

# TRADITIONAL PRODUCT INFORMATION

## What is the LIA Health Alliance?

The LIA Health Alliance is a “market based health insurance reform product” that brings Employee Choice to small businesses. The Alliance gives small business employees the ability to select the health insurer and the benefit plan that meets their personal needs.

## Who is eligible to enroll in the Alliance?

An *eligible employee* is defined as an employee who works more than 20 hours for an eligible employer on a regular scheduled work week.

## What is an HMO?

A Health Maintenance Organization (HMO) is a benefit plan that has one benefit level: in-network. It allows enrolled members, who live in a defined service area, to use participating HMO providers in order to receive benefits. HMO members must have all care authorized by their Primary Care Physician (PCP). There are minimal copayments, but no deductibles and virtually no claim forms. There aren't any out-of-network benefits.

## What is a POS?

A Point-of-Service (POS) is a benefit plan that has two benefit levels: in-network and out-of-network. In-network benefits provide the maximum benefit to members and provide the same cost and quality controls of the HMO product with minimal copayments. **To maximize in-network benefits, members are required to select a PCP from the insurer's directory of participating providers;** the member's PCP will coordinate the health care needs of all members. Members can choose, at the time services are needed, to seek care from an in-network provider and receive the highest benefit level possible or go out-of-network and receive benefits that are subject to deductibles and coinsurance.

## What is an EPO?

An Exclusive Provider Organization (EPO) is a benefit plan that has one benefit level: in-network. In-network benefits provide maximum benefit to members with minimal copayments. Referrals are not required to access in-network benefits. Members must select in-network providers to seek care for needed services. There aren't any out-of-network benefits.

## What is a PPO?

A Preferred Provider Organization (PPO) is a benefit plan that has two benefit levels: in-network and out-of-network. In-network benefits provide the maximum benefit to members with minimal copayments. Referrals are not required to access in-network benefits. To maximize in-network benefits, members

must select in-network providers to seek care for needed services. Members can choose, at the time services are needed, to seek care from an out-of-network provider and receive benefits that are subject to deductibles and coinsurance.

## What are cost sharing benefit plans?

A cost sharing benefit plan is an EPO or PPO with deductibles on hospital based services.

## What is Colonial Supplemental Insurance?

It is a medical bridge insurance program that covers deductibles for hospital based services.

## Can I cover my dependents?

Yes. The LIA Health Alliance offers dependent coverage to all eligible employees. Dependents must be listed on your enrollment form for dependent coverage to go into effect. An *eligible dependent* is defined as your spouse and any unmarried child (natural child, adopted, under legal guardianship or a stepchild) of the eligible employee. An unmarried dependent child is covered up to age 19.

Children incapable of self-support due to a physical or mental disability will continue to be covered until termination of the disability.

**An unmarried child registered as a full-time student can be covered up to age 25 on most of the benefit plans offered.**

**AGE 29** - Once a child reaches the maximum age of dependency, they may be eligible for the “Young Adult Option” and may be covered up to age 29. To be eligible for coverage, the young adult must be unmarried, live or work in New York State, and must not be eligible for health insurance through their own employer or be covered by Medicare. The young adult or parent would be responsible for a separate premium in addition to what the parent pays for coverage.

## Can I change coverage during the year?

If you experience a **significant life status change** during the year, you can change your dependent coverage (eg., Employee, Employee & Spouse, Employee & Child(ren) or Family) but *not* the benefit plan or the insurer that you have selected. The company tier level selected by your employer cannot be changed.

*Significant life status changes include:* marriage; divorce; death; birth; adoption/legal guardianship; or loss of eligibility for health coverage due to termination of employment (except for reasons of gross misconduct) or reduction in work hours below 20 hours per week.

All significant life changes must be reported on the Enrollment/Change Form and sent to the Alliance Enrollment Processing Center.

**The Enrollment/Change Form must be received within 30 days of the qualifying event.** Please contact the Alliance Enrollment Processing Center at 1-800-LIA-5513 for additional information.

### When will health coverage start?

All enrollment materials must be received at the Alliance Enrollment Processing Center on or before the last business day of the current month to be eligible for coverage on the first day of the next month.

Any enrollment information received after the last business day of the current month will be processed for coverage the first day of the month that follows that next month.

Check with your employer to verify your effective coverage date. Your employer has established a new hire waiting period for your company. For new employees, coverage will begin the first day of the month following that waiting period. Your enrollment form must be received prior to that date or your coverage won't begin until the first day of the next month.

### What is HIPAA?

In 1996, the Health Insurance Portability and Accountability Act (HIPAA) was signed into law. It was designed to accomplish the following:

- Assure the portability of health insurance.
- Reduce healthcare fraud.
- Guarantee the privacy and security of health information.
- Implement standards for health information transactions.

### What is a Pre-Existing Condition?

**A pre-existing limitation will not apply, if you have been continuously insured by creditable coverage for 12 months without any lapse of coverage exceeding 63 days.**

A pre-existing condition is a sickness or injury (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six month period prior to the enrollment date. Health insurers can exclude coverage for up to twelve months for pre-existing conditions.

**The twelve month exclusion period will be reduced provided that not more than 63 days have elapsed between the date the person's preceding health care coverage terminated and the enrollment date of the new coverage.**

Coverage will be credited:

- (a) for the length of time that the person was previously covered under previous creditable health care coverage; or
- (b) by any affiliation (waiting) period prior to previous health maintenance organization coverage.

Creditable coverage includes: a group health plan; health insurance coverage; Part A or B of Medicare; Medicaid; military sponsored health plan; Federal Employees Health Benefit Plan (FEHBP), and a public health plan.

The Pre-existing condition exclusion does not apply to:

- (a) genetic information unless a condition related to that information is diagnosed;
- (b) pregnancy;
- (c) newborns who became covered within 30 days of the date of birth; or
- (d) child, who is adopted or placed for adoption before attaining eighteen years of age, became covered within 30 days of the date of the adoption or placement for adoption.

### What if I lose coverage due to a change in employment status?

If there is a loss of coverage due to a reduction in work hours, termination of employment (except gross misconduct), disability, death, legal separation or divorce, Medicare entitlement or change in dependent eligibility, an employee may be eligible to continue coverage through COBRA (Consolidated Omnibus Budget Reconciliation Act). With COBRA the employee is responsible for payment at the group premium rate plus 2% for administration expenses.

**ARRA - COBRA** - As of October 2009, under **ARRA** (American Recovery and Reinvestment Act of 2009), certain individuals who lose their jobs through December 31, 2009 may qualify for a subsidy equal to 65% of the cost paid for continuation coverage for a period of up to 9 months. Please refer to our website for up-to-date information.

**To be eligible, the employee must be enrolled under their employer's group health plan at the time of the qualifying event. COBRA election must be made within 60 days of the qualifying event.**

Continued coverage is available for a maximum of 36 months. The LIA Health Alliance does administer COBRA benefits. The process begins with your employer. Your employer will provide you with notification of your rights and responsibilities under COBRA in the event you have a qualifying event. Direct pay conversion may be available from each insurer.

**The employer is responsible for notifying COBRA participants that their coverage is terminated, when the company's health insurance plan is terminated.**