (though there are exceptions to this rule for special circumstances, like a parent's job loss or a child's serious medical need). OHP Plus pays for the full premiums for enrollees whose families earn to 200% FPL. Otherwise, those earning 201%–300% FPL will have their premiums subsidized, and those earning 301% FPL or more must pay for the full premium. **WIC:** Must reside in Oregon. Must be a pregnant or recently pregnant woman, or child up to age 5, and determined to be at nutritional risk. Income must be at or below 185% FPL.	**GUARANTEED COVERAGE** Must be an Oregon resident and U.S. citizen or legal immigrant, uninsured for at least 2 months (unless coming off OHP/Medicaid), and have investments and savings less than $10,000 (including rental property). Income limit is 200% FPL. Must not be eligible for or receiving Medicare.	**GUARANTEED COVERAGE** Must be living in Oregon. Must have no insurance or insurance does not cover preventive health exams (e.g. mammograms, etc) or has unmet deductible of at least $500. Income limit of 250% FPL. Women age 40 and older are eligible for annual breast and cervical cancer screenings (clinical breast exam, Pap smears, pelvic exams, mammograms, etc.). Men and women age 40 and under are eligible for breast diagnostic cancer services only if they have symptoms of breast cancer and per approval of BCCP.	**GUARANTEED COVERAGE** Must exhaust all private, state, and other federal programs. Must be regarded by the local community as an Indian; is a member of an Indian or Group under Federal supervision; resides on tax-exempt land or owns restricted property; actively participates in tribal affairs; any other reasonable factor indicative of Indian descent; is a non-Indian woman pregnant with an eligible Indian's child for the duration of her pregnancy through post-partum (usually 6 weeks); is a non-Indian member of an eligible Indian's household and the medical officer in charge determines that services are necessary to control a public health hazard or an acute infectious disease which constitutes a public health hazard.	**GUARANTEED COVERAGE** Must be receiving TAA (Trade Adjustment Assistance), or Must be 55 years or older and receiving pension from the Pension Benefit Guaranty Corporation (PBGC). Must not be enrolled in certain state plans, or in prison, or receiving 65% COBRA premium reduction, or be claimed as a dependent in tax returns. Must be enrolled in qualified health plans where you pay more than 50% of the premiums.
Monthly Cost	**OHP Plus/Healthy Kids:** **$0** for families earning up to 200% FPL. Those earning 201%–300% FPL fees on a sliding scale based on income. Those earning at least 301% FPL pay $165–$475 per child. **WIC:** **$0** or minimal share of cost.	Depending on family size and income, FHIAP pays 50% to 95% of premium. FHIAP pays 100% of premium for children. Enrollees are responsible for co-pays, deductibles and co-insurance.	**$0** and sliding scale share of cost.	**$0** or minimal share of cost.	**20%** of the insurance premium including COBRA premium if employer contributes less than 50%.

Demographic	PRIVATE HEALTH INSURANCE				
	Small Businesses (2-50 Employees)	**Individuals Recently Covered by an Employer Health Plan**	**Individuals & Families**	**Individuals with Pre-Existing, Severe, or Chronic Medical Conditions**	**Low-Income Individuals & Families**
Program	**Group Plans** Pennsylvania Association of Health Underwriters 717-232-0022 www.pahu.org	**COBRA/Mini-COBRA** Contact your current carrier. After 18 months continuous group/ COBRA coverage, convert to a plan under: **HIPAA** Health Insurance Portability & Accountability Act 866-487-2365 www.dol.gov (Search: HIPAA) **HIPP** Health Insurance Premium Payment 800-644-7730 www.dpw.state.pa.us (Search: HIPP)	**Individual Plans** Pennsylvania Association of Health Underwriters 717-232-0022 www.pahu.org	**PA Fair Care** Federal program run by the Pennsylvania Insurance Department 877-881-6388 www.PaFairCare.com www.PCIP.gov **Blue Cross Blue Shield** (Contact your regional carriers) 800-275-2583 www.ibx.com	**Medical Assistance** (Medicaid) 800-692-7462 www.dpw.state.pa.us
Coverage	There is a maximum 6-month look-back and maximum 12-month exclusionary period for pre-existing conditions on enrollees that do not have prior creditable coverage. Benefits will vary depending on the chosen plan. ***Pre-Existing Health Conditions Covered***	**COBRA:** Coverage available for 18–36 months depending on qualifying events. Benefits are what you had with your previous employer. **Mini-COBRA:** Benefits are what you had with your previous employer. Coverage lasts up to 9 months. **HIPAA:** Benefits are based on program selected. There is no expiration of coverage. **HIPP:** Premium assistance that pays employer-sponsored health insurance or COBRA premiums. The assistance amount depends on the most cost-effective premium available. ***Pre-Existing Health Conditions Covered***	Assorted deductible and plan design options available for selection. Elimination riders are allowed, except for HIPAA-eligible individuals. There is a maximum 60-month look-back and maximum 36-month exclusionary period limit for pre-existing conditions on enrollees that do not have prior creditable coverage.	**PA FairCare:** Covers broad range of benefits, including primary and specialty care, hospital care, and prescription drugs. **Blue Cross/Blue Shield:** Plans operating in the state voluntarily serve as the carriers-of-last-resort for people seeking coverage in the individual market through a year-round open enrollment for specified products. Guaranteed issue coverage is available for five counties: Philadelphia, Delaware, Chester, Montgomery, and Buck. There is an exclusion period for pre-existing conditions for 1 year. ***Pre-Existing Health Conditions Covered***	Office visits, Prescription drugs, Immunizations, Vision testing and eyeglasses, Emergency room care, Lab testing and x-rays, Hearing testing and hearing aids, Mental and substance abuse treatment. Retroactive benefits available at the time of application for medical services received three months prior. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Company size 2–50 employees (including owner). Owner name on business license must draw wages from the company. Most small group carriers also require 75% employee participation and accept employees who sign a waiver indicating other coverage as counting towards the 75%. Eligible employees must work at least 17.5 hours a week. Eligible employees do not include temporary, substitute, or seasonal employees.	**GUARANTEED COVERAGE** **COBRA:** Available for employees who work for businesses with 20 or more employees. You have 60 days from date of termination to sign-up. **Mini-COBRA:** Available for employees who work for employers with less than 20 employees. Must have been covered by group insurance continuously for 3 months prior to termination. Must sign-up within 30 days of receiving notice of right to continue coverage. **HIPAA:** Must have had 18 months of continuous coverage and completely exhausted COBRA or state continuation coverage. Must not have lost coverage due to fraud or non-payment of premiums. You have 63 days to enroll. **HIPP:** Must qualify for Medicaid and have access to Employer-Sponsored Insurance or COBRA.	Eligibility is subject to medical underwriting. If you are denied coverage for a medical condition, you may be eligible for guarantee issue through Blue Cross Blue Shield or PA Fair Care. See next column.	**GUARANTEED COVERAGE** **PAFairCare:** Must be a U.S. citizen or lawfully present in the U.S. Must have been uninsured for at least 6 months prior to applying. Must have had a problem getting insurance due to a pre-existing condition. **BlueCross/BlueShield:** Must be a Pennsylvania resident, eligible for a HIPAA individual plan (see HIPAA in "Individuals Recently Covered by an Employer Health Plan" column to the left) and apply to one of BlueCross/BlueShield's designated Individual Traditional Plans within 63 days of losing group coverage.	**GUARANTEED COVERAGE** Must be a U.S. citizen or qualified alien and Pennsylvania resident. Income Limits: Pregnant Women & Infants Ages 0–1: 185% FPL. Children Ages 1–5: 133% FPL. Children Ages 6–18: 100% FPL. Parents/Caretakers Living with Children Ages 0-18: 46% FPL. Aged, Blind & Disabled: Singles and couples living up to 100% FPL, with asset limit of $2,000 for singles and $3,000 for couples. Medically-Needy: Singles earning $425 per month with asset limit of $2,400, and couples earning $442 per month with asset limit of $3,200.
Monthly Cost	Costs depend on employer contribution (also see HIPP) with rate variations allowed up to 300% of the base rate.	**COBRA/Mini-COBRA:** 102%–150% of group health rates. **HIPAA:** Premiums will depend on plan chosen. **HIPP:** Reimburses the full employer-sponsored insurance premium amount by check monthly. Pays the insurance company directly for people on COBRA or eligible small businesses.	Costs for individual coverage vary. There are no rate caps.	**PAFairCare:** About $283 per month, plus additional co-pays and coinsurance. **BlueCross/BlueShield:** Prices based on age and several coverage options, applicant needs etc.	**$0–$3** co-pays. $3–$21 per hospital admission (except in institution for mental diseases).

PUBLICLY-SPONSORED PROGRAMS

Demographic	Children	Women in Need of Cancer Screening	Seniors & Disabled	Trade Dislocated Workers (TAA Recipients)	Veterans
Program	**Children's Health Insurance Plan (CHIP)** 800-986-5437 www.chipcoverspakids.com **Healthy Baby Help Line** 800-986-2229 www.helpinpa.state.pa.us	**Healthy Woman Program** 800-215-7494 www.pahealthywoman.com	**Medicare** 800-633-4227 www.medicare.gov **Medicare Prescription Drug Program** 800-633-4227 **APPRISE** (Medicare Advice) 800-783-7067 www.aging.state.pa.us (Click: Health & Wellness)	**Health Coverage Tax Credit** 866-628-4282 www.irs.gov (Search: HCTC)	**VA Medical Benefits Package** 877-222-8387 www.va.gov www.ebenefits.va.gov
Coverage	**CHIP:** Immunizations, Routine check-ups, Diagnostic testing, Prescription drugs, Dental, Vision, Hearing services, Emergency care, Maternity care, Mental health benefits and up to 90 days hospitalization in any year, Durable medical equipment, Substance abuse treatment, Partial hospitalization for mental health services, Rehabilitation therapies, Home health care. **Healthy Baby:** Provides health insurance assistance information and referral service for pregnant women. ***Pre-Existing Health Conditions Covered***	Screening for breast and cervical cancer. Offers clinical breast exams, mammograms, pelvic examinations and Pap smears, education on breast self-exam, follow-up diagnostic care for an abnormal results. ***Pre-Existing Health Conditions Covered***	**Medicare** offers Part A, inpatient care in hospitals and rehabilitative centers; Part B, doctor and some preventive services and outpatient care; Part C allows Medicare benefits through private insurance (Medicare Advantage); Part C includes Parts A, B, and C not covered by Medicare. Part D covers prescription drugs. **APPRISE** is a Medicare counseling service. ***Pre-Existing Health Conditions Covered***	Inpatient and outpatient care (lab tests, x-rays, etc.), Doctor visits, Preventive and major medical care (surgery, physical therapy, Durable medical equipment, etc.), Mental health and substance abuse care, and Prescription drugs. ***Pre-Existing Health Conditions Covered***	Comprehensive preventive and primary care, outpatient and inpatient services. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** **CHIP:** Child must be under 19, a U.S. citizen or qualified alien and Pennsylvania resident. Must not be eligible for Medical Assistance. For low- or full-cost CHIP, enrollee must be uninsured for 6 months unless the child is under 2 years old, lost health benefits because a parent lost their job, or the child is moving from another public health insurance program. These requirements waived for enrollee eligible for free CHIP. No income limit. **Healthy Baby:** No eligibility requirements. Service is open to all.	**GUARANTEED COVERAGE** Must be Pennsylvania women who are U.S. citizens or qualified aliens, ages 40 to 64. Must have no insurance or limited insurance that does not cover breast and cervical cancer screening services. Must have income below 250% FPL. Not eligible if enrolled in Medicare Part B, Medicaid, or HMOs. Women 65 or older are eligible if not covered by Medicare. Women younger than 40 years old are eligible if they are symptomatic of breast cancer, require follow-up for an abnormal Pap test, or have not been screened in the past five years for cervical cancer.	**GUARANTEED COVERAGE** **Both:** Must be U.S. citizen or permanent U.S. resident, and: 1) If 65 years or older, you or your spouse worked for at least 10 years in Medicare-covered employment, or 2) You have a disability or end-stage renal disease (permanent kidney failure requiring dialysis or transplant) at any age.	**GUARANTEED COVERAGE** Must be receiving TAA (Trade Adjustment Assistance), or Must be 55 years or older and receiving pension from the Pension Benefit Guaranty Corporation (PBGC). Must not be enrolled in certain state plans, or in prison, or receiving 65% COBRA premium reduction, or be claimed as a dependent in tax returns. Must be enrolled in qualified health plans where you pay more than 50% of the premiums.	**GUARANTEED COVERAGE** "Veteran status" = active duty in the U.S. military, naval, or air service and a discharge or release from active military service under other than dishonorable conditions. Certain veterans must have completed 24 continuous months of service.
Monthly Cost	**CHIP:** **$0** monthly premium for each child with incomes up to 200% FPL. $48-$77 monthly premium for families living at 200%–300% FPL, and $200 monthly premium for families living above 300% FPL. Co-payments are $5 to $50. **Healthy Baby:** **$0**	**$0**	**Medicare:** **$0** and share of cost for certain services; deductibles for certain plans. Part A: $0–$451 based on length of Medicare-covered employment; Part B: $99.90-$319.70 depending on annual income; Part C: Based on provider; Part D: Varies in cost and drugs covered. **APPRISE:** **$0**	**27.5%** of the insurance premium including COBRA premium if employer contributes less than 50%.	**$0** and share of cost and co-pays depending on income level.

Demographic	PRIVATE HEALTH INSURANCE				
	Small Businesses (1-50 Employees)	**Individuals Recently Covered by an Employer Health Plan**	**Individuals & Families**	**Individuals with Pre-Existing, Severe, or Chronic Medical Conditions**	**Low-Income Individuals**
Program	**Group Plans** National Association of Health Underwriters 202-552-5060 www.nahu.org	**COBRA/Mini-COBRA** Contact your current carrier. After 18 months continuous group/COBRA coverage, convert to a plan under: **HIPAA** Health Insurance Portability & Accountability Act 866-487-2365 www.dol.gov (Search: HIPAA)	**Individual Plans** National Association of Health Underwriters 202-552-5060 www.nahu.org	**Pre-Existing Condition Insurance Plan (PCIPRI)** Federal program run by Blue Cross Blue Shield of RI 401-351-2583 Out-of-State: 800-505-2583 www.PCIP.gov www.bcbsri.com (Search: Pre-Existing Condition Insurance Plan)	**Medical Assistance** (Medicaid) 401-462-5300 TTY: 401-462-3363 www.dhs.ri.gov (Click: Adults > Health/Medical Services) **Programs:** Medical Assistance, Rhody Health Partners, Connect Care Choice
Coverage	There is a maximum look-back and exclusion period of 6 months for pre-existing conditions on enrollee with no prior coverage. Benefits will vary depending on the chosen plan. ***Pre-Existing Health Conditions Covered***	**COBRA:** Coverage available for 18–36 months depending on qualifying events. Benefits are what you had with your previous employer. **Mini-COBRA:** Coverage lasts up to 18 months. Benefits are the same as what you had with your previous employer. **HIPAA:** Benefits are based on program selected. There is no expiration of coverage. ***Pre-Existing Health Conditions Covered***	Assorted plans depending on medical needs. All carriers must guarantee issue coverage to all individuals with at least 12 months of prior coverage. Except for those with 12 months of prior coverage, there is a 36-month look-back and 12-month exclusionary period for pre-existing conditions. ***Pre-Existing Health Conditions Covered with Some Limitations***	Covers broad range of benefits, including primary and specialty care, hospital care, and prescription drugs. ***Pre-Existing Health Conditions Covered***	Adults who qualify for Medical Assistance must enroll in Rhody Health Partners or Connect Care Choice where they will get all the services currently covered by Medical Assistance. Services include Inpatient and outpatient hospital services, Clinic and emergency room care, Laboratory and x-rays, Pharmacy, Physician and dental services, Durable medical equipment, Surgical appliances, and prosthetic devices, Home health, Podiatry, Ambulance, Community mental health center services, Substance abuse, Nursing facilities, Optometry, Intermediate care facility and day treatment services for the developmentally-challenged, Hospice care, and Organ transplant services. Retroactive benefits available at the time of application for medical services received three months prior. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Company size 1–50 employees (including owner). Owner name on business license must draw wages from the company. Eligible employees must work at least 30 hours a week. They can also work between 17.5 and 30 hours a week as long as this requirement is applied uniformly to all employees. Eligible employees do not include temporary, substitute employees or those who work less than 17.5 hours a week. Any retiree under contract with any independently incorporated fire district is also an eligible employee.	**GUARANTEED COVERAGE** **COBRA:** Available for employees who work for employers with 20 or more employees. Have 60 days from date of termination to sign-up. **Mini-COBRA:** Available for employees who work for employers with less than 20 employees. You have 30 days within date of termination to elect coverage. **HIPAA:** Must have had 18 months of continuous coverage and completely exhausted COBRA or state continuation coverage. Must not have lost coverage due to fraud or non-payment of premiums. You have 63 days to enroll.	Eligibility is subject to medical underwriting. If you are denied for a medical condition, you may be eligible for coverage through PCIPRI. See next column.	**GUARANTEED COVERAGE** Must be a U.S. citizen or lawfully present in the U.S. Must have been uninsured for at least 6 months prior to applying. Must have had a problem getting insurance due to a pre-existing condition. Not enrolled in employer-sponsored coverage, Medicaid, Medicare, or another state or federally-funded program.	**GUARANTEED COVERAGE** **For all:** Must be a U.S. citizen or legal alien and Rhode Island resident. **Rhody Health Partners & Connect Care Choice:** Must be 21 years or older, ineligible for Medicare or other health insurance, and live in the community (at home, in assisted living, or a group home). **Medical Assistance:** Must be at least 18 years old, or aged, blind and disabled, receiving Supplemental Security Income, or have income up to 100% FPL and have resources of less than $4,000 for singles or $6,000 for couples. Medically-Needy: Singles earning $800 per month with asset limit of $4,000, and couples earning $842 per month with asset limit of $6,000. If income is at or above 100% FPL, beneficiaries' medical expenses can be subtracted from their income, making them eligible for Medical Assistance.
Monthly Cost	Costs depend age, gender, and employer contribution. Rates for renewal of insurance are capped at 120%.	**COBRA/Mini-COBRA:** 102%–150% of group health rates. **HIPAA:** Premiums will depend on plan chosen.	Costs for individual coverage vary. There are no rate caps.	$215.49 to $967.53 depending on your age.	**$0** or minimal share of cost.

PUBLICLY-SPONSORED PROGRAMS

Demographic	Moderate Income Children & Families	Adults	Seniors & Disabled	Trade Dislocated Workers (TAA Recipients)	Veterans
Program	**RIteCare/RIteShare** 401-462-5300 www.dhs.ri.gov (Click: Families with Children > Health/Medical Services) **Katie Beckett** 401-462-0633 www.dhs.ri.gov (Click: Children with Special Needs > Health/Medical Services)	**General Public Assistance (GPA)** DHS Info Line 401-462-5300 www.dhs.ri.gov (Click: Adults - General Public Assistance) **Women's Cancer Screening (WCS)** 401-222-4324 401-222-1161 www.health.ri.gov/disease/cancer/women-screening.php	**Medicare** 800-633-4227 www.medicare.gov **Medicare Prescription Drug Program** 800-633-4227 **Senior's Health Insurance Program (SHIP)** 401-462-3000 www.dea.ri.gov/insurance	**Health Coverage Tax Credit** 866-628-4282 www.irs.gov (Search: HCTC)	**VA Medical Benefits Package** 877-222-8387 www.va.gov www.ebenefits.va.gov
Coverage	**RIteCare:** Offers comprehensive coverage through 3 different options. **RIteShare:** Helps families get health insurance coverage through their employer by paying for all or part of the employee's share of the health insurance premium. RIteShare also pays for co-payments in the employer's health insurance plan. **RIteCare:** Offers comprehensive coverage through 3 different options. ***Pre-Existing Health Conditions Covered***	**GPA:** Covers primary care doctors' office visits/health centers visits and most generic prescription medications. **WCS:** Offers pelvic exams, Pap tests, clinical breast exams, and mammograms (breast x-rays) to eligible women. Also covers diagnostic tests and possibly full treatment through Medicaid.	**Medicare** offers Part A, inpatient care in hospitals and rehabilitative centers; Part B, doctor and some preventive services and outpatient care; Part C allows Medicare benefits through private insurance (Medicare Advantage); Part C includes Parts A, B, and C not covered by Medicare. Part D covers prescription drugs. **SHIP** is a Medicare counseling service. ***Pre-Existing Health Conditions Covered***	Inpatient and outpatient care (lab tests, x-rays, etc.), Doctor visits, Preventive and major medical care (surgery, physical therapy, Durable medical equipment, etc.), Mental health and substance abuse care, and Prescription drugs. ***Pre-Existing Health Conditions Covered***	Comprehensive preventive and primary care, outpatient and inpatient services. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** **RIteCare/RIteShare:** Must be Rhode Island residents and U.S. citizens or legal aliens, not covered by health insurance (including Medicaid), be pregnant women or children 0–18 years old with incomes of up to 250% FPL, or be parents with children ages 18 and with incomes up to 175% FPL.	**GUARANTEED COVERAGE** **GPA:** Must be a Rhode Island resident between the ages of 19 and 64. Must have an illness, injury, or medical condition, which is expected to last at least 30 days and prevents you from working. Income at 35% FPL or less, have resources of less than $400 and an automobile with a value of less than $4,650. Must not be eligible for any other federal assistance programs. Must not be pregnant or have a child under 18 living with the applicant. **WCS:** Must be a resident of Rhode Island, have no health insurance coverage for the services provided by the program, have a family income less than 250% FPL and be between 40–64 years old. Women ages 40 and younger may receive services if found to have a palpable lump or a clinical finding of something suspicious for cancer. Women over 65 years old who are in Medicare, but do not have Medicare part B may also be eligible for the program. Undocumented women over 65 years old may be eligible.	**GUARANTEED COVERAGE** **Both:** Must be U.S. citizen or permanent U.S. resident, and: 1) If 65 years or older, you or your spouse worked for at least 10 years in Medicare-covered employment, or 2) You have a disability or end-stage renal disease (permanent kidney failure requiring dialysis or transplant) at any age.	**GUARANTEED COVERAGE** Must be receiving TAA (Trade Adjustment Assistance), or Must be 55 years or older and receiving pension from the Pension Benefit Guaranty Corporation (PBGC). Must not be enrolled in certain state plans, or in prison, or receiving 65% COBRA premium reduction, or be claimed as a dependent in tax returns. Must be enrolled in qualified health plans where you pay more than 50% of the premiums.	**GUARANTEED COVERAGE** "Veteran status" = active duty in the U.S. military, naval, or air service and a discharge or release from active military service under other than dishonorable conditions. Certain veterans must have completed 24 continuous months of service.
Monthly Cost	**RIteShare and RIteCare: $0** for members with incomes at or less than 150% FPL. For members earning 151%–250% FPL, premiums are $61–$92.	**Both: $0** or minimal share of cost.	**Medicare: $0** and share of cost for certain services; deductibles for certain plans. Part A: $0–$451 based on length of Medicare-covered employment; Part B: $99.90-$319.70 depending on annual income; Part C: Based on provider; Part D: Varies in cost and drugs covered. **SHIP: $0**	**27.5%** of the insurance premium including COBRA premium if employer contributes less than 50%.	**$0** and share of cost and co-pays depending on income level.

PRIVATE HEALTH INSURANCE

Demographic	Small Businesses (2-50 Employees)	Individuals Recently Covered by an Employer Health Plan	Individuals & Families	Individuals with Pre-Existing, Severe, or Chronic Medical Conditions	Low-Income Individuals & Families
Program	**Group Plans** South Carolina Association of Health Underwriters www.scahu.org	**COBRA/Mini-COBRA** Contact your current carrier. After 18 months continuous group/ COBRA coverage, convert to a plan under: **HIPAA** Health Insurance Portability & Accountability Act 866-487-2365 www.dol.gov (Search: HIPAA) **HIPP** Health Insurance Premium Payment 803-933-1800 www.scdhhs.gov (Search: HIPP)	**Individual Plans** South Carolina Association of Health Underwriters www.scahu.org	**South Carolina Health Insurance Pool (SCHIP)** 803-788-0500 x46401 (Columbia) 800-868-2500 x46401 (Outside Columbia) doi.sc.gov (Search: SCHIP) **Pre-Existing Condition Insurance Plan (PCIP)** Run by the U.S. Department of Health and Human Services 866-717-5826 www.PCIP.gov www.pciplan.com **Adult Sickle Cell Program** 866-717-5826 www.scdhec.gov (Search: Adult Sickle Cell)	**Healthy Connections** (Medicaid) 888-549-0820 803-898-2500 www.scdhhs.gov
Coverage	There is a maximum look-back period of 6 months and exclusionary period of 12 months for pre-existing conditions on enrollees that do not have prior coverage. Benefits will vary depending on the chosen plan. ***Pre-Existing Health Conditions Covered***	**COBRA:** Coverage available for 18–36 months depending on qualifying events. Benefits are what you had with your previous employer. **Mini-COBRA:** Benefits are what you had with your previous employer. Coverage lasts up to 6 months. **HIPAA:** Benefits are based on program selected. There is no expiration of coverage. **HIPP:** Premium assistance that pays employer-sponsored health insurance or COBRA premiums. The assistance amount depends on the most cost-effective premium available. ***Pre-Existing Health Conditions Covered***	Assorted plans depending on medical needs. There is no limit to the look-back period and there is a maximum exclusion period of 24 months on enrollees with no prior coverage. However, there is a 12-month look-back and exclusionary period limit for pre-existing conditions for HMOs. Elimination riders are permitted. ***Pre-Existing Health Conditions Covered with Some Limitations***	**SCHIP:** Doctor visits, Prescription drugs, Outpatient and in-hospital care, Labs and x-rays, skilled nursing care, Hospice, Home health visits, Transplants, Durable medical equipment, Mental health, Physical, speech and occupational therapy. **PCIP:** Covers broad range of benefits, including primary and specialty care, hospital care, and prescription drugs. **ASCP:** Outpatient Medical services, supplies, equipment, and prescription medications related to sickle cell disease treatment. Care coordination, nursing, nutrition, and social work consultation. ***Pre-Existing Health Conditions Covered***	Hospitalization, Well child/adult appointments, Lab and x-rays, Doctor visits, Vision, Dental, Prescription drugs, Family planning, Medical equipment, Hospice, Ambulance, Transportation, Nursing facility, Inpatient psychiatric care, Home health, Physical and speech therapy, Mental health, Family support services, Case management, Behavioral health, Home and community-based LTC services and more. Also offers intermediate care facilities for the developmentally-challenged. Retroactive benefits available at the time of application for medical services received three months prior. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Company size 2–50 employees. Owner can count as an employee. Owner name on business license must draw wages from the company. Eligible employees must work at least 30 hours a week.	**GUARANTEED COVERAGE** **COBRA:** Available for employees who work for businesses with 20 or more employees. Have 60 days from date of termination to sign-up. **Mini-COBRA:** Available for employees who work for employers with less than 20 employees. Must have had 6 months of group coverage prior to termination. Continuation coverage applies only if group policy or a successor policy remains in force. A successor policy must begin coverage within 62 days after the date of the termination of coverage by the prior insurer. Must pay premium upon or before election to continue coverage. **HIPAA:** Must have had 18 months of continuous coverage and completely exhausted COBRA or state continuation coverage. Must not have lost coverage due to fraud or non-payment of premiums. You have 63 days to enroll. **HIPP:** Must qualify for Medicaid and have access to Employer-Sponsored Insurance or COBRA.	Eligibility is subject to medical underwriting. If you are denied coverage for a medical condition, you may be eligible for SCHIP or PCIP. See next column.	**GUARANTEED COVERAGE** **SCHIP:** Must have resided in South Carolina for at least 30 days. Must have been denied health insurance due to pre-existing health conditions, or offered coverage that excluded pre-existing conditions within the last 12 months, or offered coverage with rates exceeding 150% of the pool rate. These medical and residency requirements are waived for Trade Adjustment Assistance- or HIPAA-eligible individuals. Must prove South Carolina residency within 30 days after acceptance into the pool. **PCIP:** Must have been uninsured for at least 6 months prior to applying. Must prove being a U.S. citizen or legal U.S. resident, a South Carolina resident, and having problems getting insurance due to a pre-existing condition. **ASCP:** Must be a U.S. citizen and a South Carolina resident, age 18 years or older with an income limit of 200% FPL. Must have been diagnosed with sickle cell disease or other congenital hemoglobinopathies.	**GUARANTEED COVERAGE** Must be a U.S. citizen or legal alien and South Carolina resident. Income Limits: Pregnant Women & Infants Ages 0–1: 185% FPL. Children Ages 1–18: 150% FPL. Aged, Blind & Disabled: 100% FPL. Working Disabled: 250% FPL. Family Planning Services: 185% FPL Parents/Caretakers Living with Children Ages 0–18: 91% FPL with resource limit of $30,000. Aged, Blind or Disabled residents of licensed community residential care facilities participating in the Optional State Supplementation Program: $1,157 per month with resources of $2,000 or less. Low-Income Medicare Beneficiaries: 120% FPL.
Monthly Cost	Costs depend on employer contribution and ± 25% of the insurance company's index rate.	**COBRA/Mini-COBRA:** 102%–150% of group health rates. **HIPAA:** Premiums will depend on plan chosen. **HIPP:** Reimburses the full employer-sponsored insurance premium amount by check monthly. Pays the insurance company directly for people on COBRA or eligible small businesses.	Costs for individual coverage vary. There are no rate caps.	**SCHIP:** $326.58 to $4,151.69 depending on plan chosen, age, and gender with deductibles of $500–$1,500 and various co-insurance requirements. **PCIP:** $139 to $596 depending on age and plan chosen. **ASCP:** **$0** or minimal share of cost.	**$0** or minimal share of cost.

PUBLICLY-SPONSORED PROGRAMS

Demographic	Children	Women & Infants	Seniors & Disabled	Trade Dislocated Workers (TAA Recipients)	Veterans
Program	**Partners for Healthy Children (PHC)** 888-549-0820 803-898-2500 (Columbia) www.scdhhs.gov (Search: Partners for Healthy Children) **Children's Rehabilitative Services (CRS)** 803-533-7193 803-898-0784 www.scdhec.gov (Search: CRS)	**Best Chance Network (BCN)** 803-545-4116 www.scdhec.gov (Search: Best Chance Network) **Women-Infants-Children (WIC)** 800 868-0404 803-898-0743 www.scdhec.gov (Search: WIC) **BabyNet** 866-637-6831 800-868-0404 www.scdhec.gov (Search: BabyNet)	**Medicare** 800-633-4227 www.medicare.gov **Medicare Prescription Drug Program** 800-633-4227 **State Health Insurance Assistance Program (SHIP)** (Also known as I-Care) 800-868-9095 aging.sc.gov (Search: SHIP)	**Health Coverage Tax Credit** 866-628-4282 www.irs.gov (Search: HCTC)	**VA Medical Benefits Package** 877-222-8387 www.va.gov www.ebenefits.va.gov
Coverage	**PHC:** All Medicaid covered services. **CRS:** Hospital care, Braces, equipment, Hearing aids, and hearing aid batteries, Medicines and medical supplies, Therapies (speech, physical, occupational), summer camp for children, and other services. ***Pre-Existing Health Conditions Covered***	**BCN:** Mammograms, clinical breast exams, pap tests, pelvic exams, diagnostic procedures, case management, community education on breast/cervical cancer and early detection. **WIC:** Nutrition education and services, breastfeeding promotion and education, monthly food prescription of nutritious foods, and maternal, prenatal, and pediatric health care services. **BabyNet:** Services for infants and toddlers with developmental delays or diagnosed disabilities. ***Pre-Existing Health Conditions Covered***	**Medicare** offers Part A, inpatient care in hospitals and rehabilitative centers; Part B, doctor and some preventive services and outpatient care; Part C allows Medicare benefits through private insurance (Medicare Advantage); Part C includes Parts A, B, and C not covered by Medicare. Part D covers prescription drugs. **SHIP** is a Medicare counseling service. ***Pre-Existing Health Conditions Covered***	Inpatient and outpatient care (lab tests, x-rays, etc.), Doctor visits, Preventive and major medical care (surgery, physical therapy, Durable medical equipment, etc.), Mental health and substance abuse care, and Prescription drugs. ***Pre-Existing Health Conditions Covered***	Comprehensive preventive and primary care, outpatient and inpatient services. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** **PHC:** Must be a U.S. citizen or a legal resident residing in South Carolina, under 19 years old. Income must be at or below 200% FPL and have resources at or below $30,000 per Budget Group. **CRS:** Must be a U.S. citizen or a legal resident residing in South Carolina, under 18 years old, be diagnosed with a disability, chronic illness, or severe developmental delay, with family income up to 250% FPL.	**GUARANTEED COVERAGE** **BCN:** Must be South Carolina women with no insurance or have insurance that only covers hospital care. Must be between 47 and 64 years old, and have incomes at or below 200% FPL. **WIC:** Must reside in South Carolina, be a pregnant or recently pregnant woman, or child up to age 5. Must be determined to be at nutritional risk. Income must be at or below 185% FPL. **BabyNet:** Must be children 0–3 years old who are diagnosed with a physical, emotional, or cognitive condition that will likely result in delay of development.	**GUARANTEED COVERAGE** **Both:** Must be U.S. citizen or permanent U.S. resident, and: 1) If 65 years or older, you or your spouse worked for at least 10 years in Medicare-covered employment, or 2) You have a disability or end-stage renal disease (permanent kidney failure requiring dialysis or transplant) at any age.	**GUARANTEED COVERAGE** Must be receiving TAA (Trade Adjustment Assistance), or Must be 55 years or older and receiving pension from the Pension Benefit Guaranty Corporation (PBGC). Must not be enrolled in certain state plans, or in prison, or receiving 65% COBRA premium reduction, or be claimed as a dependent in tax returns. Must be enrolled in qualified health plans where you pay more than 50% of the premiums.	**GUARANTEED COVERAGE** "Veteran status" = active duty in the U.S. military, naval, or air service and a discharge or release from active military service under other than dishonorable conditions. Certain veterans must have completed 24 continuous months of service.
Monthly Cost	**PHC:** **$0** or minimal share of cost. **CRS:** Medicaid or private insurance is billed for eligible patients.	**BCN & WIC:** **$0** or minimal share of cost. **BabyNet:** **$0** co-payments and deductibles for BabyNet early intervention services.	**Medicare:** **$0** and share of cost for certain services; deductibles for certain plans. Part A: $0–$451 based on length of Medicare-covered employment; Part B: $99.90-$319.70 depending on annual income; Part C: Based on provider; Part D: Varies in cost and drugs covered. **SHIP:** **$0**	**27.5%** of the insurance premium including COBRA premium if employer contributes less than 50%.	**$0** and share of cost and co-pays depending on income level.

PRIVATE HEALTH INSURANCE

Demographic	Small Businesses (2-50 Employees)	Individuals Recently Covered by an Employer Health Plan	Individuals & Families	Individuals with Pre-Existing, Severe, or Chronic Medical Conditions	Low-Income Families
Program	**Group Plans** National Association of Health Underwriters 202-552-5060 www.nahu.org	**COBRA/Mini-COBRA** Contact your current carrier. After 18 months continuous group/COBRA coverage, convert to a plan under: **HIPAA** Health Insurance Portability & Accountability Act 866-487-2365 www.dol.gov (Search: HIPAA)	**Individual Plans** National Association of Health Underwriters 202-552-5060 www.nahu.org	**South Dakota Risk Pool** 605-773-3148 riskpool.sd.gov **Pre-Existing Condition Insurance Plan (PCIP)** Federal program run by the South Dakota Bureau of Personnel 605-773-3148 www.PCIP.gov fedhighriskpool.sd.gov	**South Dakota Medical Assistance** 800-305-3064 www.state.sd.us/social
Coverage	There is a maximum look-back period of 6 months and maximum exclusion period of 12 months for pre-existing conditions on enrollees with no prior coverage. ***Pre-Existing Health Conditions Covered***	**COBRA/Mini-COBRA:** Coverage available for 18–36 months depending on qualifying events. Benefits are what you had with your previous employer. **HIPAA:** Benefits are based on program selected. There is no expiration of coverage. ***Pre-Existing Health Conditions Covered***	There is a maximum look-back and exclusion period of 12 months for pre-existing conditions on enrollees with no prior coverage. ***Pre-Existing Health Conditions Covered with Some Limitations***	**Risk Pool:** Offers four health plan options with similar benefits, including Daily hospital room and board, Miscellaneous hospital services, Surgical services, Anesthesia services, In-hospital medical services, and Out-of-hospital care including pharmaceuticals. **PCIP:** Primary and specialty care, hospital care, and prescription drugs. ***Pre-Existing Health Conditions Covered***	Ambulance, Chiropractor, Clinics, Dental, Orthodontic services, Diabetes education, Durable medical equipment (DME), Family planning, Home health, Hospital, Hysterectomy, Mental health, Nursing home, Out-of-state coverage, Personal care, Physician, Podiatry, Prescriptions, Rehabilitative services, Sterilization, Other transportation services, Vision, wheelchair transportation, and Well-child exams. Retroactive benefits available at the time of application for medical services received three months prior. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Company size 2–50 employees. Owner can count as an employee. Owner name on business license must draw wages from the company. Eligible employees must work at least 30 hours a week. They do not include temporary or substitute employees.	**GUARANTEED COVERAGE** **COBRA:** Available for employees who work for employers with 20 or more employees. Have 60 days from date of termination to sign-up. **Mini-COBRA:** Available for employees who work for employers with less than 20 employees. Must sign-up within 60 days from date of receiving notice of termination of group coverage. Eligibility expires 90 days after date of termination of group coverage. **HIPAA:** Must have had 18 months of continuous coverage and completely exhausted COBRA or state continuation coverage. Must not have lost coverage due to fraud or non-payment of premiums. You have 63 days to enroll.	Eligibility is subject to medical underwriting. If you are denied coverage for a medical condition, you may be eligible for the South Dakota Risk Pool or PCIP. See next column.	**GUARANTEED COVERAGE** **Risk Pool:** Children must be U.S. citizens, ages 0–18, be denied coverage by at least one insurance company, and have been uninsured for 6 months. Adults and children ages 0–18 must be residents of South Dakota, have had at least 12 months of continuous creditable coverage, must have exhausted COBRA or state continuation coverage, and be ineligible for and not enrolled in any other health insurance. Must have lost insurance not due non-payment of premiums or fraud, and apply within 63 days of losing prior coverage, and are near or have reached their lifetime maximum benefit of their insurance carrier. **PCIP:** Must be a U.S. citizen or lawfully present in the U.S. Must have been uninsured for at least 6 months prior to applying. Must have had a problem getting insurance due to a pre-existing condition.	**GUARANTEED COVERAGE** Must be a U.S. citizen or legal alien and South Dakota resident. Income Limits: Pregnant Women: 133% FPL. Children Ages 0–5 133% FPL. Children Ages 6–18: 100% FPL. Parents/Caretakers Living with Children under 19: 52% FPL. Aged, Blind, & Disabled: 75% FPL and asset limit of $2,000 for singles; 83% FPL and asset limit of $3,000 for couples.
Monthly Cost	Costs depend on employer contribution and ± 25% of the insurance company's index rate.	**COBRA/Mini-COBRA:** 102%–150% of group health rates. **HIPAA:** Premiums will depend on plan chosen.	Costs for individual coverage vary. Rates are ±30% of the base individual market rate.	**Risk Pool:** $127 to $1,579 depending on age, gender, tobacco use, and deductible. **PCIP:** $172 to $800 depending on your age and tobacco use.	**$0** or minimal share of cost.

PUBLICLY-SPONSORED PROGRAMS

Demographic	Children	Women in Need of Cancer Screening	Refugees Newly Arriving in U.S.	Native Americans	Seniors & Disabled
Program	**Children's Health Insurance Program (CHIP)** 800-305-3064 dss.sd.gov (Search: CHIP) **Women-Infants-Children (WIC)** 605-773-3361 605-773-3638 doh.sd.gov/WIC	**All Women Count** 800-738-2301 getscreened.sd.gov/count	**South Dakota Medical Assistance** 800-305-3064 www.state.sd.us/social	**Indian Health Services** 605-226-7582 www.ihs.gov (Search: Aberdeen)	**Medicare** 800-633-4227 www.medicare.gov **Medicare Prescription Drug Program** 800-633-4227 **Senior Health Information & Insurance Education (SHIINE)** 800-536-8197 605-333-3314 www.shiine.net
Coverage	**CHIP:** Doctor appointments, Hospital stays, Dental and vision services, Prescription drugs, Mental health care and other medical services. **WIC:** Nutrition education and services, breastfeeding promotion and education, monthly food prescription of nutritious foods, and maternal, prenatal and pediatric health care services. ***Pre-Existing Health Conditions Covered***	Pelvic exams, Pap smears, Clinical breast exams, Mammograms, Some additional diagnostic services ***Pre-Existing Health Conditions Covered***	Covered services include Doctor appointments, Hospital stays, Dental and vision services, Prescription drugs, Rehabilitation, Therapy, and Chiropractic, etc. Coverage is limited to 8 months from the date of the person's entry to the United States. ***Pre-Existing Health Conditions Covered***	Inpatient and outpatient services, Physical therapy, Pediatric, Optometry, Diabetes, Emergency rooms, Specialty care, Medical supplies, Lab & x-ray, Ambulance. ***Pre-Existing Health Conditions Covered***	**Medicare** offers Part A, inpatient care in hospitals and rehabilitative centers; Part B, doctor and some preventive services and outpatient care; Part C allows Medicare benefits through private insurance (Medicare Advantage); Part C includes Parts A, B, and C not covered by Medicare. Part D covers prescription drugs. **SHIINE** is a Medicare counseling service. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** **CHIP:** Must be a U.S. citizen or legal alien and South Dakota resident. Must be children under 19 years old. Uninsured children must have family incomes of up to 200% FPL, and insured children with family incomes of up to 140% FPL. May not be eligible if, 3 months prior to enrollment in CHIP, private health insurance was deliberately dropped in order to qualify for CHIP. The exception is that if the private health insurance was dropped for "good cause" (i.e. children's insurance exceeds 5% of family's gross income; the parent providing primary insurance is fired or laid off; the employer discontinued the insurance). "Good cause" is determined on a case-by-case basis. **WIC:** Must reside in South Dakota, be a pregnant or recently pregnant woman, or a child up to age 5. Must be determined to be at nutritional risk. Income limit of 185% FPL.	**GUARANTEED COVERAGE** Must be a woman living in South Dakota whose income is below 200% FPL. Women ages 30-64 years old are eligible for Pap tests, and women ages 40-64 years old are eligible for mammograms.	**GUARANTEED COVERAGE** Must be a refugee in South Dakota. Income limit is 60% FPL.	**GUARANTEED COVERAGE** Must exhaust all private, state, and other federal programs. Must be regarded by the local community as an Indian; is a member of an Indian or Group under Federal supervision; resides on tax-exempt land or owns restricted property; actively participates in tribal affairs; any other reasonable factor indicative of Indian descent; is a non-Indian woman pregnant with an eligible Indian's child for the duration of her pregnancy through postpartum (usually 6 weeks); is a non-Indian member of an eligible Indian's household and the medical officer in charge determines that services are necessary to control a public health hazard or an acute infectious disease which constitutes a public health hazard.	**GUARANTEED COVERAGE** **Both:** Must be U.S. citizen or permanent U.S. resident, and: 1) If 65 years or older, you or your spouse worked for at least 10 years in Medicare-covered employment, or 2) You have a disability or end-stage renal disease (permanent kidney failure requiring dialysis or transplant) at any age.
Monthly Cost	**CHIP & WIC: $0** or minimal share of cost.	**$0** or minimal share of cost.	**$0** or minimal share of cost.	**$0** or minimal share of cost.	**$0** and share of cost for certain services; deductibles for certain plans. Part A: $0–$451 based on length of Medicare-covered employment; Part B: $99.90-$319.70 depending on annual income; Part C: Based on provider; Part D: Varies in cost and drugs covered. **SHIINE: $0**

Demographic	PRIVATE HEALTH INSURANCE				
	Small Businesses (2-50 Employees)	Individuals Recently Covered by an Employer Health Plan	Individuals & Families	Individuals with Pre-Existing, Severe, or Chronic Medical Conditions	Low-Income Individuals & Families
Program	**Group Plans** Tennessee Association of Health Underwriters www.tnahu.org	**COBRA/Mini-COBRA** Contact your current carrier. After 18 months continuous group/COBRA coverage, convert to a plan under: **HIPAA** Health Insurance Portability & Accountability Act 866-487-2365 www.dol.gov (Search: HIPAA)	**Individual Plans** Tennessee Association of Health Underwriters www.tnahu.org	**AccessTN** 866-268-3786 www.covertn.gov (Click: AccessTN) **Pre-Existing Condition Insurance Plan (PCIP)** Run by U.S. Department of Health and Human Services 866-717-5826 www.PCIP.gov www.pciplan.com	**TennCare** (Medicaid) 800-342-3145 www.tn.gov/tenncare
Coverage	There is a maximum 6-month look-back and a maximum 12-month exclusionary period for pre-existing conditions on enrollees that do not have prior coverage. Benefits will vary depending on the chosen plan. ***Pre-Existing Health Conditions Covered***	**COBRA:** Coverage available for 18–36 months depending on qualifying events. Benefits are what you had with your previous employer. **Mini-COBRA**: Coverage lasts 3–15 months depending on qualifying events. Benefits are what you had with your previous employer. **HIPAA:** Benefits are based on program selected. There is no expiration of coverage. ***Pre-Existing Health Conditions Covered***	Assorted plans depending on medical needs. Elimination riders are allowed. There is no limit to the look-back period, but there is a maximum exclusion period of 24 months for pre-existing conditions on enrollees that do not have prior coverage. ***Pre-Existing Health Conditions Covered with Some Limitations***	**AccessTN:** Three plans with comprehensive health coverage similar to the benefits offered to state employees. Participants will be able to select the plan that is best for their situation. Refer to the benefit plan for more information on covered services. **PCIP:** Primary and specialty care, hospital care, and prescription drugs. ***Pre-Existing Health Conditions Covered***	Inpatient and outpatient hospital services, Prenatal care, Vaccines for children, Physician services, Nursing facility services for persons aged 21 or older, Family planning services and supplies, Rural health clinic services, Home health care for persons eligible for skilled-nursing services, Laboratory and x-ray services, Pediatric and family nurse practitioner services, Nurse/midwife services. Retroactive benefits available at the time of application for medical services received three months prior. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Company size 2–50 employees (including owner). Eligible employees must work at least 30 hours a week, and they do not include part-time, temporary, or substitute employees.	**GUARANTEED COVERAGE** **COBRA:** Available for employees who work for employers with 20 or more employees. You have 60 days from date of termination to sign-up. **Mini-COBRA:** Available for employees who work for employers with less than 20 employees. Must have had 3 months group coverage prior to job termination. You have 31 days from date of termination to sign-up. **HIPAA:** Must have had 18 months of continuous coverage and completely exhausted COBRA or state continuation coverage. Must not have lost coverage due to fraud or non-payment of premiums. You have 63 days to enroll.	Must be a Tennessee resident. Eligibility is subject to medical underwriting. If you are denied coverage for a medical condition, you may be eligible for AccessTN, or PCIP. See next column.	**GUARANTEED COVERAGE** **AccessTN:** Must be a Tennessee resident, U.S. citizen or qualified legal alien and age 64 or younger. Must be uninsurable by medical or insurance determination and have no access to employer-sponsored health insurance at the time of application. Must have been denied by two unaffiliated insurance carriers for individual coverage due to a health-related condition and without coverage for 6 months. **PCIP:** Must have been uninsured for at least 6 months prior to applying. Must prove being a U.S. citizen or legal U.S. resident, a Tennessee resident, and having problems getting insurance due to a pre-existing condition.	**GUARANTEED COVERAGE** Must be located or reside in Tennessee and be U.S. citizens or qualified aliens. Income Limits: Pregnant Women & Infants Ages 0–1: 185% FPL. Children Ages 1–5: 133% FPL. Children Ages 6–19: 100% FPL. Parents Living with Children under 19: 126% FPL. Aged, Blind & Disabled: 75% FPL and asset limit of $2,000 for singles; 83% FPL and asset limit of $3,000 for couples. Individuals living in nursing homes: $2,022 per month.
Monthly Cost	Costs depend on employer contribution and ± 35% of the insurance company's index rate.	**COBRA/Mini-COBRA:** 102%–150% of group health rates. **HIPAA:** Premiums will depend on plan chosen.	Costs for individual coverage vary. There are no rate caps.	**AccessTN:** $284–$1,225 depending on age, weight tobacco use, and plan chosen. **PCIP:** $133 to $571 depending on your age and plan chosen.	**$0** or small share of cost. $0-$100 co-pays (based on income) for prescription drugs.

PUBLICLY-SPONSORED PROGRAMS

Demographic	Children	Women in Need of Cancer Screening	Native Americans	Seniors & Disabled	Trade Dislocated Workers (TAA Recipients)
Program	**TennCare Standard** 866-311-4287 www.tn.gov (Search: TennCare Standard) **TENNderCare** 866-311-4287 www.tn.gov (Search: TENNderCARE) **CoverKids** 866-620-8864 www.coverkids.com	**Breast & Cervical Cancer Screening Program (BCCSP)** 615-532-8494 health.state.tn.us/bcc	**Indian Health Services (IHS)** 615-467-1500 www.ihs.gov/nashville	**Medicare** 800-633-4227 www.medicare.gov **Medicare Prescription Drug Program** 800-633-4227	**Health Coverage Tax Credit** 866-628-4282 www.irs.gov (Search: HCTC)
Coverage	**TennCare Standard:** Same coverage as TennCare. **TENNderCare:** Check-ups that include health history, complete physical exams, lab tests (as needed), immunizations, vision and hearing screening, developmental and behavioral screening (as needed), and counseling on how to keep your child healthy. **CoverKids:** Physician office visits, Hospital care, Prescription drug, Maternity, Routine health assessment and immunizations, Emergency room, Chiropractic care, Ambulance service (air and ground), Lab and x-ray, Physical, speech and occupational therapy,Inpatient and outpatient mental health and substance abuse treatment, Dental, and Vision care. ***Pre-Existing Health Conditions Covered***	Clinical breast exams, mammograms, and Pap tests to screen for breast and cervical cancer. ***Pre-Existing Health Conditions Covered***	The Nashville office serves American Indians in the southern and eastern United States. Two types of services are available: Direct Health Services (services provided at an IHS facility) and Contract Health Services (services that the IHS is unable to provide in its own facilities). CHS are provided by non-IHS health care providers and facilities. For children ages 13-18 years old, the Unity Healing Center the center is a long-term residential facility that focuses on the physical, mental, emotional and spiritual requirements of patients. ***Pre-Existing Health Conditions Covered***	Offers Part A, inpatient care in hospitals and rehabilitative centers; Part B, doctor and some preventive services and outpatient care; Part C allows Medicare benefits through private insurance (Medicare Advantage); Part C includes Parts A, B, and C not covered by Medicare. Part D covers prescription drugs. ***Pre-Existing Health Conditions Covered***	Inpatient and outpatient care (lab tests, x-rays, etc.), Doctor visits, Preventive and major medical care (surgery, physical therapy, Durable medical equipment, etc.), Mental health and substance abuse care, and Prescription drugs. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** **TennCare Standard:** Medicaid-covered children ages 0–18 whose eligibility for and enrollment in Medicaid are ending. Must have no access to group health insurance, and have incomes of up to 200% FPL. If above 200% FPL, then patient must have problems getting health insurance due to a pre-existing medical condition. **TENNderCare:** Children with TennCare up to age 21. **CoverKids:** Must be Tennessee residents and U. S. citizens or qualified aliens. Must either be pregnant women or children ages 0–18. Must have no access to state-sponsored health insurance, and are ineligible for TennCare. Children enrollees must have been uninsured and pregnant women must have had no maternity coverage within the last 3 months prior to enrolling in CoverKids. There is no income limit but anyone making more than 250% FPL must pay full premiums.	**GUARANTEED COVERAGE** Must be women at least age 40 residing in Tennessee with no insurance, or have insurance that do not pay for these services covered by the BCCSP, and with incomes at or below 250% FPL.	**GUARANTEED COVERAGE** Must exhaust all private, state, and other federal programs. Must be regarded by the local community as an Indian; is a member of an Indian or Group under Federal supervision; resides on tax-exempt land or owns restricted property; actively participates in tribal affairs; any other reasonable factor indicative of Indian descent; is a non-Indian woman pregnant with an eligible Indian's child for the duration of her pregnancy through postpartum (usually 6 weeks); is a non-Indian member of an eligible Indian's household and the medical officer in charge determines that services are necessary to control a public health hazard or an acute infectious disease which constitutes a public health hazard.	**GUARANTEED COVERAGE** Must be U.S. citizen or permanent U.S. resident, and: 1) If 65 years or older, you or your spouse worked for at least 10 years in Medicare-covered employment, or 2) You have a disability or end-stage renal disease (permanent kidney failure requiring dialysis or transplant) at any age.	**GUARANTEED COVERAGE** Must be receiving TAA (Trade Adjustment Assistance), or Must be 55 years or older and receiving pension from the Pension Benefit Guaranty Corporation (PBGC). Must not be enrolled in certain state plans, or in prison, or receiving 65% COBRA premium reduction, or be claimed as a dependent in tax returns. Must be enrolled in qualified health plans where you pay more than 50% of the premiums.
Monthly Cost	**TENNderCare & TennCare Standard: $0** or small share of cost. **CoverKids: $0** for families living at or below 250% FPL. Children over 250% start at $268. Up to $341 per month per child. No co-pays are required from federally recognized American Indian or Alaskan Native tribes.	**$0**	**$0** or minimal share of cost.	**$0** and share of cost for certain services; deductibles for certain plans. Part A: $0–$451 based on length of Medicare-covered employment; Part B: $99.90-$319.70 depending on annual income; Part C: Based on provider; Part D: Varies in cost and drugs covered.	**27.5%** of the insurance premium including COBRA premium if employer contributes less than 50%.

PRIVATE HEALTH INSURANCE

Demographic	Small Businesses (2-50 Employees)	Individuals Recently Covered by an Employer Health Plan	Individuals & Families	Individuals with Pre-Existing, Severe, or Chronic Medical Conditions	State Employees & Their Families
Program	**Group Plans** Texas Association of Health Underwriters www.tahu.org **Healthy Texas (HT)** 800-252-3439 www.healthytexasonline.com	**COBRA/Mini-COBRA** Contact your current carrier. After 18 months continuous group/ COBRA coverage, convert to a plan under: **HIPAA** Health Insurance Portability & Accountability Act 866-487-2365 www.dol.gov (Search: HIPAA) **HIPP** Health Insurance Premium Payment 800-440-0493 www.gethipptexas.com	**Individual Plans** Texas Association of Health Underwriters www.tahu.org	**Texas Health Insurance Pool (The Pool)** 888-398-3927 TDD 800-735-2989 www.txhealthpool.org **Pre-Existing Condition Insurance Plan (PCIP)** Run by U.S. Dept. of Health & Human Services 866-717-5826 www.PCIP.gov www.pciplan.com	**Medicaid** In Texas: 2-1-1 877-541-7905 800-252-8263 www.hhsc.state.tx.us/ medicaid **CHIP Perinatal** 800-647-6558, 877-543-7669 www.chipmedicaid.org
Coverage	Coverage varies according to plan. By law all insurers must offer at least one plan that includes coverage for state mandated benefits such as preventive care, mammograms. **HT:** Health insurance program administered by the Texas Department of Insurance (TDI). TDI created a standard benefit package that participating carriers must offer that includes inpatient and outpatient hospital services, maternity, physician services and prescription drugs. Also offered are MultiShare plans, which focus on wellness, primary and preventive care, but do not provide comprehensive health coverage. By law, HT plans are exempt from certain mandated benefit requirements. **Both:** There is a 6-month look-back and 12-month exclusion period for pre-existing conditions. ***Pre-Existing Health Conditions Covered***	**COBRA:** Coverage available for 18–36 months depending on qualifying events. Benefits are what you had with your previous employer. **Mini-COBRA:** Coverage lasts up to 9 months. Benefits are what you had with your previous employer. **HIPAA:** Benefits are based on program selected. There is no expiration of coverage. **HIPP:** Premium assistance that pays employer-sponsored health insurance or COBRA premiums. The assistance amount depends on the most cost-effective premium available. ***Pre-Existing Health Conditions Covered***	There is a maximum look-back period of 60 months and a maximum exclusion period of 24 months for pre-existing conditions on enrollees with no prior coverage. Benefits will vary depending on the chosen plan. ***Pre-Existing Health Conditions Covered***	**The Pool:** Hospitalizations, Physician care, Pregnancy complications, Prescriptions, drugs, Treatment for serious mental health illnesses, and other services. There are 5 plans to choose from including an HSA-Qualified Plan. There is a 12-month waiting period for people with pre-existing health conditions where the policy will not pay any expenses for the condition. If you were covered by creditable coverage in place during the 12 months before your effective date your wait time will be reduced. **PCIP:** Primary and specialty care, hospital care, and prescription drugs. ***Pre-Existing Health Conditions Covered***	**Medicaid:** Acute health care (physician, inpatient, outpatient, pharmacy, lab, and x-ray services), and long-term services and supports for aged and disabled clients. Retroactive benefits available at the time of application for medical services received three months prior. **CHIP Perinatal:** Care before child is born and 12 months after child is enrolled. 20 prenatal visits, prescriptions and prenatal vitamins, labor with delivery of the baby, 2 doctor visits for the mother after the baby is born, and regular check-ups, immunizations and prescriptions for the baby after the baby leaves the hospital. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Eligible employees must work at least 30 hours a week (sole proprietor, a partner, and independent contractor who is included as an employee under a health benefit plan). Does not include temporary, seasonal, or substitute employees. **HT:** Employers must be located in Texas. Must not have offered group insurance 12 months prior to applying for HT, or offered plans with less than $50K annual benefit and contributed less than an average of $50 per employee per month. Employer must offer coverage to employees' dependents. Employees must be U.S. citizens or legal aliens, must work at least 30 hours a week, and may be a sole proprietors, partners or independent contractors. Does not include temporary, seasonal, or substitute employees, or employees already covered by other group health plans (including federal programs or foreign plans). At least 30% of eligible employees must earn at or below 300% FPL. At least 60% of eligible employees must participate in HT.	**GUARANTEED COVERAGE** **COBRA:** Available for employees who work for businesses with 20 or more employees. You have 60 days from date of termination to sign-up. **Mini-COBRA:** Available for employees who work for employers with less than 20 employees. Must elect coverage within 60 days after the date on of receiving notice or right to continue coverage. **HIPAA:** Must have had 18 months of continuous coverage and completely exhausted COBRA or state continuation coverage. Must not have lost coverage due to fraud or non-payment of premiums. You have 63 days to enroll. **HIPP:** Must qualify for Medicaid and have access to Employer-Sponsored Insurance or COBRA.	Eligibility is subject to medical underwriting. If you are denied coverage for a medical condition, you may be eligible for The Pool or PCIP. See next column.	**GUARANTEED COVERAGE** **The Pool:** Must be a Texas resident and U.S. citizen under age 65 (or over age 64 if not eligible for Medicare) and have a qualifying pre-existing condition. Renewable as long as you pay your premiums and continue to reside in Texas and are ineligible for public or employer-based coverage. If one family member qualifies then all are qualified. Must be HIPAA eligible. **PCIP:** Must be a U.S. citizen or lawfully present in the U.S. Must have been uninsured for at least 6 months prior to applying. Must have had a problem getting insurance due to a pre-existing condition.	**GUARANTEED COVERAGE** **Medicaid:** Must be a U.S. citizen or legal permanent resident and live in Texas. Income limits for the following: Pregnant Women & Infants Ages 0–1: 185% FPL. Children Ages 1–5: 133% FPL. Children Ages 6–18 100% FPL. Parents/Caretakers Living with Children Ages 0–18: 26% FPL. Aged, Blind & Disabled: 75% FPL with an asset limit of $2,000 for singles; 83% FPL with asset limit of $3,000 for couples. **CHIP Perinatal:** Must be Texas women who are U.S. citizens or legal permanent residents, pregnant, with incomes up to 200% FPL uninsured, and not eligible for Medicaid.
Monthly Cost	Costs depend on employer contribution and ± 25% of the insurance company's index rate. Renewals are capped at 15% plus trend. **HT:** Employer must pay at least 50% of the premium for employees.	**COBRA/Mini-COBRA:** 102%–150% of group health rates. **HIPAA:** Premiums will depend on plan chosen. **HIPP:** Reimburses the full employer-sponsored insurance premium amount by check monthly. Pays the insurance company directly for people on COBRA or eligible small businesses.	Costs for individual coverage vary.	**The Pool:** $162 to $2,295 depending on health plan chosen, age, gender, tobacco use, and geographic zone. Premium assistance available to those up to 300% FPL. **PCIP:** $133-$572 depending on your age and plan chosen.	**Both:** **$0** or minimal share of cost.

PUBLICLY-SPONSORED PROGRAMS

Demographic	Children	Women in Need of Cancer Screening	Native Americans	Seniors, Disabled & Retirees
Program	**Children's Health Insurance Program (CHIP)** 800-647-6558 877-543-7669 (Texas only) www.chipmedicaid.org **Children with Special Health Care Needs (CSHCN)** 800-252-8023 www.dshs.state.tx.us/cshcn	**Breast & Cervical Cancer Service (BCCS)** 512-458-7796 www.dshs.state.tx.us/bcccs	**Indian Health Services (IHS)** **Albuquerque Office** 505-248-4500 www.ihs.gov (Search: Albuquerque) **Oklahoma City Office** 405-951-3820 www.ihs.gov/oklahoma (Serves portions of Texas)	**Medicare** 800-633-4227 www.medicare.gov **Medicare Prescription Drug Program** 800-633-4227
Coverage	**CHIP:** Dental, Vision, Doctors, Checkups, Office visits, Prescription drugs, Medical specialists, Mental health care, Hospital care and services, Special health needs, Treatment of pre-existing conditions. **CSHCN:** Medical, Dental, Mental health care, Prescription drugs, Special therapies, Case management, Family Support Services, Travel to health care visits, Insurance premiums, Transportation of deceased clients. ***Pre-Existing Health Conditions Covered***	Offers screening services such as clinical breast examinations, mamograms, pap tests, diagnostic services, cervical dysplasia treatment services, and case management. ***Pre-Existing Health Conditions Covered***	Acute, Chronic, Major/Minor illnesses, Disease prevention, Screenings, Nursing, Lab & x-ray, Prescription drugs, Vision, Nutrition, Medical records, behavior health, Dietetics, Diabetes, Environmental health. Specialty care services dependent on funding and are routinely scheduled on a weekly, bi-weekly, or monthly basis. ***Pre-Existing Health Conditions Covered***	Offers Part A, inpatient care in hospitals and rehabilitative centers; Part B, doctor and some preventive services and outpatient care; Part C allows Medicare benefits through private insurance (Medicare Advantage); Part C includes Parts A, B, and C not covered by Medicare. Part D covers prescription drugs. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** **CHIP:** Must be a U.S. citizen or legal permanent resident, age 0–18 and live in Texas. Income limit of 101% to 200% FPL. Must have no health insurance for six months prior to time of application. **CSHCN:** Must be a Texas resident and either be: A) Younger than 21 years old with a chronic physical or developmental condition that will last for at least 12 months; that if not treated may result in disability; that requires health and related services beyond those required by children generally; and the condition must show physically (body, bodily tissue or organ). Condition must not be only a delay in intellectual development or solely a mental, behavioral, or emotional condition. B) A person of any age with cystic fibrosis. Enrollees must keep private health insurance, Medicaid, or CHIP coverage all times. CSHCN is the payer of last resort. It will pay only after private or public insurance has been billed.	**GUARANTEED COVERAGE** Must be a woman living in Texas. Income limit of 200% FPL. Must not be eligible for other programs/benefits providing the same services. Must be uninsured or unable to afford co-payments or deductible. Age Limits for Services: Age 40–64: Breast cancer screening and diagnostic services Age 21–64: Cervical cancer screening Age 18–64: Cervical cancer diagnostic services	**GUARANTEED COVERAGE** Must exhaust all private, state, and other federal programs. Must be regarded by the local community as an Indian; is a member of an Indian or Group under Federal supervision; resides on tax-exempt land or owns restricted property; actively participates in tribal affairs; any other reasonable factor indicative of Indian descent; is a non-Indian woman pregnant with an eligible Indian's child for the duration of her pregnancy through postpartum (usually 6 weeks); is a non-Indian member of an eligible Indian's household and the medical officer in charge determines that services are necessary to control a public health hazard or an acute infectious disease which constitutes a public health hazard.	**GUARANTEED COVERAGE** Must be U.S. citizen or permanent U.S. resident, and: 1) If 65 years or older, you or your spouse worked for at least 10 years in Medicare-covered employment, or 2) You have a disability or end-stage renal disease (permanent kidney failure requiring dialysis or transplant) at any age.
Monthly Cost	**CHIP:** **$0-$50** enrollment fee every year. Co-payments between $3 to $10. **CSHCN:** **$0**	**$0** or minimal share of cost	**$0** or minimal share of cost.	**$0** and share of cost for certain services; deductibles for certain plans. Part A: $0–$451 based on length of Medicare-covered employment; Part B:$99.90-$319.70 depending on annual income; Part C: Based on provider; Part D: Varies in cost and drugs covered.

PRIVATE HEALTH INSURANCE

Demographic	Small Businesses (2-50 Employees)	Individuals Recently Covered by an Employer Health Plan	Individuals & Families	Individuals with Pre-Existing, Severe, or Chronic Medical Conditions	Low-Income Families & Medically-Needy
Program	**Group Plans** Utah Association of Health Underwriters www.uahu.org **Utah's Premium Partnership for Health Insurance (UPP)** 888-222-2542 health.utah.gov/upp	**COBRA/Mini-COBRA** Contact your current carrier. After 18 months continuous group/COBRA coverage, convert to a plan under: **HIPAA** Health Insurance Portability & Accountability Act 866-487-2365 www.dol.gov (Search: HIPAA)	**Individual Plans** Utah Association of Health Underwriters www.uahu.org	**Utah Comprehensive Health Insurance Pool (HIPUtah)** Application Help: 800-705-9173, 801-442-6660 Member Services: 800-538-5038, 801-442-5038 www.selecthealth.org (Search: HIPUtah) www.insurance.utah.gov/hiputah **Federal-HIPUtah** Federal program run by Select Health 800-705-9173 www.PCIP.gov www.selecthealth.org (Search: Federal-HIPUtah)	**Medicaid** 800-662-9651 801- 538-6155 health.utah.gov/medicaid **Medicaid Work Incentive Program (MWI)** www.utah.gov (Search: MWI under "All of Utah.gov") **Both:** 800-662-9651 801-538-6155 **Primary Care Network (PCN)** 888-222-2542 www.health.utah.gov/pcn
Coverage	There is a maximum 6-month look-back/12-month exclusionary period for pre-existing conditions on enrollees that do not have prior coverage. **UPP** is a premium assistance program for adults and children who do not currently have health insurance or COBRA coverage. UPP will help pay for monthly insurance premiums for individuals enrolled in their employer's health insurance plan or COBRA. ***Pre-Existing Health Conditions Covered***	**COBRA:** Coverage available for 18–36 months depending on qualifying events. Benefits are what you had with your previous employer. **Mini-COBRA:** Coverage lasts 12 months. Benefits are what you had with your previous employer. **HIPAA:** Benefits are based on program selected. There is no expiration of coverage. ***Pre-Existing Health Conditions Covered***	Benefits will vary depending on the chosen plan. Elimination riders are permitted. There is a maximum 6-month look-back/12-month exclusionary period for pre-existing conditions on enrollees that do not have prior coverage. No waiting period for children under 19 years old with pre-existing conditions. ***Limits on Pre-Existing Health Conditions May Apply***	**HIPUtah:** Doctor visits, prescription drugs, outpatient and in-hospital care, maternity, ambulance, labs and x-rays, skilled nursing care, hospice, home health visits, transplants, rehabilitation, durable medical equipment, mental health and substance abuse, physical, speech and occupational therapy, and preventive care, among other services. HIPUtah also offers a Premium Assistance Subsidy (PAS) Program. **Fed-HIPUtah:** Primary and specialty care, hospital care, and prescription drugs. ***Pre-Existing Health Conditions Covered***	**Medicaid & MWI:** Inpatient hospital, Outpatient hospital services, Prenatal care, Vaccines for children, Physician, Nursing facility services, Family planning, Rural health clinic services, Home health care for persons eligible for skilled nursing services, Laboratory and x-ray services, Pediatric and family nurse practitioner services, Nurse-midwife services and more. Retroactive benefits available at the time of application for medical services received three months prior. **PCN:** Primary care services, Prescriptions drugs, Dental benefits, Immunizations, Eye exams (no glasses or contact lenses), Lab and x-rays services, Emergency room visits, (restrictions apply), Emergency medical transportation, Birth control, Insulin, Lancets, Test strips, Syringes (for diabetes control and management). ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Company size 2–50 employees. Eligible employees must work at least 30 hours a week. Eligible employees include a business owner or sole proprietor. **UPP:** Must be 0–64 years old, not be covered by other health insurance, be a U.S. citizen or legal resident and live in Utah, be able to get health insurance through employer, have health insurance costs of more than 5% of income. Children ages 0–18 must have incomes up to 200% FPL, and adults 19–64 years old must have incomes up to 150% FPL.	**GUARANTEED COVERAGE** **COBRA:** Available for employees who work for employers with 20 or more employees. You have 60 days from date of termination to sign-up. **Mini-COBRA:** Available for employees who work for employers with less than 20 employees. Must have had at least 3 months of continuous group coverage prior to termination. You have 30 days to sign-up from date of receiving notice of right to continue coverage. **HIPAA:** Must have had 18 months of continuous coverage and completely exhausted COBRA or state continuation coverage. Must not have lost coverage due to fraud or non-payment of premiums. You have 63 days to enroll.	Eligibility is subject to medical underwriting. If you are denied coverage for a medical condition, you may be eligible for HIPUtah or Federal-HIPUtah. See next column.	**GUARANTEED COVERAGE** **HIPUtah:** Previous coverage terminated for reasons other than non-payment of premium or fraud or rejected for coverage within previous 6 months. Cannot be eligible for COBRA, or government programs. Must have resided in Utah for 12 consecutive months immediately preceding the date of application for HIPUtah (the 12-month requirement can be waived if moving from another state's high risk pool). For HIPUtah Premium Assistance, you must earn up to 300% FPL to be eligible for premium discounts of up to 25%. **Fed-HIPUtah:** Must be a U.S. citizen or lawfully present in the U.S. Must have been uninsured for at least 6 months prior to applying. Must have had a problem getting insurance due to a pre-existing condition.	**GUARANTEED COVERAGE** **All:** Must be a U.S. citizen or legal alien and Utah resident. **Medicaid:** Income Limits: Aged, Blind & Disabled: 100% FPL for singles and couples with asset limit of $2,000 for singles and $3,000 for couples. Pregnant Women & Children Ages 0–5: 133% FPL. Children Ages 6–18: 100% FPL. Parents/Caretakers Living with Children Ages 0–18: 4% to 60% FPL. **MWI:** Must be disabled (as determined by Social Security Administration or Utah's Medicaid Disability Office), employed, with income limit of 250% FPL and asset limit of $15,000 (not counting home, vehicle, children's assets, or retirement funds). **PCN:** Must be 19–64 years old, uninsured, ineligible for Medicaid, not have access to student health insurance, Medicare or Veterans' Benefits. Income limit of 150% FPL.
Monthly Cost	Costs depend on employer contribution and ± 30% of the insurance company's index rate. **UPP:** Reimbursed up to $150 per adult and up to $120 per child in the family, every month.	**COBRA/Mini-COBRA:** 102%–150% of group health rates. **HIPAA:** Premiums will depend on plan chosen.	Costs depend on age and county/zone. Rates are ±30% of the indexed individual market rate. The self-employed who buy their own insurance can deduct 100% of the cost of the premium from their federal income tax.	**HIPUtah:** $204 to $1,148 based on age and plan chosen. Deductibles/out-of-pocket expenses range from $500/$2000 to $5,000/$5,000. **Fed-HIPUtah:** $144 to $809 depending on your age and deductible choice.	**Medicaid:** **$0** or small share of cost. **MWI:** **$0** if income is at or below 100% FPL. Up to 15% of income if between 100%-250% FPL. **PCN:** Yearly enrollment fee is $15–$50 based on income. Maximum annual co-pay is $1,000 per person.

PUBLICLY-SPONSORED PROGRAMS

Demographic	Low-Income Children	Adults in Need of Cancer Screening	Native Americans	Trade Dislocated Workers (TAA Recipients)	Veterans
Program	**Children's Health Insurance Program (CHIP)** 877-543-7669 866-435-7414 health.utah.gov/chip **Women-Infants-Children (WIC)** 877-942-5437 www.health.utah.gov/wic	**Utah Cancer Control Program (UCCP)** 800-717-1811 www.cancerutah.org	**Indian Health Services (IHS)** **Navajo Office** 928-871-5811 www.ihs.gov/Navajo **Phoenix Office** 602-364-5039 www.ihs.gov/phoenix	**Health Coverage Tax Credit** 866-628-4282 www.irs.gov (Search: HCTC)	**VA Medical Benefits Package** 877-222-8387 www.va.gov www.ebenefits.va.gov
Coverage	**CHIP:** Well-child exams, Immunizations, Health care provider visits, Prescriptions, Hearing and eye exams, Mental health services, Dental services for prevention and treatment of tooth decay. **WIC:** Nutrition education and services, breastfeeding promotion and education, monthly food prescription of nutritious foods, and maternal, prenatal and pediatric health care services. ***Pre-Existing Health Conditions Covered***	Pap test, Pelvic exam, Clinical breast exam, Instruction on self-breast examination, Mammogram, Colonoscopy, Fecal occult blood test (FOBT), Blood pressure screening, Cholesterol screening, and Glucose testing.	Primary comprehensive care, and Inpatient and outpatient care, Tertiary care and specialty services, Dental services, Behavioral health, Public health nursing, Health education, and Environmental health services are provided. ***Pre-Existing Health Conditions Covered***	Inpatient and outpatient care (lab tests, x-rays, etc.), Doctor visits, Preventive and major medical care (surgery, physical therapy, Durable medical equipment, etc.), Mental health and substance abuse care, and Prescription drugs. ***Pre-Existing Health Conditions Covered***	Comprehensive preventive and primary care, outpatient and inpatient services. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** **CHIP:** Must be a U.S. citizen or legal alien and Utah resident, under 19 years old, not covered by health insurance (including Medicaid), with income up to 200% FPL. **WIC:** Must reside in Utah, be a pregnant or recently pregnant woman, or a child up to age 5, be determined to be at nutritional risk. Income limit of 185% FPL.	**GUARANTEED COVERAGE** Women ages 40-49 may qualify for low-cost screenings related to breast and cervical cancers. Women ages 50-64 with income limit of 250% FPL are eligible for breast, cervical cancer, and cardiovascular screening. Men and women ages 50-64 with income limit of 200% FPL are eligible for colonoscopies and biopsies.	**GUARANTEED COVERAGE** Must exhaust all private, state, and other federal programs. Must be regarded by the local community as an Indian; is a member of an Indian or Group under Federal supervision; resides on tax-exempt land or owns restricted property; actively participates in tribal affairs; any other reasonable factor indicative of Indian descent; is a non-Indian woman pregnant with an eligible Indian's child for the duration of her pregnancy through postpartum (usually 6 weeks); is a non-Indian member of an eligible Indian's household and the medical officer in charge determines that services are necessary to control a public health hazard or an acute infectious disease which constitutes a public health hazard.	**GUARANTEED COVERAGE** Must be receiving TAA (Trade Adjustment Assistance), or Must be 55 years or older and receiving pension from the Pension Benefit Guaranty Corporation (PBGC). Must not be enrolled in certain state plans, or in prison, or receiving 65% COBRA premium reduction, or be claimed as a dependent in tax returns. Must be enrolled in qualified health plans where you pay more than 50% of the premiums.	**GUARANTEED COVERAGE** "Veteran status" = active duty in the U.S. military, naval, or air service and a discharge or release from active military service under other than dishonorable conditions. Certain veterans must have completed 24 continuous months of service.
Monthly Cost	**CHIP:** **$0–$75** every quarter depending on income. No co-pays, premiums or deductibles required from Native Americans. **WIC:** **$0** or minimal share of cost.	**$0**	**$0** or minimal share of cost.	**27.5%** of the insurance premium including COBRA premium if employer contributes less than 50%.	**$0** and share of cost and co-pays depending on income level.

Demographic	PRIVATE HEALTH INSURANCE				
	Small Business (1-50 Employees)	**Individuals Recently Covered by an Employer Health Plan**	**Individuals & Families**	**Individuals with Pre-Existing, Severe, or Chronic Medical Conditions**	**Low-Income Families, Adults & Medically-Needy**
Program	**Group Plans** National Association of Health Underwriters 202-552-5060 www.nahu.org **Employer-Sponsored Insurance (ESI) Premium Assistance** 800-250-8427 www.greenmountaincare.org (Search: ESI)	**COBRA/Mini-COBRA** Contact your current carrier. After 18 months continuous group/ COBRA coverage, convert to a plan under: **HIPAA** Health Insurance Portability & Accountability Act 866-487-2365 www.dol.gov (Search: HIPAA)	**Individual Plans** National Association of Health Underwriters 202-552-5060 www.nahu.org	**Pre-Existing Condition Insurance Plan (PCIP)** Run by the U.S. Department of Health and Human Services 866-717-5826 www.PCIP.gov www.pciplan.com	**Medicaid** 800-250-8427 www.greenmountaincare.org **Vermont Health Access Plan (VHAP)** 800-250-8427 888-834-7898 TTY www.dsw.state.vt.us or www.greenmountaincare.org
Coverage	There is a maximum 6-month look-back/12-month exclusionary period for pre-existing conditions on enrollees that do not have prior coverage. **ESI:** State of Vermont pays a portion of employees' premiums. ***Pre-Existing Health Conditions Covered***	**COBRA:** Coverage available for 18-36 months depending on qualifying events. Benefits are what you had with your previous employer. **Mini-COBRA:** Coverage lasts up to 18 months. Benefits are what you had with your previous employer. **HIPAA:** Benefits are based on program selected. There is no expiration of coverage. ***Pre-Existing Health Conditions Covered***	Benefits will vary depending on the chosen plan. There is a maximum look-back and exclusion period of 12 months on enrollees with no prior coverage. ***Limits on Pre-Existing Health Conditions May Apply***	Primary and specialty care, hospital care, and prescription drugs. ***Pre-Existing Health Conditions Covered***	**Medicaid:** Doctor visits, Prescriptions, Hospital care (including emergency care), Tests, X-rays, Family planning, Mental health services, Substance abuse services, Home health care, Dental care, Eye care, Occupational therapy, physical and speech therapy. **VHAP:** Hospital care, prescription medicines, mental health, and doctor visits. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Company size is 1–50 employees. Owner can count as an employee. Eligible employees must work at least 30 hours a week. **ESI:** Must be Vermont residents, eligible for Catamount Health or the Vermont Health Access Plan (VHAP), and earn up to 300% FPL. Must not yet be enrolled in employer's plan, or employer's plan is not comprehensive insurance (covering hospital care and physician visits), and it is more cost-effective for the state to pay for your premium in your employer's plan than to enroll you in and pay your premium for Catamount Health or VHAP.	**GUARANTEED COVERAGE** **COBRA:** Available for employees who work for employers with 20 or more employees. You have 60 days from date of termination to sign-up. **Mini-COBRA:** Available for employees who work for employers with less than 20 employees. Must elect within 60 days after receiving notice of right to continue coverage. **HIPAA:** Must have had 18 months of continuous coverage and completely exhausted COBRA or state continuation coverage. Must not have lost coverage due to fraud or non-payment of premiums. You have 63 days to enroll.	**GUARANTEED COVERAGE** Eligibility is NOT subject to medical underwriting.	**GUARANTEED COVERAGE** Must have been uninsured for at least 6 months prior to applying. Must prove being a U.S. citizen or legal U.S. resident, a Vermont resident, and having problems getting insurance due to a pre-existing condition.	**GUARANTEED COVERAGE** **Both:** Must be Vermont resident and U.S. citizen or legal alien. **Medicaid:** Income Limits: Children Ages 0 –18: 225% FPL. Pregnant Women: 200% FPL. Aged, Blind, & Disabled Chittenden Residents: $1,033/month for singles and couples. $1,225 for household of 3 and $1,375 for household of 4. Aged, Blind, & Disabled Non-Chittenden Residents: $958/month for singles and couples; $1,150 for household of 3, and $1,300 for household of 4. Asset Limits for Aged, Blind, & Disabled: $2,000 for singles and $3,000 for couples. **VHAP:** Must be at least 18 years old, have been uninsured for at least 12 months (except for those who lost insurance due to divorce or job loss), and have income of 50%–185% FPL.
Monthly Cost	Costs depend on employer contribution and ±30% of the community rate. **ESI:** $60–$205.	**COBRA/Mini-COBRA:** 102%-150% of group health rates. **HIPAA:** Premiums will depend on plan chosen.	Rates set ±20% of the average group rate based on age and gender. If you are self-employed and buy your own insurance you are eligible to deduct 100% of the cost of the premium from your federal income tax.	$148 to $635 depending on your age and plan chosen.	**Medicaid: $0** or small share of cost. No co-payments for children under 21, pregnant women, women in the 60 day post-pregnancy period, and people in nursing facilities. **VHAP: $0–$49** depending on income.

PUBLICLY-SPONSORED PROGRAMS

Demographic	Low-Income Children & Pregnant Women	Women in Need of Cancer Screening	Adults	Seniors & Disabled	Trade Dislocated Workers (TAA Recipients)
Program	**Dr. Dynasaur** (Children's Health Insurance Program) 800-250-8427 www.greenmountaincare.org **Women-Infants-Children (WIC)** 800-649-4357 healthvermont.gov/wic	**Ladies First** 800-508-2222 TDD: 800-319-3141 healthvermont.gov (Search: Women Cancer)	**Catamount Health & Catamount Health with Premium Assistance (CHAP)** 800-250-8427 www.greenmountaincare.org	**Medicare** 800-633-4227 www.medicare.gov **Medicare Prescription Drug Program** 800-633-4227 **State Health Insurance Assistance Program (SHIP)** 800-642-5119 www.medicarehelpvt.net	**Health Coverage Tax Credit** 866-628-4282 www.irs.gov (Search: HCTC)
Coverage	**Dr. Dynasaur:** Doctor visits, Prescription medicines, Dental care, Skin care, Hospital visits, Vision care, Mental health care, Immunizations and Special services for pregnant women, such as lab work and tests, Prenatal vitamins. **WIC:** Nutrition education and services, breastfeeding promotion and education, monthly food prescription of nutritious foods, and access to maternal, prenatal and pediatric health care services. ***Pre-Existing Health Conditions Covered***	Breast, cervical cancer and heart health screenings, mammograms, clinical breast exams, pelvic exams, Pap tests, instruction in breast self-exam, and cardiovascular disease risk factor (cholesterol, high blood pressure, diabetes) screening. Full coverage for some women. ***Pre-Existing Health Conditions Covered***	**Catamount Health:** Doctor visits, Check-ups and screenings, Hospital visits, Emergency care, Chronic disease care, Prescription medicines. **CHAP:** Premium assistance program for Catamount Health enrollees. ***Pre-Existing Health Conditions Covered***	**Medicare** offers Part A, inpatient care in hospitals and rehabilitative centers; Part B, doctor and some preventive services and outpatient care; Part C allows Medicare benefits through private insurance (Medicare Advantage); Part C includes Parts A, B, and C not covered by Medicare. Part D covers prescription drugs. **SHIP** is a Medicare counseling service. ***Pre-Existing Health Conditions Covered***	Inpatient and outpatient care (lab tests, x-rays, etc.), Doctor visits, Preventive and major medical care (surgery, physical therapy, Durable medical equipment, etc.), Mental health and substance abuse care, and Prescription drugs. Can also use funds to purchase coverage through the Blue Cross Blue Shield of Vermont, MVP Health Plans, and GreenMountain Care. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** **Dr. Dynasaur:** Must be U.S. citizen or legal alien and Vermont resident, children 0–18 years old with family incomes of up to 300% FPL or pregnant women with incomes up to 200% FPL. **WIC:** Must reside in Vermont, Must be a pregnant, postpartum or breastfeeding woman, or child up to 5 years old, and be at nutritional risk. Income must be at or below 185% FPL.	**GUARANTEED COVERAGE** Must be Vermont women with income limit of 250% FPL. Age limits for breast and cervical cancer screening: Ages 18–39 with breast cancer symptoms, without Medicaid, VHAP, or Medicare Part B; ages 21–39 with abnormal Pap tests. Age 40 years or older without Medicaid, VHAP, or Medicare Part B: All benefits plus cardiovascular disease screening. In addition, all women who have been screened through Ladies First and need treatment for breast and cervical cancer may be eligible for full Medicaid benefits during treatment, including coverage for pre-malignant conditions.	**GUARANTEED COVERAGE** **Catamount Health:** Must be Vermont residents age 18 or older, ineligible for other Green Mountain Care plans, such as the Vermont Health Access Plan (VHAP), or premium assistance programs, have been uninsured for at least 12 months (except for those who lost coverage though divorce or job loss), or have been enrolled for at least six months in an individual plan with deductibles of $7,500 or more for an individual or $15,000 or more for a family. **CHAP:** Must have been enrolled in Catamount Health for at least 12 months, not have access to comprehensive insurance (covering hospital care and physician visits) through an employer, and have income at or below 300% FPL.	**GUARANTEED COVERAGE** **Medicare & SHIP:** Must be U.S. citizen or permanent U.S. resident, and: 1) If 65 years or older, you or your spouse worked for at least 10 years in Medicare-covered employment, or 2) You have a disability or end-stage renal disease (permanent kidney failure requiring dialysis or transplant) at any age.	**GUARANTEED COVERAGE** Must be receiving TAA (Trade Adjustment Assistance), or Must be 55 years or older and receiving pension from the Pension Benefit Guaranty Corporation (PBGC). Must not be enrolled in certain state plans, or in prison, or receiving 65% COBRA premium reduction, or be claimed as a dependent in tax returns. Must be enrolled in qualified health plans where you pay more than 50% of the premiums. ***Pre-Existing Health Conditions Covered***
Monthly Cost	**Dr. Dynasaur:** Pregnant women $0–$15, and children $0–$60. No premiums required from federally-designated members of Native American tribes. **WIC:** **$0** or minimal share of cost.	**$0**	**Catamount Health:** $453.68 or $512.60 per individual. **CHAP:** $60 to $267 per individual.	**Medicare:** **$0** and share of cost for certain services; deductibles for certain plans. Part A: $0–$451 based on length of Medicare-covered employment; Part B: $99.90-$319.70 depending on annual income; Part C: Based on provider; Part D: Varies in cost and drugs covered. **SHIP:** **$0**	**27.5%** of the insurance premium including COBRA premium if employer contributes less than 50%.

PRIVATE HEALTH INSURANCE

Demographic	Small Businesses (2-50 Employees)	Individuals Recently Covered by an Employer Health Plan	Individuals & Families	Individuals with Pre-Existing, Severe, or Chronic Medical Conditions	Low-Income Individuals & Families
Program	**Group Plans** Virginia Association of Health Underwriters www.vahu.org	**COBRA/Virginia (VA) Continuation & Conversion Plans** Contact your current carrier. After 18 months continuous group/COBRA coverage, convert to a plan under: **HIPAA** Health Insurance Portability & Accountability Act 866-487-2365 www.dol.gov (Search: HIPAA) **HIPP** Health Insurance Premium Payment 800-432-5924, 804-225-4236 portal.virginia.gov (Search: HIPP)	**Individual Plans** Virginia Association of Health Underwriters www.vahu.org	**Pre-Existing Condition Insurance Plan (PCIP)** Run by U.S. Department of Health and Human Services 866-717-5826 www.PCIP.gov www.pciplan.com **Blue Cross Blue Shield** **Anthem** 800-304-0372 anthem.com **Carefirst** 866-520-6099 carefirst.com	**Medicaid, Medicaid Works, & FAMIS Plus** 804-786-6145 www.dmas.virginia.gov/Content_pgs/rcp-home.aspx
Coverage	There is a maximum 6-month look-back and 12-month exclusionary period for pre-existing conditions on enrollees that do not have prior coverage. Benefits will vary depending on the chosen plan. ***Pre-Existing Health Conditions Covered with Some Limitations***	**COBRA:** Coverage available for 18–36 months depending on qualifying events. Benefits are what you had with your previous employer. **VA Continuation & Conversion:** Insurers are required by law to issue group policies that offer either continuation or conversion of a plan. Benefits are what you had with your previous employer. The continuation plan lasts up to 12 months. The conversion plan does not expire. **HIPAA:** Benefits are based on program selected. There is no expiration of coverage. **HIPP:** Premium assistance that pays employer-sponsored health insurance or COBRA premiums. The assistance amount depends on the most cost-effective premium available. ***Pre-Existing Health Conditions Covered***	Plans will vary but insurers are required to offer certain benefits, such as postpartum care and mammograms. There are maximum look-back and exclusion periods of 12 months for pre-existing conditions on enrollees who do not have prior coverage. ***Pre-Existing Health Conditions Covered with Some Limitations***	**PCIP:** Primary and specialty care, hospital care, and prescription drugs. **Blue Cross Blue Shield:** Anthem and Carefirst are insurers of last resort. Insurers are required by law to offer two individual market policies for people who are eligible for HIPAA plans. Availability of plans vary based on residence. Benefits vary based on plan chosen. ***Pre-Existing Health Conditions Covered***	**All:** Inpatient and outpatient hospital care, Emergency care, Physician and nurse midwife services, Health centers, Rural health clinic services, Laboratories and x-ray, Transportation, Family planning, Nursing facilities, Home health services, EPSDT, Rehabilitation, Occupational therapy, Speech, language, and pathology services, Home health services, Hospice, Certified pediatric nurse and family nurse practitioner services, Dental care, Prescription drugs, and much more. Retroactive benefits available at the time of application for medical services received three months prior. **FAMIS Plus:** Also known as Children's Medicaid. Same benefits as Medicaid. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Company size 2–50 employees. Owner can count as an employee. Proprietor-name on license must draw wages. Eligible employees must work at least 30 hours a week and satisfy waiting period requirements. They must not be part-time, temporary or substitute employees.	**GUARANTEED COVERAGE** **COBRA:** Available for employees who work for employers with 20 or more employees. You have 60 days from date of termination to sign-up. **VA Continuation:** Available to employees who work for employers with less than 20 employees. Must have had group coverage continuously for 3 months before termination. Must sign up and pay premium for plan within 31 days of receiving notice of right to either continue or convert plan. Eligibility expires if more than 60 days passed after date of termination. **VA Conversion:** Must sign up and pay premium for plan within 31 days of receiving notice of right to either continue or convert plan. Eligibility expires if more than 60 days have passed after date of termination. **HIPAA:** Must have had 18 months of continuous coverage and completely exhausted COBRA or state continuation coverage. Must not have lost coverage due to fraud or non-payment of premiums. You have 63 days to enroll. **HIPP:** Must qualify for Medicaid and have access to Employer-Sponsored Insurance or COBRA.	Medical underwriting will determine eligibility. If you are denied coverage for a medical condition, you may be eligible for coverage through Blue Cross Blue Shield or PCIP. See next column.	**GUARANTEED COVERAGE** **PCIP:** Must have been uninsured for at least 6 months prior to applying. Must prove being a U.S. citizen or legal U.S. resident, a Virginia resident, and having problems getting insurance due to a pre-existing condition. **Blue Cross Blue Shield:** Must be HIPAA-eligible, see "Individuals Recently Covered by an Employer Health Plan."	**GUARANTEED COVERAGE** **All:** Must be U.S. citizen or qualified alien and Virginia resident. **Medicaid:** Income Limits: Pregnant Women: 133% FPL Parents/Caretakers Living with Children Ages 0–18: 31% FPL Aged, Blind & Disabled: 80% FPL for singles and couples. Asset limit of $2,000 for singles and $3,000 for couples. Medically-Needy: Monthly income limit from $281.28 to $427.92 for singles, and $363.24 to $515.96 for couples. Asset limit of $2,000 for singles and $3,000 for couples. **Medicaid Works:** Must be blind or disabled and enrolled in Medicaid, are employed, annual earnings in 2012 as high as $45,468 and resources up to $34,272. Must be ages 16–64, employed, and open and deposit into a Work Incentive Account (WIN), which is a regular bank account. **FAMIS Plus:** Income Limits: Children under 19: 133% FPL
Monthly Cost	Costs depend on employer contribution and for standardized plans, ± 25% of the insurance company's index rate.	**COBRA/VA Continuation:** 102%–150% of group health rates. **HIPAA/VA Conversion:** Premiums will depend on plan chosen. **HIPP:** Reimburses the full employer-sponsored insurance premium amount by check monthly. Pays the insurance company directly for people on COBRA or eligible small businesses.	Costs depend on plan selected.	**PCIP:** $93 to $401 depending on your age and plan chosen. **Blue Cross Blue Shield:** Varies based on age and gender.	**Medicaid: $0–$1** co-pays per office visit, and $5 for non-emergency visits in ER. **Medicaid Works: $0** **FAMIS Plus: $0**

PUBLICLY-SPONSORED PROGRAMS

Demographic	Children In Moderate Income Families	Women in Need of Cancer Screening	Individuals with Life-Threatening Illness or Injury	Trade Dislocated Workers (TAA Recipients)	Veterans
Program	**Family Access to Medical Insurance Security (FAMIS)** 866-873-2647 888-221-1590 (TDD) www.famis.org **Women-Infants-Children (WIC)** 888-942-3663 www.vahealth.org (Search: WIC)	**Every Woman's Life** 866-395-4968 866-864-8204 www.vahealth.org/ewl	**Uninsured Medical Catastrophe Fund (UMCF)** 800-432-5924 portal.virginia.gov (Search: UMCF)	**Health Coverage Tax Credit** 866-628-4282 www.irs.gov (Search: HCTC)	**VA Medical Benefits Package** 877-222-8387 www.va.gov www.ebenefits.va.gov
Coverage	**FAMIS:** Doctor visits, Well-baby checkups, Hospital visits, Vaccinations, prescription medicine, Tests and x-rays, Dental care, Emergency care, Vision care, and Mental health care. **WIC:** Nutrition education and services, breastfeeding promotion and education, monthly food prescription of nutritious foods, and maternal, prenatal and pediatric health care services. ***Pre-Existing Health Conditions Covered***	Mammograms, clinical breast exams, Pap tests and pelvic exams. If screened and diagnosed for breast or cervical cancer, may be eligible for free treatment by Medicaid. ***Pre-Existing Health Conditions Covered***	Inpatient and outpatient hospital services and surgical centers, ambulatory care, laboratory and x-ray, physician, ambulatory care, medical care furnished by licensed practitioners, prescribed drugs and rehabilitative services to recover from medical treatment. The only organ and tissue transplant procedures covered are for kidneys, liver, heart, lung, and bone marrow. ***Pre-Existing Health Conditions Covered***	Inpatient and outpatient care (lab tests, x-rays, etc.), Doctor visits, Preventive and major medical care (surgery, physical therapy, Durable medical equipment, etc.), Mental health and substance abuse care, and Prescription drugs. ***Pre-Existing Health Conditions Covered***	Comprehensive preventive and primary care, outpatient and inpatient services. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** **FAMIS:** Must be a U.S. citizen or legal resident alien and Virginia resident, under age 19, with family income up to 200% FPL, have had no health insurance for at least 4 months (with some exceptions), not eligible for any Virginia state employee health insurance plan, or for FAMIS Plus (Children's Medicaid). **WIC:** Must live in Virginia, be a pregnant or recently pregnant woman, or child up to age 5, and determined to be at nutritional risk. Income must be at or below 185% FPL.	**GUARANTEED COVERAGE** Must be women, ages 40– 64, and Virginia residents. Must be uninsured or unable to afford to insurance deductible, or have insurance that does not cover screening exams, and income must be up to 200% FPL Women ages 18–39 can also be eligible if they have symptoms of breast cancer or have abnormal Pap test results.	**GUARANTEED COVERAGE** Must be a U.S. citizen or legal resident alien and Virginia resident, and have income up to 300% FPL. Must have a life threatening illness or injury, be uninsured for the needed treatment and not eligible for it through private health insurance or federal, state, or local government medical assistance programs. Must provide a medical treatment plan certified by your treating physician and treatment must not be open-ended and last less than 12 months. Must find a provider willing to accept the global fee established for the medical treatment plan.	**GUARANTEED COVERAGE** Must be receiving TAA (Trade Adjustment Assistance), or Must be 55 years or older and receiving pension from the Pension Benefit Guaranty Corporation (PBGC). Must not be enrolled in certain state plans, or in prison, or receiving 65% COBRA premium reduction, or be claimed as a dependent in tax returns. Must be enrolled in qualified health plans where you pay more than 50% of the premiums.	**GUARANTEED COVERAGE** "Veteran status" = active duty in the U.S. military, naval, or air service and a discharge or release from active military service under other than dishonorable conditions. Certain veterans must have completed 24 continuous months of service.
Monthly Cost	**FAMIS: $2–$5** co-pays, **$0** for well-child and well-baby check-ups. **WIC: $0** or minimal share of cost.	**$1** per visit.	**$0** or minimal share of cost.	**27.5%** of the insurance premium including COBRA premium if employer contributes less than 50%.	**$0** and share of cost and co-pays depending on income level.

Demographic	PRIVATE HEALTH INSURANCE				
	Small Businesses (1-50 Employees)	**Individuals Recently Covered by an Employer Health Plan**	**Individuals & Families**	**Individuals with Pre-Existing, Severe, or Chronic Medical Conditions**	**Low-Income Individuals & Families**
Program	**Group Plans** Washington Association of Health Underwriters 206-623-8632 www.wahu-online.org	**COBRA** Contact your current carrier. After 18 months continuous group/COBRA coverage, convert to a plan under: **HIPAA** Health Insurance Portability & Accountability Act 866-487-2365 www.dol.gov (Search: HIPAA)	**Individual Plans** Washington Association of Health Underwriters 206-623-8632 www.wahu-online.org	**Washington State Health Insurance Pool (WSHIP)** 800-877-5187 www.wship.org **Pre-Existing Condition Insurance Plan (PCIP)** Federal program run by the WSHIP 877-505-0514 www.wship.org/PCIP-WA www.PCIP.gov	**Medicaid & Health Care for Workers with Disabilities (HWD)** 206-272-2169 800-562-3022 hrsa.dshs.wa.gov **Healthy Options** (Medicaid Managed Care Program) 800-562-3022 TTD: 800-848-5429 maa.dshs.wa.gov/HealthyOptions
Coverage	Benefits will vary depending on the chosen plan. There is a maximum look-back period of 6 months and maximum exclusion period of 9 months for pre-existing conditions on enrollees who do not have prior coverage. ***Pre-Existing Health Conditions Covered***	**COBRA:** Available for 18–36 months depending on qualifying events. Benefits are what you had with your previous employer. **HIPAA:** Benefits are based on program selected. There is no expiration of coverage. ***Pre-Existing Health Conditions Covered***	Benefits will vary depending on the chosen plan. Elimination riders are not permitted. There is a maximum look-back period of 6 months and maximum exclusion period of 9 months for pre-existing conditions on enrollees who do not have prior coverage. ***Limits on Pre-Existing Health Conditions May Apply***	**WSHIP:** No maximum lifetime benefits. Choose from Medicare and non-Medicare plans. There is a 6-month pre-existing condition exclusion period. Exceptions apply (if applicant signs up through a portability policy). **PCIP:** Primary and specialty care, hospital care, and prescription drugs. ***Pre-Existing Health Conditions Covered***	**Medicaid & HWD:** Physician services, Checkups (medical and dental), Family planning, Maternity, Prenatal, and newborn care, Prescriptions, Mental health, Hospital services, Comfort care, Hospice, Dental services, Drug and alcohol treatment, Eye glasses, Hearing aids. Retroactive benefits available at the time of application for medical services received three months prior. **Healthy Options:** Prepaid, comprehensive system of medical and health care delivery, including preventive, primary, specialty and ancillary health services. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Company size 1–50 eligible employees. Eligible employees must work at least 30 hours a week. Owner can count as an employee with proprietor. Name on license must draw wages. Limits on insurance carriers' participation requirements: No more than 100% of eligible employees in groups with 3 or less employees. No more than 75% of eligible employees working for groups with 4 or more employees.	**GUARANTEED COVERAGE** **COBRA:** Available for employees who work for businesses with 20 or more employees. You have 60 days from date of termination to sign-up. **HIPAA:** Must have had 18 months of continuous coverage and completely exhausted COBRA or state continuation coverage. Must not have lost coverage due to fraud or non-payment of premiums. You have 63 days to enroll.	There is limited medical underwriting on enrollees. If you are denied coverage for a medical condition, you may be eligible for WSHIP or PCIP. See next column.	**GUARANTEED COVERAGE** **WSHIP:** Must be a Washington resident. Must have been rejected for coverage by an insurance carrier. Cannot have any other health coverage. Individuals who are eligible for Medicare may qualify for the WSHIP Medicare plan. Not eligible if you have terminated coverage in WSHIP within the last 12 months, unless you have been involuntarily terminated for any reason other than non-payments or premiums or WSHIP has paid out $2,000,000 in benefits on your behalf. **PCIP:** Must be a U.S. citizen or lawfully present in the U.S. Must have been uninsured for at least 6 months prior to applying. Must have had a problem getting insurance due to a pre-existing condition.	**GUARANTEED COVERAGE** **Medicaid:** Must be Washington residents and U.S. citizens or legal aliens. Income Limits: Pregnant Women: 185% FPL. Aged, Blind, & Disabled: Singles with incomes of up to 75% FPL and asset limit of $2,000 , and couples with incomes up to 83% FPL and asset limit of $3,000. Parents/Caretakers Living with Children Ages 0–18: 73% FPL. Children Ages 0–18: 200% FPL. **HWD:** Must be ages 16 to 64, meet federal disability requirements, self-employed or employed full or part time, earning up to 220% FPL. **Healthy Options:** Must be one of the following: 1) Receiving Temporary Assistance for Needy Families (TANF); 2) Ineligible for cash assistance, children ages 0 -18, or pregnant women eligible for Medicaid; 3) Children eligible for Apple Health for Kids (see "Children" column).
Monthly Cost	The rating between the highest rate and lowest rate for the community cannot exceed 375%.	**COBRA:** 102%–150% of group health rates. **HIPAA:** Premiums will depend on plan chosen.	Costs based on age, geography, wellness, family size and tenure in the plan. If you are self-employed and buy your own insurance you are eligible to deduct 100% of the cost of the premium from your federal income (your taxable income).	**WSHIP:** $184 to $2,609 depending on age, tobacco use, deductible, and plan chosen. **PCIP:** $203 to $1,805 depending on your age, tobacco use, and deductible choice.	**Medicaid & Healthy Options: $0** or minimal share of cost. **HWD:** Monthly premium of 7.5% or less of income.

PUBLICLY-SPONSORED PROGRAMS

Demographic	Individuals & Families	Children	Cancer Screening for Men & Women	Native Americans	Seniors & Disabled
Program	**Washington Basic Health Plan (BH)** 800-660-9840 www.basichealth.hca.wa.gov (Basic Health is no longer processing applications. There is now a waiting list for applicants, with some exceptions.) **Washington Prescription Drug Discount Card (WPPD)** 877-208-1131, 800-913-4146 www.rx.wa.gov	**Apple Health for Kids** 877-543-7669 800-562-3022 hrsa.dshs.wa.gov/applehealth **Women-Infants-Children (WIC)** 800-841-1410 www.doh.wa.gov/cfh/wic	**Breast, Cervical & Colon Health Program (BCCHP)** **Susan G. Komen for the Cure** **Both:** 888-438-2247 www.doh.wa.gov (Search: Breast, Cervical, Colon Health Program)	**Indian Health Services (IHS)** 503-326-2020 503-414-5555 (Portland-based) www.ihs.gov (Search: Portland) **Seattle Indian Health Board (SIHB)** 206-324-9360 www.sihb.org	**Medicare** 800-633-4227 www.medicare.gov **Medicare Prescription Drug Program** 800-633-4227
Coverage	**BH:** Preventive care, Office visits, pharmacy, Emergency services, Urgent care, Skilled nursing, Hospice, Home health care, Maternity, Oxygen, Inpatient and outpatient hospital care, Mental health, Laboratory, Radiology, Ambulance Services, Chiropractic/ physical therapy, Chemical dependency, and Organ transplants. Providers are Columbia United Providers, Community Health Plan of Washington, Group Health Cooperative, and Molina. There is a waiting period of 9 to 12 months for treatment of pre-existing conditions, except services for children up to age 19, maternity care, prescription drugs, and routine diabetic care. **WPDD:** Prescription drug discounts. ***Pre-Existing Health Conditions Covered***	**Apple Health:** Ambulance, urgent or emergent care, Eye exams, Well-child checkups, Home health care, Hospital care, Immunizations (shots), Lab services, Maternity care, Medical supplies & equipment, Office visits, Respiratory therapy, Prescription drugs, Physical therapy, Occupational therapy, Speech therapy, Surgery, Specialty care, X-ray, Dental. **WIC:** Nutrition education and services, breastfeeding promotion and education, monthly food prescription of nutritious foods, and access to maternal, prenatal and pediatric health care services. ***Pre-Existing Health Conditions Covered***	**BCCHP:** Clinical breast exams, mammograms, pap tests, pelvic exams, services related to treatment for breast or cervical cancer, case management services, and colorectal cancer screening for women. Colorectal cancer screening for men. **Susan G. Komen for the Cure:** Breast cancer screening for women.	**IHS:** Ambulatory primary care, Public health, Dental services, Mental health and substance abuse, Optometry, Audiology, Internal medicine, Women's health care, Elder care clinic and pediatrics, and In-patient services at local private hospital facility. **SIHB:** Multi-service non-profit community health center serving urban Indians living in the greater Seattle-King County area. ***Pre-Existing Health Conditions Covered***	**Medicare** offers Part A, inpatient care in hospitals and rehabilitative centers; Part B, doctor and some preventive services and outpatient care; Part C allows Medicare benefits through private insurance (Medicare Advantage); Part C includes Parts A, B, and C not covered by Medicare. Part D covers prescription drugs. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** **BH:** Must be Washington resident, age 19-64 years old and earning up to 200% FPL. Must not be one of the following: eligible for Medicare, receiving Medicaid, institutionalized, attending school full-time in the U.S. on a student visa, or be enrolled in the Washington Health Program. There is no waiting list for the following, if eligible: Foster parents, personal care workers, beneficiaries of Health Coverage Tax Credit (HCTC), tribally-sponsored accounts, Washington National Guard or Reserves who served in Operation Enduring Freedom, Iraqi Freedom, or Noble Eagle, Basic Health Plus and Maternity applicants sent to Dept. of Social and Health Services (DSHS) and were ineligible for DSHS programs, and former BH Plus and Maternity members who notified BH within 30 days after losing their Medicaid coverage. **WPDD:** Each person must enroll individually and be a Washington resident. No income or age requirements.	**GUARANTEED COVERAGE** **Apple Health:** Must be a Washington resident and U.S. citizen or qualified non-citizen, under 19 years old, not covered by health insurance (including Medicaid). Family incomes must be at or below 300% FPL. **WIC:** Must reside in Washington, be a pregnant or recently pregnant woman, infant or child up to age 5, determined to be at nutritional risk, and must have income at or below 185% FPL.	**GUARANTEED COVERAGE** **BCCHP:** Must be uninsured or underinsured, have income up to 250% FPL and be women ages 40 to 64 years, or men ages 50 and 64 years old. There are limited openings for women ages 35 to 39 years old with breast symptoms. **Susan G. Komen for the Cure:** Must be women ages 18 to 34 years old with breast symptoms, earn up to 300% FPL. Or, must be women ages 35 to 64 years old, earn up to 251% to 300% FPL, and be either uninsured or underinsured.	**GUARANTEED COVERAGE** **IHS:** Must exhaust all private, state, and other federal programs. Must be regarded by the local community as an Indian; is a member of an Indian or Group under Federal supervision; resides on tax-exempt land or owns restricted property; actively participates in tribal affairs; any other reasonable factor indicative of Indian descent; is a non-Indian woman pregnant with an eligible Indian's child for the duration of her pregnancy through postpartum (usually 6 weeks); is a non-Indian member of an eligible Indian's household and the medical officer in charge determines that services are necessary to control a public health hazard or an acute infectious disease which constitutes a public health hazard. **SIHB:** Services are open to anyone. Some programs may have limited openings or contract restrictions. Patients must first register before receiving service.	Must be U.S. citizen or permanent U.S. resident, and: 1) If 65 years or older, you or your spouse worked for at least 10 years in Medicare-covered employment, or 2) You have a disability or end-stage renal disease (permanent kidney failure requiring dialysis or transplant) at any age.
Monthly Cost	**BH:** Premiums vary depending on plan chosen. $1,500 annual out-of-pocket maximum. **WPDD:** **$0**	**Apple Health:** **$0–$30** depending on income. $98-$196 for families of non-federally-qualified children. Families of federally-qualified children pay no more than $60. **WIC:** **$0** or minimal share of cost.	**Both:** **$0** or minimal share of cost.	**IHS:** **$0** or minimal share of cost. **SIHB:** Fees based on services given. Accepts public and private insurances. Fee discounts based on family size and income. To get discount, patients must first complete application for discount and prove income and family size.	**$0** and share of cost for certain services; deductibles for certain plans. Part A: $0–$451 based on length of Medicare-covered employment; Part B: $99.90-$319.70 depending on annual income; Part C: Based on provider; Part D: Varies in cost and drugs covered.

PRIVATE HEALTH INSURANCE

Demographic	Small Businesses (2-50 Employees)	Individuals Recently Covered by an Employer Health Plan	Individuals & Families	Individuals with Pre-Existing, Severe, or Chronic Medical Conditions	Low-Income Families & Medically-Needy
Program	**Group Plans** National Association of Health Underwriters 202-552-5060 www.nahu.org	**COBRA/Mini-COBRA** Contact your current carrier. After 18 months continuous group/COBRA coverage, convert to a plan under: **HIPAA** Health Insurance Portability & Accountability Act 866-487-2365 www.dol.gov (Search: HIPAA)	**Individual Plans** National Association of Health Underwriters 202-552-5060 www.nahu.org	**CareFirst Blue Cross Blue Shield** 800-321-3497 www.carefirst.com **Pre-Existing Condition Insurance Plan (PCIP)** Run by the U.S. Department of Health and Human Services 866-717-5826 www.PCIP.gov www.pciplan.com	**Medicaid** 202-442-5988 202-698-3900 dhcf.dc.gov (Search: Medicaid) **D.C. HealthCare Alliance** ("Alliance") 202-639-4030 TTY: 202-639-4041 dhcf.dc.gov
Coverage	Benefits will vary depending on the chosen plan. There is a maximum 6-month look-back and a maximum 12-month exclusionary period for pre-existing conditions on enrollees that do not have prior coverage. ***Pre-Existing Health Conditions Covered***	**COBRA:** Coverage available for 18–36 months depending on qualifying events. Benefits are what you had with your previous employer. **Mini-COBRA:** Benefits are what you had with your previous employer. Coverage lasts 3 months or for as long as beneficiary is eligible for COBRA subsidy. **HIPAA:** Benefits are based on program selected. There is no expiration of coverage. ***Pre-Existing Health Conditions Covered***	Benefits will vary depending on the chosen plan. Insurers are required to offer at least two different policies on a guaranteed issue basis for individuals who are eligible for HIPAA plans. There is a 12-month exclusionary period limit for pre-existing conditions for HMOs, and a 10-month exclusionary period limit for pre-existing conditions for Carefirst Blue Cross Blue Shield (except for those qualified under HIPAA). Otherwise, there is no limit to the look-back and exclusion periods for pre-existing conditions on enrollees with no prior coverage. ***Pre-Existing Health Conditions Covered***	**CareFirst:** Comprehensive plans available depending on needs of applicant. D.C. requires that all policies cover certain benefits such as mammograms, prostate cancer screening, and diabetes treatment. A two-month waiting period applies. **PCIP:** Covers broad range of benefits, including primary and specialty care, hospital care, and prescription drugs. ***Pre-Existing Health Conditions Covered***	**Medicaid:** Doctor visits, Hospitalization, Eye care, Ambulatory surgical center, Medically-necessary transportation, Dental services and related treatment, Dialysis services, Durable medical equipment, Emergency ambulance services, Hospice services, Laboratory services, Radiology, Medical supplies, Mental health services, Physician services, Nurse practitioner services, Home and community based services (HCBS), Transplants, and more. Retroactive benefits available at the time of application for medical services received three months prior. **Alliance:** Inpatient hospital care, Outpatient medical care (including preventive care), Emergency services, Urgent care services, Prescription drugs, Rehabilitative services, Home health care, Dental services, Specialty care, and Wellness programs. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Company size 2–50 employees. Most carriers require proof of the business or business owner, viability etc. Eligible employees must work at least 30 hours a week and they do not include part-time, temporary, or substitute employees.	**GUARANTEED COVERAGE** **COBRA:** Available for employees who work for employers with 20 or more employees. You have 60 days from date of termination to sign-up. **Mini-COBRA**: Available for employees who work for employers with less than 20 employees. Must sign-up within 45 days after the date of termination. **HIPAA:** Must have had 18 months of continuous coverage and completely exhausted COBRA or state continuation coverage. Must not have lost coverage due to fraud or non-payment of premiums. You have 63 days to enroll.	**GUARANTEED COVERAGE** Eligibility is subject to medical underwriting. If you are denied coverage for a medical condition, you may be eligible for CareFirst or PCIP. See next column.	**GUARANTEED COVERAGE** **CareFirst:** If you are not HIPAA eligible and buy a guaranteed coverage policy, CareFirst can impose a 10-month pre-existing condition exclusion period. Can exclude conditions for which you received care or for which the insurer thought you should have sought care; this is called the prudent person rule. CareFirst is not required to credit your prior health coverage toward pre-existing condition exclusion periods. **PCIP:** Must have been uninsured for at least 6 months prior to applying. Must prove being a U.S. citizen or legal U.S. resident, Washington D.C. resident, and having problems getting insurance due to a pre-existing condition.	**GUARANTEED COVERAGE** **Medicaid :** Must be U.S. citizens or qualified aliens living in Washington D.C. Income Limits: Pregnant Women: 300% FPL. Children Ages 0-1: 185% FPL. Children Ages 1-5: 133% FPL. Children Ages 6-19: 100% FPL. Adults Ages 19–20: 200% FPL. Parents/Caretakers of Children : 206% FPL. Childless Adults: 200% FPL. Aged, Blind & Disabled: 100% FPL for singles and couples. Asset limits of $4,000 for singles and $6,000 for couples. Retroactive benefits available at the time of application for medical services received three months prior. **Alliance:** Must be a U.S. citizen, age 21 or older, living in Washington D.C., be uninsured, not eligible for Medicaid or Medicare. Income limit of 200% FPL and asset limits of $4,000 for singles and $6,000 for couples. U.S. citizenship is not required.
Monthly Cost	Costs depend on employer contribution. There are no rate caps.	**COBRA/Mini-COBRA:** 102%–150% of group health rates. **HIPAA:** Premiums will depend on plan chosen.	Costs depend on age and county/zone. There are no rate caps.	**CareFirst:** $109-$1,297 depending on age and number of household members. $2,500 out-of-pocket maximum **PCIP:** $141 to $606 depending on your age or plan chosen.	**Both: $0** or minimal share of cost.

PUBLICLY-SPONSORED PROGRAMS

Demographic	Moderate Income Families	Women	Seniors & Disabled	Trade Dislocated Workers (TAA Recipients)	Veterans
Program	**D.C. Healthy Families** 202-639-4030 TTY: 202-639-4041 dhcf.dc.gov	**Project Wish** (Breast & Cervical Cancer Early Detection Program) 202-442-5900 202-442-9128 (Spanish) doh.dc.gov/doh	**Medicare** 800-633-4227 www.medicare.gov **Medicare Prescription Drug Program** 800-633-4227	**Health Coverage Tax Credit** 866-628-4282 www.irs.gov (Search: HCTC)	**VA Medical Benefits Package** 877-222-8387 www.va.gov www.ebenefits.va.gov
Coverage	Choose one of two health plans: Unison Health Plan and D.C. Chartered Health Plan. Program covers Doctor visits, Immunizations (shots), School physicals, Emergency care, Hospital stays, Prescriptions, Prenatal labor and delivery, Vision care and glasses, Dental, Family planning, Transportation to doctor appointments, Home Health care, Durable medical equipment, Health education services, Mental health services, Drug and alcohol treatment and more. ***Pre-Existing Health Conditions Covered***	Cancer education, screening, and diagnostic services to screen for breast and cervical cancer. Also offers free transportation and interpreter services. ***Pre-Existing Health Conditions Covered***	Offers Part A, inpatient care in hospitals and rehabilitative centers; Part B, doctor and some preventive services and outpatient care; Part C allows Medicare benefits through private insurance (Medicare Advantage); Part C includes Parts A, B, and C not covered by Medicare. Part D covers prescription drugs ***Pre-Existing Health Conditions Covered***	Inpatient and outpatient care (lab tests, x-rays, etc.), Doctor visits, Preventive and major medical care (surgery, physical therapy, Durable medical equipment, etc.), Mental health and substance abuse care, and Prescription drugs. ***Pre-Existing Health Conditions Covered***	Comprehensive preventive and primary care, outpatient and inpatient services. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Must be U.S. citizens or qualified aliens and live in Washington D.C. and must not have health insurance (including Medicaid). Income limit requirements depends on coverage: 300% FPL if covering only children under 19 years old who live alone. 200% FPL income for parents/ guardians living with children ages 0–18 or pregnant women.	**GUARANTEED COVERAGE** Must live in Washington D.C. Must be women ages 50–64. Must never had a Pap test or have not had it in the past 5 years. Must be uninsured or underinsured. Income limit under 250% FPL. Women ages 40 and older are also eligible for a free annual mammogram.	**GUARANTEED COVERAGE** Must be U.S. citizen or permanent U.S. resident, and: 1) If 65 years or older, you or your spouse worked for at least 10 years in Medicare-covered employment, or 2) You have a disability or end-stage renal disease (permanent kidney failure requiring dialysis or transplant) at any age.	**GUARANTEED COVERAGE** Must be receiving TAA (Trade Adjustment Assistance), or Must be 55 years or older and receiving pension from the Pension Benefit Guaranty Corporation (PBGC). Must not be enrolled in certain state plans, or in prison, or receiving 65% COBRA premium reduction, or be claimed as a dependent in tax returns. Must be enrolled in qualified health plans where you pay more than 50% of the premiums.	**GUARANTEED COVERAGE** "Veteran status" = active duty in the U.S. military, naval, or air service and a discharge or release from active military service under other than dishonorable conditions. Certain veterans must have completed 24 continuous months of service.
Monthly Cost	**$0**	**$0**	**$0** and share of cost for certain services; deductibles for certain plans. Part A: $0–$451 based on length of Medicare-covered employment; Part B: $99.90-$319.70 depending on annual income; Part C: Based on provider; Part D: Varies in cost and drugs covered.	**27.5%** of the insurance premium including COBRA premium if employer contributes less than 50%.	**$0** and share of cost and co-pays depending on income level.

PRIVATE HEALTH INSURANCE

Demographic	Small Businesses (2-50 Employees)	Individuals Recently Covered by an Employer Health Plan	Individuals & Families	Individuals with Pre-Existing, Severe, or Chronic Medical Conditions	Low-Income Families
Program	**Group Plans** National Association of Health Underwriters 202-552-5060 www.nahu.org	**COBRA/Mini-COBRA** Contact your current carrier. After 18 months continuous group/COBRA coverage, convert to a plan under: **HIPAA** Health Insurance Portability & Accountability Act 866-487-2365 www.dol.gov (Search: HIPPA) **HIPP** Health Insurance Premium Payment 304-558-1700 www.dhhr.wv.gov/bms/Documents/YourGuideMedicaid.pdf	**Individual Plans** National Association of Health Underwriters 202-552-5060 www.nahu.org	**AccessWV** 866-445-8491 304-558-8264 www.accesswv.org **Pre-Existing Condition Insurance Plan (PCIP)** Run by the Department of Health and Human Services 866-717-5826 www.PCIP.gov www.pciplan.com	**Medicaid** 304-348-3365 888-483-0797 www.dhhr.wv.gov/bms
Coverage	There is a maximum 6-month look-back period and maximum 12-month exclusionary period for pre-existing conditions on enrollees that do not have prior coverage. Benefits will vary depending on the chosen plan. ***Pre-Existing Health Conditions Covered***	**COBRA:** Coverage available for 18–36 months depending on qualifying events. Benefits are what you had with your previous employer. **Mini-COBRA:** Benefits are what you had with your previous employer. Coverage lasts 18 months. **HIPAA:** Benefits are based on program selected. There is no expiration of coverage. **HIPP:** Premium assistance that pays employer-sponsored health insurance or COBRA premiums. The assistance amount depends on the most cost-effective premium available. ***Pre-Existing Health Conditions Covered***	Assorted plans depending on medical needs. There is a maximum 12-month look-back period and a maximum 24-month exclusionary period for pre-existing conditions on enrollees that do not have prior coverage. ***Pre-Existing Health Conditions Covered***	**AccessWV:** 4 plans that cover physician visits, preventive care, inpatient and outpatient hospital care, mental health and chemical dependency services, durable medical equipment and supplies, nursing, emergency services, home health and hospice, prenatal and maternity care, and prescription drugs. Annual benefit maximum $200K and lifetime $1M. There is a 6-month waiting period for pre-existing conditions before AccessWV pays for services. **PCIP:** Covers broad range of benefits, including primary and specialty care, hospital care, and prescription drugs. ***Pre-Existing Health Conditions Covered***	Inpatient and outpatient hospital care, Nursing home care, Physician services, Laboratory and x-rays, Immunizations and other Early and periodic screening, diagnostic, and treatment (EPSDT) services for children, Family planning, Health centers and rural health clinics. Retroactive benefits available at the time of application for medical services received three months prior. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Company size 2–50 employees (including owner). Eligible employees must work or reside in West Virginia and meet all requirements for enrollment in a health benefit plan. Owner's name on business license must draw wages from the company.	**GUARANTEED COVERAGE** **COBRA:** Available for employees who work for employers with 20 or more employees. You have 60 days from date of termination to sign-up. **Mini-COBRA:** Available for employees who work for businesses with less than 20 employees. Must have had group insurance for 3 months continuously prior to signing up for Mini-COBRA. Must sign-up within 31 days after date of termination. **HIPAA:** Must have had 18 months of continuous coverage and completely exhausted COBRA or state continuation coverage. Must not have lost coverage due to fraud or non-payment of premiums. You have 63 days to enroll. **HIPP:** Must qualify for Medicaid and have access to Employer-Sponsored Insurance or COBRA.	Eligibility is subject to medical underwriting. If you are denied coverage for a medical condition, you may be eligible for AccessWV or PCIP. See next column.	**GUARANTEED COVERAGE** **AccessWV:** Must be live in West Virginia and have been a resident for at least 30 days. Must have been denied health coverage in the last 6 months; or only able to get coverage with limited benefits or rates higher than plans by AccessWV; or be uninsurable (as determined by AccessWV) due to severe or chronic pre-existing medical condition. West Virginia residents who are HIPAA- or HCTC-eligible are also qualified (length of West Virginia residency requirement is waived). Must not be eligible for any group or publicly-funded coverage (e.g. Medicare, Medicaid) and must not be in a public institution. **PCIP:** Must have been uninsured or at least 6 months prior to applying. Must prove being a U.S. citizen or legal U.S. resident, a West Virginia resident, and having problems getting insurance due to a pre-existing condition.	**GUARANTEED COVERAGE** Must be West Virginia resident and U.S. citizen or legal aliens. Income limits: Pregnant Women & Children Ages 0–1: 150% FPL. Children Ages 1–5: 133% FPL. Children Ages 6–18: 100% FPL. Parents/Caretakers Living with Children Ages 0–18: 32% FPL. Aged, Blind & Disabled: 75% FPL and with asset limit of $2,000 for singles; 83% FPL and with asset limit of $3,000 for couples. Medically-Needy: Monthly income limit of $200 for singles and $275 for couples. Asset limit of $2,000 for singles and $3,000 for couples.
Monthly Cost	Costs depend on employer contribution and ± 30% of the insurance company's index rate.	**COBRA/Mini-COBRA:** 102%–150% of group health rates. **HIPAA:** Premiums will depend on plan chosen. **HIPP:** Reimburses the full employer-sponsored insurance premium amount by check monthly. Pays the insurance company directly for people on COBRA or eligible small businesses.	Costs for individual coverage vary. Rates are ± 30% of the base individual market rate.	**AccessWV:** $120 to $1,018 depending on age, region, gender, and plan chosen. $400 –$4,000 deductible for one person depending on plan. **PCIP:** $115 to $511 depending on your age and plan chosen.	**$0** or minimal share of cost.

PUBLICLY-SPONSORED PROGRAMS

Demographic	Children in Moderate Income Families	Women in Need of Cancer Screening	Seniors & Disabled	Trade Dislocated Workers (TAA Recipients)	Veterans
Program	**Children's Health Insurance Plan (CHIP)** 877-982-2447 304-558-2732 www.chip.wv.gov **Women-Infants-Children (WIC)** 304-558-0030 ons.wvdhhr.org	**West Virginia Breast and Cervical Cancer Screening Program (WVBCCSP)** 800-642-8522 304-558-5388 www.wvdhhr.org/bccsp	**Medicare** 800-633-4227 www.medicare.gov **Medicare Prescription Drug Program** 800-633-4227 **WVSHIP** 304-558-3317 877-987-4463 www.wvship.org	**Health Coverage Tax Credit** 866-628-4282 www.irs.gov (Search: HCTC)	**VA Medical Benefits Package** 877-222-8387 www.va.gov www.ebenefits.va.gov
Coverage	**CHIP:** Doctor visits, Check-ups, Hospital visits, Immunizations, Prescriptions, Tests and x-rays, Dental care, Vision, Emergency care, 24 hour nurse-line, Mental health, Diabetic supplies, Urgent care or after hour clinic visits, Case management for special needs and other services. Three plans are available based on income limits: Gold for 150% FPL, Blue for 151% to 200%FPL, and Premium for over 200%FPL. **WIC**: Nutrition education and services, breastfeeding promotion and education, monthly food prescription of nutritious foods, and maternal, prenatal and pediatric health care services. ***Pre-Existing Health Conditions Covered***	Offers Pap tests and clinical breast exams for women ages 25 to 64 and mammograms for women ages 50 to 64. If screening shows that patient has abnormal results or is diagnosed with cancer, patient may be eligible for treatment. ***Pre-Existing Health Conditions Covered***	**Medicare** offers Part A, inpatient care in hospitals and rehabilitative centers; Part B, doctor and some preventive services and outpatient care; Part C allows Medicare benefits through private insurance (Medicare Advantage); Part C includes Parts A, B, and C not covered by Medicare. Part D covers prescription drugs. **WVSHIP** is a Medicare counseling service. ***Pre-Existing Health Conditions Covered***	Inpatient and outpatient care (lab tests, x-rays, etc.), Doctor visits, Preventive and major medical care (surgery, physical therapy, Durable medical equipment, etc.), Mental health and substance abuse care, and Prescription drugs. ***Pre-Existing Health Conditions Covered***	Comprehensive preventive and primary care, outpatient and inpatient services. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** **CHIP:** Must be a U.S. citizen or qualified alien and West Virginia resident, 0–18 years old. Income limit up to 400% FPL. Must be ineligible for Medicaid or West Virginia State Employee Health Insurance. Must have been uninsured (including COBRA) in last 6 or 12 months. Exceptions: Child's health premiums are 10% or more of annual income; or lost insurance in the last 6 months due to layoff or job change of parent(s), or employer dropped coverage; or child is covered under insurance of non-custodial parent's and the insurance services are in another state or not accessible. **WIC:** Must reside in West Virginia, be a pregnant or recently pregnant woman, infant or child up to age 5, be determined to have a nutritional risk. Income must be at or below 185% FPL.	**GUARANTEED COVERAGE** Must be women 25–64 years old, residents of West Virginia, earning up to 200% FPL, uninsured, or have insurance policies that do not cover or require high unaffordable deductibles/ co-payments for services similar to WVBCCSP's.	**GUARANTEED COVERAGE** **Medicare & WVSHIP:** Must be U.S. citizen or permanent U.S. resident, and: 1) If 65 years or older, you or your spouse worked for at least 10 years in Medicare-covered employment, or 2) You have a disability or end-stage renal disease (permanent kidney failure requiring dialysis or transplant) at any age.	**GUARANTEED COVERAGE** Must be receiving TAA (Trade Adjustment Assistance), or Must be 55 years or older and receiving pension from the Pension Benefit Guaranty Corporation (PBGC). Must not be enrolled in certain state plans, or in prison, or receiving 65% COBRA premium reduction, or be claimed as a dependent in tax returns. Must be enrolled in qualified health plans where you pay more than 50% of the premiums.	**GUARANTEED COVERAGE** "Veteran status" = active duty in the U.S. military, naval, or air service and a discharge or release from active military service under other than dishonorable conditions. Certain veterans must have completed 24 continuous months of service.
Monthly Cost	**CHIP: $0** for Gold and Blue enrollees. For Premium enrollees, of $35 per child and $71 for two or more children. For all plans, maximum annual co-pay of $150–$600 per child. **WIC: $0** or minimal share of cost.	**$0** or minimal share of cost.	**Medicare: $0** and share of cost for certain services; deductibles for certain plans. Part A: $0–$451 based on length of Medicare-covered employment; Part B: $99.90-$319.70 depending on annual income; Part C: Based on provider; Part D: Varies in cost and drugs covered. **WVSHIP: $0**	**27.5%** of the insurance premium including COBRA premium if employer contributes less than 50%.	**$0** and share of cost and co-pays depending on income level.

PRIVATE HEALTH INSURANCE

Demographic	Small Businesses (2-50 Employees)	Individuals Recently Covered by an Employer Health Plan	Individuals & Families	Individuals with Pre-Existing, Severe, or Chronic Medical Conditions	Low-Income Adults, Children & Families
Program	**Group Plans** Wisconsin Association of Health Underwriters 608-268-0200 www.ewahu.org	**COBRA/Wisconsin (WI) Continuation Coverage** Contact your current carrier. After 18 months continuous group/ COBRA coverage, convert to a plan under: **HIPAA** Health Insurance Portability & Accountability Act 866-487-2365 www.dol.gov (Search: HIPAA) **HIPP** Health Insurance Premium Payment 800-362-2002 www.dhs.wisconsin.gov (Search: HIPP)	**Individual Plans** Wisconsin Association of Health Underwriters 608-268-0200 www.ewahu.org	**Health Insurance Risk Sharing Plan (HIRSP)** 800-828-4777 608-221-4551 www.hirsp.org **HIRSP Federal Plan** Federal Program run by HIRSP 800-828-4777 608-221-4551 www.hirsp.org www.PCIP.gov	**Medicaid** 800-362-3002 www.dhfs.state.wi.us/Medicaid **Badger Care Plus (BCP)** 800-362-3002 www.badgercareplus.org
Coverage	There is a maximum 6-month look-back and there is a maximum 12-month exclusionary period for pre-existing conditions on enrollees that do not have prior coverage. Benefits will vary depending on the chosen plan. ***Pre-Existing Health Conditions Covered with Some Limitations***	**COBRA:** Coverage available for 18–36 months depending on qualifying events. Benefits are what you had with your previous employer. **WI Continuation Coverage:** Benefits are what you had with your previous employer. Coverage lasts 18 months. **HIPAA:** Benefits are based on program selected. There is no expiration of coverage. **HIPP:** Premium assistance that pays employer-sponsored health insurance or COBRA premiums. The assistance amount depends on the most cost-effective premium available. ***Pre-Existing Health Conditions Covered***	There is no limit to the look-back period and there is a maximum exclusion period of 24 months on enrollees with no prior coverage. Elimination riders are permitted. Coverage options vary by carrier, but most offer plans that are HSA (Health Savings Account) compatible. ***Pre-Existing Health Conditions Covered with Some Limitations***	**HIRSP:** Offers five plan options. Covers hospital and physician care, prescription drugs and insulin, maternity care and other services. **HIRSP-Fed:** Covers broad range of benefits, including primary and specialty care, hospital care, and prescription drugs. ***Pre-Existing Health Conditions Covered***	**Medicaid:** Benefits include but are not limited to Hospital care (inpatient and outpatient), Nursing home care, Physician services, Laboratory and x-ray services, Immunizations and other Early and periodic screening, diagnostic, and treatment (EPSDT) services for children, Family planning services, Health center (FQHC) and rural health clinic (RHC) services, Nurse midwife and nurse practitioner services. Retroactive benefits available at the time of application for medical services received three months prior. **BCP:** Comprehensive care including but not limited to doctor visits, mental, dental, prescriptions, hospitalization and more (offers same as Medicaid). ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Company size 2–50 employees. Owner can count as an employee. Proprietor-name on license must draw wages. Eligible employees must work 30 hours a week. They do not include temporary or substitute employees.	**GUARANTEED COVERAGE** **COBRA:** Available for employees who work for employers with 20 or more employees. You have 60 days from date of termination to sign-up. **WI Continuation Coverage:** Available for employees who work for employers of any size. Must have been covered for 3 continuous months by group insurance. Must sign-up within 30 days from date of receiving notice of continuation rights. **HIPAA:** Must have had 18 months of continuous coverage and completely exhausted COBRA or state continuation coverage. Must not have lost coverage due to fraud or non-payment of premiums. You have 63 days to enroll. **HIPP:** Must qualify for Medicaid and have access to Employer-Sponsored Insurance or COBRA.	Eligibility is based on medical underwriting. Must be resident of state or documented immigrant. If you are denied coverage for a medical condition, you may be eligible for HIRSP or HIRSP Federal Plan. See next column.	**GUARANTEED COVERAGE** **HIRSP:** Must be under age 65, a Wisconsin resident for at least 3 months, ineligible for employer-offered group health insurance or Medicaid or Badger Care Plus, and either: 1) Not eligible for Medicare, Lost your employer-offered group health insurance and did not voluntarily cancel coverage. In last 9 months was denied coverage due to health, or offered coverage with restricted benefits, or offered 2 coverages with premiums 50% or higher than a standard risk would be charged for the coverage, or diagnosed as HIV positive, or be eligible for Medicare due to disability. Or, 2) Be a HIPAA-eligible individual. **HIRSP-Fed:** Must be a U.S. citizen or legal alien, uninsured for 6 months prior to the HIRSP Federal Plan effective date, ineligible for employer-offered group health insurance or Medicaid or Badger Care Plus, and in last 9 months was denied coverage due to health, or offered coverage with restricted benefits, or offered 2 coverages with premiums 50% or higher than a standard risk would be charged for the coverage, or diagnosed as HIV-positive.	**GUARANTEED COVERAGE** **Medicaid:** Must be U.S. citizen or legal alien and resident of Wisconsin. Income Limits: Pregnant Women & Children Ages 0–1: 300% FPL. Insured pregnant women earning 200%–300% FPL must keep their insurance. Childless Adults & Parents/Caretakers who live with Children Ages 0–18: 200% FPL. Children Ages 1-5: 185% FPL Children Ages 6-19: 100% FPL Parents with Children in Foster Care: 200% FPL. Ages 18 Leaving Foster Care: No income limit. Aged, Blind & Disabled: 84% FPL and asset limit of $2,000 for singles and 94% FPL and asset limit of $3,000 for couples. **BCP:** Must be U.S. citizen or legal alien and resident of Wisconsin. Must be children under 19 years old without access to health insurance; or pregnant women with incomes up to 300% FPL; or parents or caretakers earning up to 200% FPL. Children under 19 years old with income greater than 200% will be transferred to the Benchmark plan.
Monthly Cost	Costs depend on employer contribution and ± 30% of the insurance company's index rate.	**COBRA/WI Continuation Coverage:** 102%–150% of group health rates. **HIPAA:** Premiums will depend on plan chosen. **HIPP:** Reimburses the full employer-sponsored insurance premium amount by check monthly. Pays the insurance company directly for people on COBRA or eligible small businesses.	Various price ranges depending on deductible and what plan you buy. There are no rate caps.	**HIRSP:** $119 to $1,456 depending on age, gender, and plan chosen. **HIRSP-Fed:** $94 to $754 depending on age and deductible choice.	**Medicaid:** **$0** or minimal share of cost. **BCP:** **$0** or minimal share of cost and copays. If income is above 133% FPL (200% for children, parents, stepparents, caretaker relatives), you may be subject to premiums based on income levels.

PUBLICLY-SPONSORED PROGRAMS

Demographic	Children	Women in Need of Cancer Screening	Individuals with Chronic Health Conditions	Adults without Dependents	Trade Dislocated Workers (TAA Recipients)
Program	**Women-Infants-Children (WIC)** 800-722-2295 dhs.wisconsin.gov/wic/index.htm **Wisconsin First Step (WFS)** 800-642-7837 www.mch-hotlines.org (Click: Wisconsin First Step)	**Well Woman Program** 608-266-8311 www.dhfs.wisconsin.gov/womenshealth/wwwp	**Wisconsin Chronic Disease Program (WCDP)** 866-908-1363 www.forwardhealth.wi.gov (Search: WCDP)	**BadgerCare Plus Core & Basic Plans** 800-291-2002 www.badgercareplus.org The Department of Health Services will no longer signs up new members in the BadgerCare Plus Basic Plan. However, it will continue to serve those already enrolled.	**Health Coverage Tax Credit** 866-628-4282 www.irs.gov (Search: HCTC)
Coverage	**WIC:** Nutrition education and services, breastfeeding promotion and education, monthly food prescription of nutritious foods, and access to maternal, prenatal and pediatric health care services. **WFS:** Hotline that provides information on and referrals to Birth to 3 Programs and Regional Centers for Children and Youth with Special Health Care Needs. These programs serve Wisconsin residents ages 0–21 who may have developmental delays or disabilities. ***Pre-Existing Health Conditions Covered***	Mammograms, Pap tests, certain other health screenings, and multiple sclerosis testing for women with high risk signs of multiple sclerosis ***Pre-Existing Health Conditions Covered***	Assists Wisconsin residents with chronic renal disease, hemophilia, and adult cystic fibrosis. Pays health care providers for disease-related services and supplies provided to certified patients in Wisconsin Chronic Disease Program after all other sources of payment have been exhausted.	**BadgerCare Plus Core & Basic:** Limited plans with basic services such as Doctor visits, Hospital services, Emergency room and ambulance, Emergency dental services, Prescription drugs, Therapy (physical, occupational therapy, and speech), Cardiac rehabilitation, Durable medical equipment, Disposable medical supplies, Dialysis/kidney-related services. ***Pre-Existing Health Conditions Covered***	Inpatient and outpatient care (lab tests, x-rays, etc.), Doctor visits, Preventive and major medical care (surgery, physical therapy, Durable medical equipment, etc.), Mental health and substance abuse care, and Prescription drugs. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** **WIC:** Must reside in Wisconsin, be a pregnant or recently pregnant woman, or child up to age 5. Must be determined to be at nutritional risk. Income limit of 185% FPL. **WFS:** Wisconsin residency is required.	**GUARANTEED COVERAGE** Must be a woman age 45 to 64, living in Wisconsin, with income up to 250% FPL, and must be uininsured, or have insurance that does not cover routine check-ups and screening, or charges high unaffordable deductibles or co-payments.	**GUARANTEED COVERAGE** Must live and intend to permanently stay in Wisconsin. Must first apply for Medicaid, BadgerCare or SeniorCare (65 or older) to see if potentially eligible. Must be one of the following: 1) Diagnosed with end-stage renal disease. If eligible for Medicare, must pay Medicare Part B premiums to receive WCDP benefits. If ineligible for Medicare but chose to delay Medicare participation, patient will not be eligible for WCDP benefits. Or, 2) Diagnosed with cystic fibrosis and at least 18 years old. Or 3) Diagnosed with hemophilia. Patients earning above 300% FPL must pay a certain percent of out-of-pocket expense before becoming eligible to receive WCDP benefits. The state seeks repayment of WCDP benefits provided to participants under the Estate Recovery Program.	**GUARANTEED COVERAGE** **BadgerCare Plus Core:** Must be Wisconsin resident and U.S. citizen or qualified immigrant, age 19 to 64 years old, have income at or below 200% FPL. Must NOT be or have the following: Be pregnant. Have children under 19 living with you. Be eligible for or have BadgerCare Plus, Medicaid, Medicare. Have private health insurance in the last 12 months before and during the date you request Core Plan, unless you lost your health insurance for a good reason. Have access to employer-based insurance in the month you apply or next three months. Had access to employer-based health insurance in the last 12 months. Have access to insurance in the 3 months following the date of applying. **BadgerCare Plus Basic:** Must be on the BadgerCare Core waitlist to have the option to enroll in BagerCare Plus Basic.	**GUARANTEED COVERAGE** Must be receiving TAA (Trade Adjustment Assistance), or Must be 55 years or older and receiving pension from the Pension Benefit Guaranty Corporation (PBGC). Must not be enrolled in certain state plans, or in prison, or receiving 65% COBRA premium reduction, or be claimed as a dependent in tax returns. Must be enrolled in qualified health plans where you pay more than 50% of the premiums.
Monthly Cost	**WIC:** **$0** or minimal share of cost. **WFS:** **$0**	**$0**	**$0** or minimal share of cost.	**BadgerCare Plus Core:** **$0** or minimal share of cost. **BadgerCore Plus Basic:** **$325** monthly premium with a $60 application fee. Co-payments vary based on income for some services.	**20%** of the insurance premium including COBRA premium if employer contributes less than 50%.

PRIVATE HEALTH INSURANCE

Demographic	Small Businesses (2-50 Employees)	Individuals Recently Covered by an Employer Health Plan	Individuals & Families	Individuals with Pre-Existing, Severe, or Chronic Medical Conditions	Low-Income Individuals & Families
Program	**Group Plans** National Association of Health Underwriters 202-552-5060 www.nahu.org	**COBRA/Mini-COBRA** Contact your current carrier. After 18 months continuous group/COBRA coverage, convert to a plan under: **HIPAA** Health Insurance Portability & Accountability Act 866-487-2365 www.dol.gov (Search: HIPAA)	**Individual Plans** National Association of Health Underwriters 202-552-5060 www.nahu.org	**Wyoming Health Insurance Pool (WHIP)** 800-442-2376 307-634-1393 insurance.state.wy.us/whip.html **Pre-Existing Condition Insurance Plan (PCIP)** Run by the U.S. Department of Health and Human Services 866-717-5826 www.PCIP.gov www.pciplan.com	**Medicaid** 307-777-7531 307-777-7656 www.health.wyo.gov/healthcarefin/equalitycare
Coverage	Benefits will vary depending on the chosen plan. There is a maximum look-back period of 6 months and a maximum exclusion period of 12 months for enrollees who do not have prior coverage. ***Pre-Existing Health Conditions Covered***	**COBRA:** Coverage available for 18–36 months depending on qualifying events. Benefits are what you had with your previous employer. **Mini-COBRA:** Benefits are what you had with your previous employer. Coverage lasts 12 months. **HIPAA:** Benefits are based on program selected. There is no expiration of coverage. ***Pre-Existing Health Conditions Covered***	Benefits will vary depending on the chosen plan. There is a maximum look-back period of 6 months and a maximum exclusion period of 12 months for enrollees who do not have prior coverage. ***Limits on Pre-Existing Health Conditions May Apply***	**WHIP:** Doctor visits, Prescription drugs, Outpatient and in-hospital care, Maternity, Ambulance, Labs and x-rays, Skilled nursing care, Hospice, Home health visits, Rehabilitation, Durable medical equipment, and Mental health and substance abuse, among other services. Three plans: Brown, Gold and Catastrophic. Lifetime maximum benefit for each of the Brown and Catastrophic Plan is $750,000, while Gold Plan's is $1 million. **PCIP:** Primary and specialty care, hospital care, and prescription drugs. ***Pre-Existing Health Conditions Covered***	Inpatient and outpatient hospital care, Nursing home care, Physician services, Laboratory and x-ray services, Immunizations and other Early and periodic screening, diagnostic, and treatment (EPSDT) services for children, Family planning, Health center and rural health clinic services, Nurse midwife and nurse practitioner services. Treatment for special health problems, like breast cancer, kidney problems, nursing home needs, and AIDS. Retroactive benefits available at the time of application for medical services received three months prior. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** Company size 2–50 employees. Owner can count as an employee. Owner name on business license must draw wages from the company. Eligible employees must work at least 30 hours a week. They do not include part-time, temporary, seasonal or substitute employees.	**GUARANTEED COVERAGE** **COBRA:** Available for employees who work for employers with 20 or more employees. You have 60 days from date of termination to sign-up. **Mini-COBRA:** Available for employees who work for employers with less than 20 employees. Must have had group insurance 3 continuous months prior to termination. You have 31 days from date of termination to sign-up. **HIPAA:** Must have had 18 months of continuous coverage and completely exhausted COBRA or state continuation coverage. Must not have lost coverage due to fraud or non-payment of premiums. You have 63 days to enroll.	Eligibility is subject to medical underwriting. If you are denied coverage for a medical condition, you may be eligible for WHIP or PCIP. See next column.	**GUARANTEED COVERAGE** **WHIP:** Must be a Wyoming resident, denied insurance for health reasons, have health insurance coverage more restrictive or expensive (premium is higher by 12.5%) than WHIP's, or be under 65 and on Medicare disability. Must have exhausted COBRA, be uninsured, and ineligible for group plans. There are levels of eligibility based on income: Applicants earning or above 250% FPL will be on Level 1, while those earning under 250% FPL will be on Level 2. **PCIP:** Must have been uninsured for at least 6 months prior to applying. Must prove being a U.S. citizen or legal U.S. resident, a Wyoming resident, and having problems getting insurance due to a pre-existing condition.	**GUARANTEED COVERAGE** Must be a Wyoming resident and a U.S. citizen or legal alien who has lived in the U.S. for at least 5 years. Income limits for the following: Pregnant Women: 133% FPL. Children Ages 0–5: 133% FPL. Children Ages 6 –18: 100% FPL. Children in Foster Care: 133% FPL for Ages 0–5; 100% FPL for Ages 6–18; children through 20 years old will still be covered if income limit is greater. Parents/Caretakers Living with Children Ages 0–18: 38% FPL. Aged, Blind, & Disabled: 75% FPL and with asset limit of $2,000 for singles; 83% FPL and with asset limit of $3,000 for couples. Individuals Living in Nursing Homes (or need inpatient hospital care): $2,022/month, with asset limit of $2,000 for singles and $3,000 for couples. $109,560 is the resource limit for couples if only one member of the couple is applying.
Monthly Cost	Costs depend on employer contribution and ± 35% of the insurance company's index rate.	**COBRA/Mini-COBRA:** 102%–150% of group health rates. **HIPAA:** Premiums will depend on plan chosen.	Costs for individual coverage vary. There are no rate caps.	**WHIP:** $186.20 to $2,346.10 depending on age, income, and plan chosen **PCIP:** $126 to $542 depending on your age and plan chosen.	**$0** or minimal share of cost.

PUBLICLY-SPONSORED PROGRAMS

Demographic	Children	Children with Special Health Care Needs	Women in Need of Cancer Screening	Pregnant Women	Native Americans
Program	**KidCare CHIP** 877-543-7669 888-996-8786 www.health.wyo.gov (Search: CHIP) **Women-Infants-Children (WIC)** 800-994-4769 307-777-7494 www.health.wyo.gov/familyhealth/wic	**Children's Special Health Program (CSH)** 800-438-5795 www.health.wyo.gov/familyhealth/csh.	**Wyoming Breast & Cervical Cancer Early Detection Program (WBCCEDP)** 800-264-1296 www.health.wyo.gov/phsd/bccedp	**Best Beginnings** 307-777-3545 www.health.wyo.gov/familyhealth/bestbeginnings Contact your local Public Health Nursing Office: www.health.wyo.gov/familyhealth/nursing/offices.html	**Indian Health Services (IHS)** 406-247-7107 www.ihs.gov (Search: Billings)
Coverage	**KidCare CHIP:** Inpatient and outpatient hospital services, Doctor visits, Laboratory and x-ray services, Well-baby, well-child and well-adolescent care, Immunizations, Prescriptions, Mental health services, Dental services, Medically-necessary orthontics, Vision services, Physical therapy, and other Health benefits. **WIC:** Nutrition education and services, breastfeeding promotion and education, monthly food prescription of nutritious foods, and maternal, prenatal and pediatric health care services. ***Pre-Existing Health Conditions Covered***	Care coordination, specialty medical care, some equipment and medications, lab and x-rays related to diagnostics, support services, and diagnostic evaluations. There is an annual coverage limit of up to $40,000. ***Pre-Existing Health Conditions Covered***	Office visits, Pelvic exams, Pap tests, Clinical breast exams, Mammograms, Certain breast & cervical lab tests, Certain diagnostic tests ***Pre-Existing Health Conditions Covered***	Financial assistance for eligible women, Pregnancy counseling and teaching, Referrals to appropriate resources in the community, Education about pregnancy, Smoking-cessation assistance and referral, Prenatal class/support group, parenting classes for parents of newborns, Home visits for moms and babies, and breastfeeding support. ***Pre-Existing Health Conditions Covered***	The Billings Area Indian Health Service (IHS) provides comprehensive health services for American Indians in Montana and Wyoming. The Billings Area clinical staff consists of approximately 54 physicians, 179 nurses, 29 dentists, and 33 pharmacists delivering health care through 3 IHS hospitals, 9 health centers, 6 heath stations and numerous health locations. ***Pre-Existing Health Conditions Covered***
Eligibility	**GUARANTEED COVERAGE** **KidCare CHIP:** Must be Wyoming residents and U.S. citizens or legal aliens who have lived in the U.S. for at least 5 years. Must be children 0–18 years old with family incomes of up to 200% FPL. Must not be in a public institution, not a dependent of employees of the state of Wyoming, not eligible for Medicaid, and must have no insurance for 30 days prior to applying, unless insurance was involuntarily canceled. **WIC:** Must reside in Wyoming, be a pregnant or recently pregnant woman, infant or child up to age 5, and determined to be at nutritional risk. Income limit of 185% FPL.	**GUARANTEED COVERAGE** Must be a Wyoming resident under 19 years of age and suspected or known to have one of the medically-eligible conditions, i.e. chronic illness or disability. Enrollee may also have insurance, KidCare CHIP, or Medicaid. Must have income at or below 200% FPL.	**GUARANTEED COVERAGE** Must be women living in Wyoming with incomes at or below 250% FPL, and must not have insurance coverage, including Medicaid. Must be 50–64 years old. Women ages 30–64 may be eligible if they did not take Pap tests in past 5 years. Women ages 18–50 may be eligible if they have abnormal results from breast or cervical exams.	**GUARANTEED COVERAGE** Eligibility requirements vary from county to county. Be sure to call your local Public Health Nursing Office.	**GUARANTEED COVERAGE** Must exhaust all private, state, and other federal programs. Must be regarded by the local community as an Indian; is a member of an Indian or Group under Federal supervision; resides on tax-exempt land or owns restricted property; actively participates in tribal affairs; any other reasonable factor indicative of Indian descent; is a non-Indian woman pregnant with an eligible Indian's child for the duration of her pregnancy through post-partum (usually 6 weeks); is a non-Indian member of an eligible Indian's household and the medical officer in charge determines that services are necessary to control a public health hazard or an acute infectious disease which constitutes a public health hazard.
Monthly Cost	**KidCare CHIP: $0–$25** for medical and dental co-payments. No charges to American Indians as long as KidCare CHIP has a copy of Certificate of Indian Blood. **WIC: $0** or minimal share of cost.	**$0** or sliding scale share of cost.	**$0** or minimal share of cost.	**$0**	**$0** or minimal share of cost.

Appendices

OTHER SERVICES (BY STATE)

Alabama

WIC (Women-Infants-Children)
888-942-4673
800-654-1385
www.adph.org/wic

Family Planning
800-545-1098
www.adph.org/FamilyPlanning

Vaccines for Children
800-469-4599
www.adph.org/immunization

Alabama Department of Insurance
334-269-3550
800-433-3966 (in state)
www.aldoi.gov

Alabama Department of Public Health
334-206-5300
www.adph.org

Victims of Crime
800-541-9388
www.acvcc.state.al.us

Alaska

Anchorage Neighborhood Health Center
907-257-4600
www.anhc.org

Anchorage Community Health Services
907-343-4605
www.muni.org
(Search: Community Health Services)

Women-Infants-Children (WIC)
907-465-3100
www.hss.state.ak.us
(Search: WIC)

Alaska Division of Insurance
800-467-8725 (in state)
907- 465-2515
www.dced.state.ak.us/insurance

Alaska Health and Social Services
907-465-3030
www.hss.state.ak.us

Victims of Crime
800-541-9388
www.acvcc.state.al.us

Arizona

Women-Infants-Children (WIC)
800-252-5942
www.azwic.gov

Health Care Group of Arizona
602-417-6755

Federal Emergency Services (FES)
(for people who cannot verify Citizenship or immigration)
800-352-8401
www.ahcccs.state.az.us

Arizona Department of Insurance
800-325-2548
www.id.state.az.us

Arizona Department of Economic Security
800-352-8401
www.azdes.gov

Victims of Crime
602-364-1146
www.azcjc.gov/ACJC.Web/victim/VictComp.aspx

Arkansas

Women-Infants-Children
800-445-6175
501-661-2905
www.healthyarkansas.com
(Search: WIC)

DDS Children's Services
800-482-5850 x22277
501-682-8207
www.medicalhomear.org

Immunization Program
501-661-2793

AR Family Planning
501-661-2531

Women's Health
501-661-2480

Arkansas Department of Insurance
501-371-2600
800-282-9134
insurance.arkansas.gov

Arkansas Department of Human Services
501-682-1001
800-482-8988
www.arkansas.gov/dhhs

Women's Health: Family Planning, Maternity, and Midwifery
Run by the Arkansas Department of Health
501-661-2480
www.healthy.arkansas.gov
(Search: Family Planning)

Victims of Crime
501-682-1020
800-448-3014
www.ag.arkansas.gov

California

Indian Health Services
916-930-3927
www.ihs.gov

California Children's Services
www.dhcs.ca.gov
(Search: Children's Services)

Health Consumer Alliance
www.healthconsumer.org
(13 different languages; information about programs and legal rights by county)

California Department of Health Services
916-445-4171 (English and Spanish)
TTY: 888-757-6034
www.dhcs.ca.gov
(For information about Medi-Cal, Medicare, SSI, Food Stamps, Cash Assistance, CMSP, MISP, Healthy Families Program, CCS, MTP and more)

California Department of Insurance
800-927-4357
www.insurance.ca.gov
(English and Spanish; general information on all types of insurance)

California Department of Managed Health Care
888-466-2219
www.hmohelp.ca.gov
(English and Spanish; general information on all types of insurance)

BABY CAL
800-222-9999

WISEWOMAN
www.cdph.ca.gov
(Search: WISEWOMAN)

Women-Infants-Children (WIC)
888-942-9675
www.wicworks.ca.gov

Victims of Crime
800-777-9229
www.vcgcb.ca.gov

Colorado

Women-Infants-Children (WIC)
800-688-7777
303-692-2400
www.cdphe.state.co.us
(Search: WIC)

Colorado Indigent Care Program (CICP)
303-866-3513 (Denver Metro Area)
800-221-3943
www.chcpf.state.co.us

Colorado Division of Insurance
303-894-7490
www.dora.state.co.us/insurance

Victims of Crime
303-239-5719
888-282-1080
dcj.state.co.us
(Search: Victims Compensation Fund)

Colorado Department of Human Services
303-866-5700
www.cdhs.state.co.us

Connecticut

Women-Infants-Children (WIC)
860-509-8084
www.ct.gov
(Search: WIC)

Connecticut Insurance Department
800-203-3447
860-297-3900
www.state.ct.us/cid

Connecticut Department of Social Services
800-842-1508
860-424-5016
www.dss.state.ct.us

Victims of Crime
860-263-2761
888-286-7347
www.jud.ct.gov/crimevictim
(Search: Compensation Program)

Delaware

Women-Infants-Children (WIC)
800-222-2189
www.dhss.delaware.gov
(Search: WIC)

Immunization Services
800-282-8672

Family Planning
dhss.delaware.gov
(Search: Family Planning)

Child Development Watch
dhss.delaware.gov
(Search: Child Development Watch)

Delaware Insurance Department
800-282-8611
www.delawareinsurance.gov

Delaware Department of Health and Social Services
800-464-4357
800-273-9500
www.dhss.delaware.gov

Victims of Crime
302-255-1770
800-464-4357
attorneygeneral.delaware.gov/VCAP

Florida

Women-Infants-Children (WIC)
800-342-3556
www.doh.state.fl.us
(Search: WIC)

Alzheimer's Disease Initiative
850-414-2000

Florida AIDS Insurance Continuation Program
305-592-1452
www.doh.state.fl.us
(Search: AICP)

Florida Office of Insurance Regulation
800-342-2762
www.floir.com

Florida Health and Human Services
www.dcf.state.fl.us/ess
www.doh.state.fl.us

Victims of Crime
800-226-6667
TDD: 800-955-8771
myfloridalegal.com/victims

Georgia

Georgia Insurance Commission
800-656-2298
www.inscomm.state.ga.us

Immunization Program
404-657-3158
www.health.state.ga.us
(Search: Immunization)

Tobacco Use Prevention
404-657-6649
www.health.state.ga.us
(Search: Tobacco)

Emergency Food Assistance
800-795-3272
TTY: 202-720-6382
dfcs.dhs.georgia.gov/emergency-food-assistance

Georgia Department of Family and Children Services
404-651-9361
dfcs.dhr.georgia.gov

Georgia Department of Community Health
404-656-4507
dch.georgia.gov

Victims of Crime
404-657-2222
800-547-0060
cjcc.georgia.gov/victims-compensation

Hawaii

PACE Hawaii Maluhia Health Center
(age 55 and older)
808-832-6130

Hawaii Immunization Program
800-933-4832
808-586-8300
hawaii.gov
(Search: Immunization)

STD/AIDS Prevention Branch
808-733-9281
(Search: STD/AIDS)

Women-Infants-Children (WIC)
586-8175 (Oahu)
888-820-6425 (Neighbor Islands)
hawaii.gov
(Search: WIC)

Hawaii Division of Insurance
808-586-2790
808-586-2799
hawaii.gov/dcca/ins

Hawaii Department of Health
808-586-4400
www.hawaii.gov/health

Victims of Crime
808-587-1143
hawaii.gov/psd/cvcc

Idaho

Indian Health Services
503-326-2020
www.ihs.gov
(Search: Idaho)

Women-Infants-Children (WIC)
800-334-4905
healthandwelfare.idaho.gov
(Search: WIC)

Idaho Department of Insurance
208-334-4250
www.doi.idaho.gov

Idaho Department of Health and Welfare
800-926-2588
www.healthandwelfare.idaho.gov

Victims of Crime
208-334-6080
800-950-2110
crimevictimcomp.idaho.gov

Illinois

Health Benefits for Workers with Disabilities
800-226-0768
www.hbwdillinois.com

Women-Infants-Children (WIC)
800-843-6154
www.dhs.state.il.us
(Search: WIC)

Illinois Department of Insurance
877-527-9431
insurance.illinois.gov

Illinois Department of Human Services
800-843-6154
www.dhs.state.il.us

Victims of Crime
800-228-3368
TTY: 877-398-1130
ag.state.il.us/victims/cvc.html
(Search: Health)

Indiana

Women-Infants-Children (WIC)
800-522-0874
www.in.gov
(Search: WIC)

Indiana Department of Insurance
800-622-4461
317-232-2385
www.in.gov/idoi

Indiana Family and Social Services
317-232-4946
www.in.gov/fssa

Victims of Crime
800-353-1484
www.in.gov/cji/2348.htm

Iowa

Women-Infants-Children (WIC)
800-532-1579
www.idph.state.ia.us/wic

Iowa Insurance Division
800-325-2548
515-281-5705
www.iid.state.ia.us

Iowa Department of Human Services
www.dhs.state.ia.us

Victims of Crime
515-281-5044
800-373-5044
www.iowa.gov
(Search: Crime Victim Compensation)

Kansas

Kansas Foundation for Medical Care
800-432-0770
785-273-2552
www.kfmc.org

Senior Health Insurance Counseling of Kansas
800-860-5260
www.agingkansas.org

Kansas Insurance Department
785-296-3071
800-432-2484
www.ksinsurance.org

Kansas Department of Social and Rehabilitation Services
888-369-4777
www.srskansas.org

Victims of Crime
785-296-2359
ag.ks.gov/victim-services/victim-compensation

Kentucky

State Health Insurance Assistance Program
(Counseling for seniors and disabled)
877-293-7447
chfs.ky.gov
(Search: SHIP)

ICARE
877-422-7307
icare.ky.gov

Kentucky Office of Insurance
502-564-3630
800-595-6053
TDD: 800-462-2081
insurance.ky.gov

Kentucky Cabinet for Health and Family Services
800-372-2973
TDD:800-627-4702
www.chfs.ky.gov

Victims of Crime
502-573-2290
cvcb.ky.gov

Louisiana

BAYOU HEALTH
855-229-6848
www.dhh.louisiana.gov
(Search: Bayou Health)

Public Health Units
(Community care)
www.dhh.louisiana.gov
(Search: OPH Regions)

Louisiana Department of Insurance
800-259-5300
www.ldi.la.gov

Louisiana Department of Health and Hospitals
225-342-9500
www.dhh.louisiana.gov

Victims of Crime
225-342-1749
lcle.state.la.us/programs/cvr.asp

Maine

Maine Genetics Program
207-287-4623
TTY: 800-606-6015
www.maine.gov
(Search: Maine Genetics Program)

Maine Rx Plus
866-796-2463
TTD: 800-423-4331
www.maine.gov/dhhs/mainerx

Maine Bureau of Insurance
207-624-8475
800-300-5000
TTY: 888-577-6690
www.maineinsurancereg.org

Maine Department of Health and Human Services
207-287-3707
www.maine.gov/dhhs

Victims of Crime
800-903-7882
www.maine.gov
(Search: Crime Victims Compensation)

Maryland

Family Planning
410-767-6723
www.fha.state.md.us
(Search: Family Planning)

Vaccines for Children
410-767-6030
edcp.org
(Search: Vaccine)

Maryland AIDS Insurance Assistance Program
410-767-5227
800-358-9001
dhmh.state.md.us
(Search: AIDS Insurance Assistance)

Maryland Insurance Administration
410-468-2000
800-492-6116
800-735-2258
www.mdinsurance.state.md.us

Maryland Department of Health and Mental Hygiene
410-767-6500
877-463-3464
www.dhmh.state.md.us

Victims of Crime
410-525-3010
888-679-9347
(Search: Criminal Injuries Compensation)

Massachusetts

MASS Medline
866-633-1617
www.massmedline.com
MASSCare (AIDS)
617-994-9819
617-994-9819
www.mass.gov
(Search: MASSCare)

AIDS Action Committee Hotline
800-235-2331
617-437-6200
TTY: 617-437-1394
www.aac.org

Massachusetts Division of Insurance
617-521-7794
www.mass.gov/doi

Massachusetts Department of Public Health
617-624-6000
617-624-6001
www.mass.gov/dph

Healthcare for Artists
617-784-4652
hfainfo@healthcareforatrists.org
www.healthcareforartists.org

Health Care For All Help Line
800-272-4232
617-350-7279
www.hcfama.org

The Access Project
617-654-9911
info@accessproject.org
www.accessproject.org

Victims of Crime
617-727-2200 x2160
www.mass.gov
(Search: Crime Victims Compensation)

Michigan

Family Planning
800-642-3195
TTY: 866-501-5656

Children's Special Health Care Services
800-359-3722

Michigan Office of Financial and Insurance Regulation
517-373-0220
877-999-6442
www.michigan.gov/ofis

Michigan Department of Community Health
517-373-3740
www.michigan.gov/mdch

Victims of Crime
517-373-3740
www.michigan.gov
(Search: Crime Victim Services)

Minnesota

Disabilities Linkage Line
866-333-2466
www.semcil.org/dll.html

Family Planning
800-783-2287
sexualhealthmn.org
www.health.state.mn.us
(Search: Family Planning)

Indian Health Services
Bemidji Area Office
218-444-0458
www.ihs.gov
(Search: Bemidji)

Minnesota Department of Commerce
651-296-4026
TTD: 651-296-2860
mn.gov/commerce

Minnesota Department of Human Services
651-431-2000
TTD: 800-627-3529
www.dhs.state.mn.us

Victims of Crime
651-201-7300 ext 1
dps.mn.gov
(Search: Victims of Crime)

Mississippi

Children's Medical Program
(Chronic illnesses)
800-844-0898

Mississippi Care For Yourself
(Family Planning)
800-421-2408
www.msdh.state.ms.us/care

Donated Dental Services
601-368-9823
800-366-3640

Mississippi Department of Insurance
601-359-3569
800-562-2957
www.mid.state.ms.us

Mississippi Department of Health
866-458-4948
601-576-7400
www.msdh.state.ms.us

Victims of Crime
800-829-6766
www.ago.state.ms.us
(Click: Victims Tab)

Missouri

Missouri CLAIM
(Medicare counseling)
800-390-3330
www.missouriclaim.org

Vaccines for Children
800-219-3224
www.dhss.mo.gov/Immunizations

Missouri Department of Insurance
573-751-4126
www.insurance.mo.gov

Missouri Department of Social Services
573-751-4815
www.dss.mo.gov

Victims of Crime
800-347-6881
www.ago.mo.gov
(Search: Victims Compensation Fund)

Montana

Montana State Health Insurance Assistance Program
800-551-3191
www.dphhs.mt.gov

Montana State Auditor's Office
800-332-6148
406-444-2040
sao.mt.gov

Montana Department of Public Health and Human Services
www.dphhs.mt.gov

Victims of Crime
Helena: 406-444-3653
Outside Helena: 800-498-6455
doj.mt.gov/victims/crime-victim-compensation

Nebraska

Nebraska Health Insurance, Information, Counseling and Assistance Program
(for seniors)
800-234-7119
402-471-2201
TTD: 800-833-7352
www.doi.ne.gov/shiip

Nebraska Department of Insurance
402-471-2201
TTD: 800-833-7352
www.doi.ne.gov

Nebraska Health and Human Services
402-471-3121
www.hhs.state.ne.us

Victims of Crime
402-471-2828
TDD: 800-833-7352
www.ncc.ne.gov/services_programs/crime_victim_reparations.htm

Nevada

Vaccines for Children
775-684-5900
health.nv.gov
(Search: Immunization)

AIDS Drug Assistance
775-684-3499
health.nv.gov
(Search: HIV Program)

Nevada Department of Insurance
775-687-4270
702-486-4009
doi.state.nv.us

Nevada Department of Health and Human Services
775-684-4000
dhhs.nv.gov

Victims of Crime
702-486-2740
www.voc.nv.gov

New Hampshire

Family Planning
603-271-4517
800-852-3345 ext.4517
TTD: 800-735-2964
www.dhhs.nh.gov
(Search: Family Planning)

New Hampshire Medication Bridge Program
603-415-4297
www.healthynh.com
(Click: Medication Bridge)

New Hampshire Department of Insurance
603-271-2261
800-852-3416
www.nh.gov/insurance

New Hampshire Department of Health and Human Services
800-852-3345
www.dhhs.state.nh.us

Victims of Crime
603-271-3658
doj.nh.gov
(Search: Victims Compensation)

New Jersey

Special Child Health and Early Intervention Services
609-984-0755
www.nj.gov
(Search: Special Child Health)

Medicaid Dental
609-943-5749
www.state.nj.us/health
(Under: Family Health and Children's Dental Oral Health)

Family Planning
609-984-1384
www.state.nj.us/health
(Under: Family Health and Prenatal Services)

New Jersey Department of Banking and Insurance
800-446-7467
www.state.nj.us/dobi

New Jersey Department of Human Services
609-292-3717
800-367-6543
www.state.nj.us/humanservices

Victims of Crime
877-658-2221
www.nj.gov/oag/njvictims

New Mexico

Women-Infants-Children (WIC)
866-867-3124
nmwic.org

MEDBANK
(Emergency Prescription Drug Program)
800-432-2080
www.nmaging.state.nm.us
(Click: A-Z, M, MEDBANK)

New Mexico Health Policy Commission
505-476-1732
www.hpc.state.nm.us

New Mexico Public Regulations Commission
888-427-5772
505-827-3928
www.nmprc.state.nm.us/insurance

New Mexico Human Services Department
505-827-3100
888-997-2583
www.state.nm.us/hsd/mad

Victims of Crime
505-841-9432
800-306-6262
www.cvrc.state.nm.us

New York

Women-Infants-Children (WIC)
800-522-5006
www.health.state.ny.us
(Search: WIC)

Family Planning
800-541-2831
www.health.state.ny.us
(Search: Family Planning)

Growing Up Healthy
800-522-5006 (in state)

NYS Department of Health's AIDS Institute HIV Uninsured Care Programs
800-542-2437
www.health.ny.gov
(Search: Uninsured HIV Programs)

NY AIDS - HIV Counseling and Testing
800-541-2437 (in state)

New York Insurance Department
212-480-6400
800-342-3736
www.ins.state.ny.us

New York Department of Health
866-881-2809
www.health.state.ny.us

Victims of Crime
800-247-8035
www.ovs.ny.gov/services/VictimCompensation.aspx

North Carolina

Safety Net Dental Services
919-707-5480
www.ncdhhs.gov
(Search: Safety Net Dental Clinics)

North Carolina Health CARE LINE
English/Español
800-662-7030
TTY: 919-733-4851

North Carolina Department of Insurance
800-546-5664
919-807-6800
www.ncdoi.com

North Carolina Department of Health and Human Services
800-662-7030
TTY: 877-452-2514
919-855-4400
TTY: 919-733-4851
www.dhhs.state.nc.us

Victims of Crime
919-733-7974
www.nccrimecontrol.org
(Click: Victim Services)

North Dakota

Children's Special Health Services
800-755-2714
TTY: 701-328-2436
www.ndhealth.gov/CSHS

North Dakota Insurance Department
701-328-2440
800-247-0560
www.nd.gov/ndins

North Dakota Department of Human Services
701-328-2310
800-472-2622
www.nd.gov/dhs

Victims of Crime
701-328-6195
800-445-2322
www.nd.gov
(Search: Victims Compensation)

Ohio

Ohio Department of Insurance
800-686-1526
614-644-2658
www.ohioinsurance.gov

Ohio Department of Health
www.odh.ohio.gov

Help Me Grow Program
614-644-8389
www.ohiohelpmegrow.org

HIV Drug Assistance Program
800-777-4775
www.odh.ohio.gov
(Search: HIV Drug Assistance)

Victims of Crime
800-582-2877
www.ohioattorneygeneral.gov/victimscompensation

Oklahoma

SoonerStart
(Child Development)
405 522-5167
www.sde.state.ok.us
(Search: SoonerStart)

Chronic Disease Service
405-271-4072
www.ok.gov
(Search: Chronic Disease Service)

RX for Oklahoma
877-794-6552
www.RX4OKLA.com

Oklahoma Department of Insurance
405-521-2828
800-522-0071
www.oid.state.ok.us

Oklahoma Department of Health
405-271-5600
800-522-0203
www.ok.gov/health

Victims of Crime
405-264-5006
www.ok.gov
(Search: Victims Compensation Program)

Oregon

Oregon Insurance Division
503-947-7980
www.oregoninsurance.org

Oregon Department of Human Services
503-945-5944
www.oregon.gov/DHS

Oregon Health Authority
503-947-2340
877-398-9238
www.oregon.gov/oha

Oregon Helps
(Program screener tool)
oregonhelps.org

Victims of Crime
503-378-5348
www.doj.state.or.us/victims

Pennsylvania

Family Planning
877-724-3258
www.dpw.state.pa.us
(Under: For Adults and Family Planning)

Women-Infants-Children (WIC)
800-942-9467
www.pawic.com

SelectPlan
800-842-2020
www.selectplanforwomen.com

Pennsylvania Insurance Department
877-881-6388
www.ins.state.pa.us

Pennsylvania Department of Health
877-724-3258
www.health.state.pa.us

Victims of Crime
800-233-2339
www.pacrimevictims.state.pa.us

Rhode Island

RI Early Intervention
(Child development)
401-462-0318
TTY: 401-462-6353
www.dhs.ri.gov
(Under: Children with Special Needs and Early Intervention Program)

Immunization Program
401-222-5960
www.health.ri.gov/immunization

Rhode Island Pharmaceutical Program for Elderly
401-462-3000
TTY: 401-462-0740
www.dea.state.ri.us

Rhode Island Department of Business Regulation
401-462-9500
www.dbr.state.ri.us

Rhode Island Department of Health
401-222-2231
www.health.state.ri.us

South Carolina

Family Planning Services
800-868-0404
www.scdhec.gov
(Search: Family Planning)

South Carolina Health Insurance Assistance
800-868-9095

South Carolina Department of Insurance
803-737-6180
800-768-3467
www.doi.sc.gov

Indian Health Services
615-467-1500
www.ihs.gov/nashville

Women-Infants-Children (WIC)
800-868-0404
www.dhec.sc.gov
(Search: WIC)

South Carolina Department of Health and Human Services
888-549-0820
www.dhhs.state.sc.us

Victims of Crime
800-220-5370
803-734-1900
www.sova.sc.gov/compensation.html

South Dakota

South Dakota Division of Insurance
605-773-3563
dlr.sd.gov/insurance

South Dakota Department of Social Services
605-773-3165
www.state.sd.us/social

Victims of Crime
605-773-3656
800-696-9476
dss.sd.gov/victimservices/cvc

Tennessee

Tennessee Health Options Services
888-486-9355

Women-Infants-Children (WIC)
800-342-5942
health.state.tn.us/WIC

CoverRX
888-560-2649
866-268-3786
www.covertn.gov
(Click: CoverRX)

Prescription Assistance
888-486-9355

Family Planning
615-741-7353
health.state.tn.us/womenshealth

Tennessee Department of Commerce and Insurance
615-741-2218
800-342-4029
www.state.tn.us/commerce/insurance

Tennessee Department of Health
615-741-3111
health.state.tn.us

Victims of Crime
615-741-2734
www.treasury.state.tn.us/injury

Texas

Women-Infants-Children (WIC)
800-942-3678
www.dshs.state.tx.us/wichd

Texas Family Planning
512-458-7796
www.dshs.state.tx.us/famplan

Texas Vaccines for Children
800-252-9152
www.dshs.state.tx.us/immunize/tvfc

TX Children with Special Needs
800-252-8023
www.dshs.state.tx.us/cshcn

Texas Department of Insurance
800-252-3439
512-463-6464
www.tdi.state.tx.us

Texas Department of State Health Services
888-963-7111
www.dshs.state.tx.us

Victims of Crime
800-983-9933
512-936-1200
www.oag.state.tx.us/victims

Utah

RxConnect
866-221-0265
health.utah.gov/rxconnectutah

Health Insurance Information Program
800-541-7735

Utah Insurance Department
801-538-3800
www.insurance.utah.gov

Utah Department of Health
801-538-6101
888-222-2542
www.health.utah.gov

Victims of Crime
801-238-2360
800-621-7444
www.crimevictim.state.ut.us

Vermont

Vermont Refugee Health Program
800-464-4343
802-863-7200
healthvermont.gov
(Search: Refugee)

VScript
800-250-8427
TTD: 1-888-834-7898
www.greenmountaincare.org
(Search: Prescription Assistance)

Vermont Department of Banking, Insurance, Securities & Health Care Administration
802-828-3301
www.bishca.state.vt.us

Vermont Agency of Human Services
800-287-0589
802-241-2800
www.dsw.state.vt.us

Victims of Crime
802-241-1250
TTY: 802-241-1258
www.ccvs.state.vt.us/compensation

Virginia

Virginia Bureau of Insurance
804-371-9741
877-310-6560
www.scc.virginia.gov/division/boi

Virginia Department of Health
www.vdh.virginia.gov

Victims of Crime
800-552-4007
www.cicf.state.va.us

Washington

Washington Office of the Insurance Commissioner
Consumer Hotline
800-562-6900
www.insurance.wa.gov

Washington Department of Social and Health Services
800-737-0617
800-562-3022
www.dshs.wa.gov

Victims of Crime
800-762-3716
www.lni.wa.gov
(Search: Crime Victims)

Washington D.C.

D.C. Health Program for Refugees
202-442-9380

D.C. Healthcare Alliance
202-639-4030
TTY: 202-639-4041
dhcf.dc.gov

Women-Infants-Children (WIC)
800-345-1942
202-442-9397
doh.dc.gov/doh

District of Columbia Department of Insurance, Securities and Banking
202-727-8000
disb.dc.gov

District of Columbia Department of Health
202-737-4404
doh.dc.gov/doh

Victims of Crime
202-727-3934
oag.dc.gov
(Search: Office of Victim Services)

West Virginia

WV Birth to Three
800-642-8522
www.wvdhhr.org/birth23

WV Family Planning
304-558-5388
800-642-9704
www.wvdhhr.org/fp

West Virginia Offices of the Insurance Commissioner
304-558-3386
888-879-9842
www.wvinsurance.gov

West Virginia Health and Human Resources
304-558-0684
www.wvdhhr.org

Wisconsin

Wisconsin Office of the Commissioner of Insurance
800-236-8517
608-266-3585
oci.wi.gov

Wisconsin Department of Health Services
608-266-1865
dhs.wisconsin.gov

Victims of Crime
800-446-6564
www.doj.state.wi.us
(Search: Crime Victims)

Wyoming

Wyoming Seniors
307-856-6880
www.wyomingseniors.com

Wyoming State Health Insurance Assistance Program
(Advice Line)
800-856-4398
307-856-6880

Wyoming Department of Insurance
307 777-7401
800-438-5768
insurance.state.wy.us

Wyoming Department of Health
307-777-7656
866-571-0944
wdh.state.wy.us

Victims of Crime
888-996-8816
victimservices.wyoming.gov/vcomp.htm

National Resources

Catalog of Federal Domestic Assistance
www.cfda.gov
(Search tool for grants, loans and other benefits)

Department of Health and Human Services
www.hhs.gov
(Various health care search tools)

Employee Benefits Security Administration
www.dol.gov/ebsa
(Official information and rules from the U.S. Department of Labor)

Government Benefits Finder
800-333-4636
www.benefits.gov
(Search tool for grants, loans and other benefits)

Health Coverage Tax Credit
866-628-4282
www.irs.gov
(Search: HCTC)

Health Resources and Services Administration
Find a Health Center
www.findahealthcenter.hrsa.gov

Indian Health Services (IHS)
www.ihs.gov
301-443-3024
(Department of Public Health)

National Association of Mental Illness (NAMI) Helpline
800-950- 6264
www.nami.org

Medicare
800-633-4227
www.medicare.gov

Medicare Prescription Drug Program
800-633-4227

Partnership for Prescription Assistance
888-477-2669
www.pparx.org

Self Help Clearing House
www.mentalhelp.net/selfhelp
(Search tool for people sharing information on hundreds of diseases, health conditions and other health care related situations)

Substance Abuse and Mental Health Services Administration
National Mental Health Information Center
www.samhsa.gov/treatment
(Mental Health and Substance Abuse Services Locator)

Veterans Health Administration
877-222-8387
www.va.gov
www.ebenefits.va.gov

STATE-BY-STATE COMPARISON

State	High-deductible premium for 26-year-old (2012)	High-deductible premium for 35-year-old) (2012)	Guaranteed Coverage for Small Groups	Guarantee Issue Employee Size	MiniCOBRA Groups< 20	High Risk Options	Income-Based Buy-In Plan	Medical Underwriting for Individuals	Parental Coverage through CHIP	Indian Health Services
Alabama	$54.88	$66.20	Yes	2 +	No	Yes	No	Yes	No	Yes
Alaska	$88.00	$138.00	Yes	2 +	No	Yes	No	Yes	Yes	Yes
Arizona	$40.00	$54.00	Yes	2 +	No	Yes	No	Yes	Yes	Yes
Arkansas	$31.56	$44.16	Yes	2 +	Yes	Yes	No	Yes	No	Yes
California	$90.00	$104.00	Yes	2 +	Yes	Yes	No	Yes	Yes	Yes
Colorado	$99.53	$115.76	Yes	1+	Yes	Yes	No	Yes	Yes	Yes
Connecticut	$67.00	$84.00	Yes	1+	Yes	Yes	No	Yes	Yes	Yes
Delaware	$90.29	$114.38	Yes	1 +	No	Yes	No	Yes	No	Yes
District of Columbia	$72.00	$86.00	Yes	2 +	Yes	Yes	No	Yes	Yes	Yes
Florida	$52.00	$64.00	Yes	1+	Yes	Yes	No	Yes	No	Yes
Georgia	$41.99 ‡	$50.68 ‡	Yes	2 +	Yes	Yes	No	Yes	No	Yes
Hawaii	$63.61	$75.73	Yes	1+	No	Yes	No	Yes	No	Yes
Idaho	$53.72	$77.00	Yes	2 +	Yes	Yes	No	Yes	No	Yes
Illinois	$68.00	$78.93	Yes	2 +	Yes	Yes	No	Yes	No	Yes
Indiana	$72.41	$98.78	Yes	2 +	No	Yes	No	Yes	Yes	Yes
Iowa	$58.57	$72.38	Yes	2 +	Yes	Yes	No	Yes	No	Yes
Kansas	$78.47	$100.32	Yes	2 +	Yes	Yes	No	Yes	No	Yes
Kentucky	$43.20	$47.47	Yes	2 +	Yes	Yes	No	Yes	No	Yes
Louisiana	$35.65	$62.36	Yes	2 +	Yes	Yes	No	Yes	No	Yes
Maine	$132.00†	$167.00†	Yes	1 +	Yes	Yes	No	No	No	Yes
Maryland	$56.00	$68.00	Yes	2 +	Yes	Yes	No	Yes	No	Yes
Massachusetts	$236.00†	$258.51†	Yes	1 +	Yes	Yes	No	No	Yes	Yes
Michigan	$51.23	$57.54	Yes	2 +	No	Yes	No	Yes	No	Yes
Minnesota	$53.36	$61.23	Yes	2 +	Yes	Yes	No	Yes	Yes	Yes
Mississippi	$66.40	$80.64	Yes	1+	Yes	Yes	No	Yes	No	Yes
Missouri	$42.70	$59.46	Yes	2 +	Yes	Yes	No	Yes	No	Yes
Montana	$62.00	$77.00	Yes	2 +	No	Yes	No	Yes	No	Yes
Nebraska	$58.44	$80.33	Yes	2 +	Yes	Yes	No	Yes	Yes	Yes
Nevada	$28.00	$35.00	Yes	2 +	Yes	Yes	No	Yes	No	Yes
New Hampshire	$137.83†	$157.48†	Yes	1+	Yes	Yes	No	Yes	Yes	Yes
New Jersey	$359.62†	$465.52†	Yes	2 +	Yes	Yes	No	No	Yes	Yes
New Mexico	$52.36	$56.69	Yes	1 +	Yes	Yes	No	Yes	No	Yes
New York	$260.52*	$260.52*	Yes	2 +	Yes	Yes	No	No	Yes	Yes
North Carolina	$54.00	$66.00	Yes	1+	Yes	Yes	No	Yes	No	Yes
North Dakota	$50.70†	$96.56	Yes	2 +	Yes	Yes	No	Yes	No	Yes
Ohio	$49.72	$64.51	Yes	2 +	Yes	Yes	Yes	Yes	No	Yes
Oklahoma	$83.00	$90.00	Yes	2 +	Yes	Yes	No	Yes	No	Yes
Oregon	$42.00	$58.00	Yes	2 +	Yes	Yes	No	Yes	No	Yes
Pennsylvania	$50.00	$61.00	Yes	2 +	Yes	Yes	No	Yes	No	Yes
Rhode Island	$57.00	$70.00	Yes	1 +	Yes	Yes	No	Yes	Yes	Yes
South Carolina	$72.00	$89.00	Yes	2 +	Yes	Yes	No	Yes	No	Yes
South Dakota	$49.23	$60.80	Yes	2 +	Yes	Yes	No	Yes	No	Yes
Tennessee	$52.11	$63.23	Yes	2 +	Yes	Yes	No	Yes	No	Yes
Texas	$48.14	$63.70	Yes	2 +	Yes	Yes	No	Yes	No	Yes
Utah	$39.53	$63.09	Yes	2 +	Yes	Yes	No	Yes	No	Yes
Vermont	$56.94	$62.77	Yes	1 +	Yes	Yes	No	No	No	Yes
Virginia	$59.00	$73.00	Yes	2 +	Yes	Yes	No	Yes	No	Yes
Washington	$84.64	$115.48	Yes	1 +	No	Yes	No	No**	No	Yes
West Virginia	$66.82 ‡	$87.20 ‡	Yes	2 +	Yes	Yes	No	Yes	No	Yes
Wisconsin	$39.77	$53.20	Yes	2 +	Yes	Yes	No	Yes	Yes	Yes
Wyoming	$81.20	$106.10	Yes	2 +	Yes	Yes	No	Yes	No	Yes

Note: Premiums are based on the following information and may be subject to change: $5K-$10K deductible & above; male; nonsmoker; non-college student; about 20%–30% co-insurance; no office visits. Plans were generated by ehealthinsurance.com using zip codes from major cities. In most cases, the second least expensive plan is shown.

† With office visit. "No office visit" coverage not available. ‡ Network plan (similar to PPO) * For self-employed only, with office visit.

** Continuous for some individuals

THE UNINSURED IN AMERICA

How does your STATE compare to the rest of America?

State	Uninsured Population 2011 (in Thousands)	% of Uninsured Eligible for Government Programs	% of Uninsured with Income $50K +	% of Uninsured that is Short-term (Less than 1 Yr)	% of Uninsured that is Long-term (More than 1 Yr)
Alabama	622	28%	32%	16%	23%
Alaska	130	30%	32%	15%	22%
Arizona	1,137	30%	32%	15%	22%
Arkansas	508	33%	32%	14%	20%
California	7,425	44%	32%	10%	15%
Colorado	788	23%	32%	18%	26%
Connecticut	303	33%	32%	14%	20%
Delaware	90	52%	32%	7%	10%
District of Columbia	52	53%	31%	6%	9%
Florida	3,765	28%	32%	16%	24%
Georgia	1,862	30%	32%	16%	23%
Hawaii	105	56%	32%	4%	7%
Idaho	266	24%	32%	18%	26%
Illinois	1,873	30%	32%	15%	22%
Indiana	764	31%	32%	15%	22%
Iowa	303	38%	32%	13%	18%
Kansas	380	24%	32%	18%	26%
Kentucky	621	39%	32%	12%	17%
Louisiana	938	27%	32%	17%	24%
Maine	133	42%	32%	11%	15%
Maryland	802	33%	32%	14%	21%
Massachusetts	219	60%	32%	3%	5%
Michigan	1,209	36%	32%	13%	19%
Minnesota	487	41%	32%	11%	16%
Mississippi	476	31%	32%	15%	22%
Missouri	877	40%	32%	12%	17%
Montana	180	30%	32%	16%	22%
Nebraska	225	36%	32%	13%	19%
Nevada	607	23%	32%	19%	27%
New Hampshire	163	25%	32%	18%	25%
New Jersey	1,336	24%	32%	18%	26%
New Mexico	399	28%	32%	16%	23%
New York	2,355	35%	32%	14%	20%
North Carolina	1,550	31%	32%	15%	22%
North Dakota	61	28%	32%	17%	23%
Ohio	1,549	31%	32%	15%	22%
Oklahoma	636	27%	32%	17%	24%
Oregon	532	46%	32%	9%	13%
Pennsylvania	1,375	48%	32%	8%	12%
Rhode Island	125	55%	33%	5%	8%
South Carolina	877	42%	32%	11%	15%
South Dakota	105	33%	32%	14%	20%
Tennessee	841	NA	NA	NA	NA
Texas	6,080	24%	32%	18%	26%
Utah	412	26%	32%	17%	25%
Vermont	53	60%	33%	3%	5%
Virginia	1,066	25%	32%	17%	25%
Washington	986	34%	32%	14%	20%
West Virginia	273	38%	32%	12%	18%
Wisconsin	589	37%	32%	12%	18%
Wyoming	100	23%	32%	18%	27%
Total US	48,613	34%	32%	14%	20%

Source: www.statehealthfacts.org (for "Uninsured Population 2009"); US Census Bureau, 2011; BCBSA Analysis, Congressional Budget Office.

GLOSSARY OF TERMS

Agent A person who has a license to sell insurance in California. He or she might work alone or with a large firm and may sell all kinds of insurance. Some agents work as an employee of an insurance company and sell plans just from that company.

Carrier Carrier is another name for insurance company.

CHIP Sometimes this is called S-CHIP (State Children's Health Insurance Plan). Every state has a plan for children who are not eligible for Medicaid because the family income is too high or they don't have access to group coverage. The name of the program is usually called something like Healthy Families or Healthy Children and care is delivered by regular doctors through the state's major insurance companies. In a handful of states, coverage is extended to the parents (as with Medicaid).

Claim A request for payment of benefits received or services rendered. A billing record is generated and submitted by a provider or subscriber using paper or electronic media.

COBRA COBRA is a federal law that helps an insured person keep their health insurance when they lose their employee health plan. It's also called continuation coverage. COBRA stands for Consolidated Omnibus Budget Reconciliation Act. It applies to companies with 20 or more employees. Mini-COBRA is for companies with less than 20 employees.

Coinsurance An arrangement under which the insured person pays a fixed percentage of the cost of medical care after the deductible has been paid. For example, the insurance company might pay 80% of the allowable charge, with the insured person responsible for the remaining 20%, which is then referred to as the coinsurance amount.

Conversion Privilege The right given to an insured person to change insurance without evidence of medical insurability, usually to an individual policy upon termination of coverage under a group contract.

Co-Pay An arrangement where the insured person pays a specified amount for various services and the insurance company pays the remainder. The insured person usually must pay his or her share when the service is rendered. Similar to coinsurance, except that coinsurance is usually a percentage of certain charges where the co-payment is a dollar amount.

Coverage Another name for "health insurance." It refers to the scope of health benefits and financial risk protection provided under a contract of insurance.

Coverage Termination The end of an insured person's coverage due to loss of employment, reduction of hours, gross misconduct, covered employee and spouse divorce or become legally separated, or death of the covered employee.

Creditable Coverage	There are rules about when insurance companies have to start paying for your health benefits when you're a new member or whether or not you get COBRA (continuation) coverage when your group plan ends. For example: to get COBRA, you have to have had insurance (creditable coverage) for 18 months.
Deductible	An amount which an insured person agrees to pay, per claim or per accident, before the insurance company has to pay their part.
Employee Contribution	The employee's share of the monthly premium (payment).
Employer Based Coverage	Companies who offer health coverage at no or minimal charge to the employee.
Employer Contribution	The employer's share of the monthly premium (payment).
Federal Poverty Level	This is a percentage level assigned based on the number of people and income per household. The percentages are created by the government, and then the public programs use those percentages in a chart to decide who can qualify for what programs.
Guaranteed Coverage	An underwriting term used to describe the fact that a small business group cannot be turned down for insurance because of poor health conditions either current or past.
Guaranteed Coverage for Individual Plans	This means that no one can be turned down for insurance because of a health condition, or in other words there is no "medical underwriting." Only three states have guaranteed coverage for individuals: Maine, New York and Vermont.
High Risk Pool Insurance	This is health coverage for people who may have been denied access to a health insurance plan because of their serious medical conditions . In some states every insurance company must guarantee access to plans for these people. In other states there is an organization that oversees a program that involves a few plans from different insurance companies.
HIPAA	The right to transfer from a group health plan to an individual plan if the insured person is leaving the company or their group plan is being terminated. HIPAA is a law that has to do with both portability and privacy of medical records. It stands for Health Insurance Portability and Accountability Act.
Income Based Buy-In Plan	Some states have plans for people who have no access to group coverage and aren't eligible for Medicaid or other public programs. Similar to public programs, the monthly premiums are determined by the applicant's income level.

Indian Health Services This is a federal organization that has medical facilities in states where there is a high populations of Native American or Alaskan Indians. Services range from full health care benefits to mobile clinics that cater to the needs of local tribes.

Individual Insurance Health Insurance policies which provide protection to the insured person and/or his/her family (also called dependents).

Max out-of-pocket The most an insured person will pay considering co-payments, coinsurance, deductibles, etc.

Medicaid Medicaid is a state health coverage program that primarily covers emergencies, pregnancy-related services, kidney dialysis and treatment for breast and cervical cancer.

Medi-Cal Medi-Cal is a California's Medicaid program that primarily covers emergencies, pregnancy-related services, kidney dialysis and treatment for breast and cervical cancer.

Medical Underwriting Before you can buy a policy you must give the insurance company information about your health. This process is called underwriting. The company uses underwriting information to predict what the likelihood is that you will file claims against the insurance policy. Each company has its own underwriting standards, which means one insurance company could reject your application but another may be willing to accept it.

Mini-COBRA Mini-COBRA is simply "continuation coverage." It is a law that helps people losing their employee health plan stay insured. It is for companies with less than 20 employees. (See COBRA.)

Pre-existing Conditions When applying for health insurance, the insurance company requests the applicants medical history. A "pre-existing condition" is an illness, physical or mental, that was treated before getting insurance.

Premium The payment an insured person makes to keep their insurance policy, usually monthly.

Provider Your doctor, a hospital, clinic and anyone else that provides health care services to you is called a "provider."

Qualifying Event An occurrence (such as death, termination of employment, divorce, etc.) that changes an insured person's protection under COBRA, which requires continuation of benefits under a group insurance plan for former employees and their families who would otherwise lose health care coverage.

Small Group or Small Business A small group or business in most states is 2-50 employees, although some states consider a self-employed person or 1 employee to be a small group. Small groups or business are guaranteed health insurance coverage and can not be turned down for pre-existing conditions.

Stop Loss This is a special type of re-insurance that protects an individual or group who goes over their coverage limit.

ABOUT FHCE

The Foundation for Health Coverage Education (FHCE) is a non-profit 501(c)3 organization with the mission to simplify public and private health insurance information in order to help more people access coverage. We offer a variety of health coverage resources to help consumers, health care professionals, employers, and the uninsured navigate the complex health insurance system.

This Directory of Matrices from all 50 states and Washington D.C. represents the entire health insurance system in our country. Different states have different approaches to insurance. Certainly California with a population of 38 million has different needs than Idaho where approximately 1.6 million people reside.

FHCE views the uninsured as a humanitarian issue, as well as a public health issue. Proper education of the public could improve our country's health and save our health care system billions of dollars in claims. We have the infrastructure and capacity to take care of everyone. The U.S. has world class providers, hospitals and technology. We need to improve the administration, financing and distribution of publicly-funded programs, so that everyone who is eligible signs-up for health coverage. Together, we can lower the ranks of the uninsured.

CoverageForAll.org Resources

Health Coverage Options Matrix

Tri-fold pamphlet available for all 50 states plus Washington D.C. that provides a road map for every available health coverage program, explaining the monthly cost, coverage under each program, eligibility information, and program contact information.

Health Coverage Eligibility Quiz

Online interactive tool (access by scanning QR code) where users answer 5 basic questions and instantly receive a personalized list of all of the public and private health coverage programs for which they may qualify. Results include:

- Program Contact Information
- Sign-up check lists of documents and information needed to successfully enroll
- Public program application links
- Special resource section to locate other free or low-cost health services

Disclaimer:

An online version of this Directory is updated regularly for your convenience. Download the most recent version on www.CoverageForAll.org.

For more information on your state's health coverage options, we encourage you to utilize our other valuable health coverage resources.

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Foundation for Health Coverage Education

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