

A Consumers' Guide to Health Insurance and Health Programs in North Carolina

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for helping underwrite the publication of this book.**

The full text of this report is available on line at: www.nciom.org.

About the North Carolina Institute of Medicine

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***A Consumer's Guide*
to Health Insurance
and Health
Programs in North
Carolina**

Second Edition

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PART I

GENERAL INFORMATION FOR CONSUMERS

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About the Second Edition of *A Consumer's Guide*

When the first edition of this book was published in 1995, the country had just emerged from a debate about National Health Insurance. Though national health care is not the most widely debated issue, health care remains a primary concern throughout the country. The rising costs of health insurance and health care, prescription drug coverage for individuals on Medicare, and the availability of health coverage to those who recently lost their jobs are but a few of the often mentioned issues. During this time of economic strain, states have struggled to continue providing health care to their most vulnerable populations, and North Carolina is no exception.

Despite the passage of time, many of the problems we faced at that first publication have continued in the years since.

- ◆ More than 40 million people (14% of the population) are uninsured in the United States.
- ◆ Over a million people are without health insurance in North Carolina, almost one-fourth of them children.
- ◆ There continues to be a shortage of health professionals in about two-thirds of North Carolina counties.
- ◆ As health care costs climb, many employers have reduced, and some have eliminated, health insurance coverage for their employees.
- ◆ North Carolina spends more than \$27 billion on health care, 12% of the state's gross state product.

Despite the continued problems, there have been some bright spots in the last eight years. For example, the state implemented NC Health Choice, which has helped many low- and moderate-income families get health coverage for their children. The state has also enacted many consumer protections for individuals covered by managed care plans.

Whether or not the health care system in the United States is in a state of crisis is a matter of debate. But for individuals touched by the problems, the state of the system is irrelevant. All of the issues debated in this state and country involve real people: the grandmother who can't afford the prescriptions she needs to stay healthy, the parent whose employer recently stopped providing health insurance, or the child who can't get the treatment she needs because there are not enough doctors nearby.

Those who have adequate insurance also experience difficulties with health care. Families find themselves paying more and more in insurance premiums, while also paying more out-of-pocket when they need medical care. Pages of fine print must be read to understand what treatments are covered. People find themselves navigating a never-ending array of managed care organizations, preferred provider lists, and increasingly complex insurance policies.

A Consumer's Guide was written to help everyone navigate the health system, whether it involves understanding their private health insurance coverage, identifying available public programs, or finding community health centers in their area. We've tried to use language throughout the book that makes sense to ordinary people, but that was not always possible. We've included a glossary at the end of the book for these health care and health insurance terms and acronyms.

Each chapter of the book begins with a brief introduction to the topic, which tells you what it is and who it is for. This way, you should be able to tell at a glance if a particular type of insurance or program applies to you. The rest of the chapter describes the program in more detail, including specifics about the benefits, costs, and eligibility rules that apply to the program. The end of the chapter includes information about the relevant laws governing the insurance or public program and who to contact for more information.

Note about legal references: Where appropriate we've included references to state and federal laws and regulations, so you can further research the topic.

Federal laws that cover public programs or insurance laws will have citations like "42 U.S.C. § 601 *et seq.*" This means you can find the law in Title 42 of the United States Code, in section 601 and the following sections. The U.S. Code can be found in law libraries and many local public libraries. You can also view the U.S. Code online at <http://uscode.house.gov/>.

Programs governed by federal law will usually also include a reference to the appropriate part of the Code of Federal Regulations, which describe how a law will be implemented. These citations will look like "42 C.F.R. § 601." This means you can find the regulation in Title 42 of the Code of Federal Regulations, in section 601. Like the U.S. Code, the Code of Federal Regulations is available in law libraries and many local libraries. You can also view the C.F.R. at <http://www.access.gpo.gov/nara/cfr/index.html>.

North Carolina state laws are abbreviated "N.C.G.S 58-50-1." This tells you look in chapter 58 of the North Carolina General Statutes, section 50, subsection 1. In addition to many North Carolina libraries, you can view the statutes at <http://www.ncga.state.nc.us/Statutes/Statutes.html>.

North Carolina also has regulations that describe how the state laws should be implemented. Regulations look like "10 N.C.A.C. Chapter 23." This tells you to look in Title 10 of the North Carolina Administrative Code, Chapter 23. In addition

to many North Carolina libraries, the administrative code can be viewed at <http://ncrules.state.nc.us>.

What's new in the second edition? The second edition includes updates in every chapter to reflect changes in laws and regulations. We have also included a new chapter on NC Health Choice, the children's health insurance program in North Carolina. The chapter on state health programs has been expanded to include more of the programs available to people with particular illnesses or needs. In addition, we have an expanded section on consumer protections that includes statutory references to all the laws governing private insurance.

As so many more consumers turn to the Internet for information, the chapters now include web sites when available, to help guide your search for online information. We have also reorganized the reference section at the end of the book. Now the local references include various government offices, Legal Services locations, community, migrant, and rural health centers, school health centers, and free or low-cost clinics by county. Now you can look at a county, see what's available in the area, and have contact information for each.

We have tried very hard to make this guide as accurate and complete as possible. ***Because the health care system is always changing, some of this information may be outdated by the time you read it. Please do not take this guide as your final source of information, but rather as a starting point to making yourself a more informed consumer.*** We hope you enjoy the book and find it a useful resource in understanding health care in North Carolina.

HOW TO SHOP FOR HEALTH INSURANCE

INTRODUCTION

In the past, many people had their insurance picked by their employers. These workers were limited to whatever their employers offered. Now, many employees are given a choice of plans, so they need to know how to choose between competing plans. Others may be shopping for health insurance coverage on their own (not part of a group plan). They may be confused by the myriad of different plans offered. Wise consumers need to examine their health care needs and learn how to compare policies, to make sure that the insurance they have is adequate and reasonably priced for the benefits offered.

WHAT TYPE OF INSURANCE DO I NEED?

First, you must consider what insurance you already have and what is available to you. What does your employer offer? What does your spouse's employer offer? If you can't get health insurance through your or your spouse's employer, can you get coverage through a trade association? Are you eligible for government-sponsored health insurance (such as VA benefits, Medicare for older adults and people with disabilities, Medicaid for certain low-income individuals, or NC Health Choice for uninsured children)?

Next, try to determine the gaps in coverage between what you currently have (or what is readily available to you) and what you think you need. If your circumstances suggest that you need additional health coverage, you will need to shop for insurance that meets your needs.

DO I NEED AN AGENT?

If your employer or trade association offers health insurance, you will probably not need an insurance agent. You may want to talk to your company's Human Resources Department, if any, if you have questions about different plans. However, you may want an agent if you are trying to buy individual (non-group) coverage, or if you are trying to supplement insurance coverage you already have.

If you decide you need an insurance agent, you will want a reputable insurance agent who can help you find a policy that is right for you. In North Carolina there are many different insurance companies licensed to offer health insurance policies. These companies offer a staggering number of different policies. Consumers may find it impossible to understand so many options or to choose among them without some assistance. Policies are not standardized, so it is difficult to comparison-shop

without help. A good insurance agent will be familiar with the range of options and can help you decide which company and policy will most closely match your needs.

There are a number of ways to choose a health insurance agent. One place to start is asking trusted family members and friends for a recommendation. Next, look for a professional designation — usually an abbreviation following the agent’s name in advertisements or literature. Agents with membership in the CLU (Charter Life Underwriters) or FLMI (Fellow of the Life Management Institute) must take extensive courses and examinations to qualify. Agents with RHU (Registered Health Underwriters) or LUTCF (Life Underwriters Training Council Fellow) membership also must take qualifying examinations, but these are less extensive than the requirements for the CLU and FLMI designations.

Insurance agents are listed in the Yellow Pages. Some agents are independent and can help you choose among policies offered by several different companies. Others are affiliated with a specific insurance company and will work only with that company’s policies. There are also professional organizations that can help you locate an agent. Their phone numbers are listed at the end of this chapter under “For more information.”

It is also wise to talk to more than one agent. Compare sales tactics. Ask questions. Evaluate your comfort level with the agent. Do you feel pressured? Are your questions answered in terms you can understand? Talking with more than one agent will help you understand all your options.

WHAT TYPES OF HEALTH INSURANCE POLICIES EXIST?

There are several different categories of health insurance policies sold in North Carolina. The most comprehensive are generally considered **major medical plans**. These may be offered through a traditional insurance company or by a health maintenance organization (HMO). In general, major medical plans offer comprehensive coverage of a wide range of medical services.

Insurance companies also offer plans that are not intended to be comprehensive. Some of the more common restricted policies are called “bare-bones” policies, catastrophic coverage, or “dread disease” coverage.

- ◆ **Bare-bones policies** may offer limited (or very limited) benefits.
- ◆ **Catastrophic plans** begin paying for health coverage only after you have incurred large medical bills (for example, a catastrophic policy may not cover the first \$5,000 of health care expenses that you incur). Catastrophic policies are generally most useful in covering hospital bills, but they do not provide much coverage of preventive services or general doctor’s visits.
- ◆ **Dread disease policies** cover care associated with only the disease named in the policy, such as cancer or heart disease.

Major medical plans do tend to be more expensive than these other types of policies, but they also offer far more coverage.

WHAT IS MANAGED CARE?

Managed care is a generic term that applies to different types of health care insurance arrangements. The goal of a managed care system is to provide patients with needed health care services at the least cost. Managed care systems typically combine the financing and delivery of health services. They do this by covering some or all of the costs of health care services while encouraging the enrollees to obtain services from the organization's network of providers. In some managed care arrangements, the patients must seek care from within the health plan's network of providers. In other arrangements, the patient can obtain services from any provider, but the health plan will pay more of the bill if the patient obtains care from a network provider.

Two of the primary components of a managed care system are "utilization reviews," which oversee the amount and type of health care services being used, and provider reimbursement methods that discourage unnecessary care. Managed care organizations often require patients to get prior approval before obtaining certain services. Some of the most common managed care arrangements are:

- ◆ **Preferred Provider Organizations (PPOs).** PPOs seek to manage medical costs by contracting with a network of providers who are willing to accept lower reimbursement rates. The providers must often meet other requirements of the insurer, such as quality assurance or utilization review. Patients can choose any health care provider, but must pay additional money if they use a provider who is not part of the PPO network. In addition, they may be subject to the same utilization review requirements if they use a non-network provider, such as requiring prior authorization before a nonemergency hospitalization. PPOs are usually offered by traditional insurance companies.
- ◆ **Health Maintenance Organizations (HMOs).** HMOs have exclusive provider networks. They may also use primary care providers as "gatekeepers." Gatekeepers are responsible for arranging the patient's referral to a specialist or a non-emergency admission to a hospital. While some HMOs use gatekeepers, many HMOs now have "open access" plans. These plans allow the patient to choose any primary care provider or specialist in the network without a referral. Many HMOs also use reimbursement systems to encourage providers to be more cost conscious. HMOs typically contract directly with physicians or a network of physicians in the community. This arrangement is called a network or IPA model HMO. Alternatively, HMOs may have their own doctors on salary or in an exclusive contractual arrangement. This is called a group- or staff-model HMO.
- ◆ **Point-of-Service (POS).** POS are HMO plans that give the patient the opportunity to see providers outside of the network. Patients who use the HMO network of providers pay less than patients who see providers outside the network. The HMO may require the use of a gatekeeper to authorize in- or out-of-network services; however, they cannot impose greater restrictions on the use of non-network providers than they impose on accessing network providers.

HMOs may still use the same utilization review requirements for out-of-network care—such as the need to obtain prior authorization before a nonemergency hospitalization.

- ♦ **Primary Care Case Management (PCCM).** Primary care case management programs operate only within the Medicaid program. In PCCM programs the Medicaid agency pays a primary care provider a small monthly management fee to manage the patient's care. However, the doctor is reimbursed for the services he or she provides on a fee-for-service basis. The primary care provider acts as the patient's gatekeeper and must authorize all nonemergency visits to the hospital and all referrals to specialists. *Carolina Access* is the name of North Carolina's PCCM program.

HOW DO MANAGED CARE PLANS DIFFER FROM TRADITIONAL INSURANCE COVERAGE?

In a traditional insurance system the insurance company pays the bills but the patient has freedom to choose the provider. In most managed care arrangements the company limits the network of providers. Managed care plans usually give patients a financial incentive to obtain care from within the network.

What Is the Difference between an HMO, POS, and PPO?

HMOs have exclusive networks of providers. An HMO will not usually pay any part of your bill if you choose a provider outside of your HMO's network without prior authorization. HMOs do not usually require their members to pay a deductible, although there may be a co-payment each time you receive services.

HMOs are the most different from traditional insurance plans. They offer both advantages and potential disadvantages over other forms of health insurance. For example, HMOs emphasize prevention and are more likely to cover annual physicals or well child check-ups than are other insurance products. In addition, the HMO industry has made greater efforts to measure the quality of care provided to its members. While HMOs offer advantages over traditional insurance plans, there are also potential disadvantages. HMO members must obtain care from health care providers who are in the HMO's network. Sometimes, HMO members must obtain approval from their primary care provider before receiving care from a specialist. In addition, HMOs sometimes give doctors or other health care providers financial incentives to be more efficient managers of care. While these payment mechanisms provide an incentive to reduce unnecessary care, some people worry that they also may provide incentives to withhold necessary care.

If you have a point-of-service plan (POS), you can see providers outside the HMO network. The HMO will help pay part of the bill but will not pay as much as if you go to a provider within the network. For example, if you see a doctor inside the network, the HMO may pay all of the costs except any required co-payment. If you choose to see a doctor outside the network, the HMO may pay only 70-80% of the costs. You would be responsible for paying the remaining 20-30% of the costs. In

addition, you may also have to meet a deductible for out-of-network services, and may have to pay a higher premium. Under state law, HMOs can exclude coverage for preventive services if you obtain care from a non-network provider.

PPOs are more like traditional insurance companies. Once you meet the deductible, the insurance company will pay a certain percentage of the health care bill. However, you must go to one of the network providers to get the highest level of coverage. A PPO will pay a smaller percentage of the bill if you go to a provider outside the network. For example, the insurance company may pay 80% of the costs if you seek care from an in-network provider, but only 50-60% of the costs if you seek care from a non-network provider. Patients are allowed to make the decision themselves about which doctor to use.

WHAT SERVICES WILL BE COVERED?

It's important to figure out what health services will be covered by a given plan. Most major medical plans cover health services such as hospitalization and doctor's visits. However, not all insurance plans cover preventive services (such as immunizations or annual physicals). In addition, many plans limit the amount of services that are covered. For example, the company may limit the number of physical or occupational therapy visits that will be covered, or put dollar limits on certain services. It is very important to examine the list of covered services and exclusions, particularly if you have a special health care need. Ask to see a copy of the policy contract or evidence of coverage—these provide much more comprehensive descriptions of the services that are covered and excluded.

HOW MUCH DOES HEALTH INSURANCE COST?

There are very few restrictions on how much an insurance policy can cost. Wise shopping for health care coverage is difficult because of the wide variation in the cost of policies and in what the policies cover. When looking for health care coverage, you should be prepared to pay close attention to details and keep looking until you find a plan that meets your needs and is reasonably priced for the benefits it offers.

Be sure to find out the annual cost of the premium and consider this in relation to your annual income. Don't be afraid to reject the first quote that an agent gives you. Ask for another quote from another insurance company for the same or similar coverage. Premium charges can vary widely. An independent agent may very well be able to find you comparable coverage for a lower price with another insurance company. Also, ask your agent if there are any group plans that you may be able to join (such as an association or church plans). Depending on your age and health status, group plans may be more affordable than non-group, individual plans.

Note: if it sounds too good to be true, it probably is! Comprehensive coverage from a reliable insurance company will almost never be cheap. Paying a few more dollars to get the

coverage you want from the insurance company you trust may well be the best buy in the long run.

ARE THERE ANY “HIDDEN” COSTS?

Policies have varying deductibles and levels of co-payments or coinsurance. A “*deductible*” is the amount you must spend on medical services out of pocket, usually in the space of one year, before the insurance policy begins to pay benefits. A “co-payment” or “coinsurance” is what the insurance company requires you to pay when you use medical services. A *co-payment* is usually a fixed amount (for example, \$20 for a doctor’s visit). *Coinsurance* is generally a percentage of the allowable charges (for example, the insurer may pay 70% of the allowable charges, leaving you 30% of the bill to pay).

Some policies have a deductible of \$500 for an individual or \$1,500 for a family. With this kind of policy you would have to pay \$500 in medical costs out of your own pocket before the insurance company would begin to pay claims. Once the combined uncovered bills for all of your family members reaches \$1,500, then the insurer will pay the remainder of allowable claims for all of the family members. Other policies have larger annual deductibles—in the \$1000-\$2000 range (some are even larger).

Plans also have varying levels of co-payments and coinsurance. Certain services, such as inpatient hospitalization or certain preventive health services, may be 100% covered. Other services are not fully covered. You may be required to pay a percentage of the provider’s bills (coinsurance) or a fixed payment per visit (co-payment). Some policies have both co-payment and coinsurance requirements, depending on the service. Read your policy for the schedule of benefits or plan summary, which will, among other things, list the co-payments, coinsurance and deductibles.

Some policies also have pre-certification requirements. For instance, your policy may require you to call a special phone number at the insurance company before your doctor performs surgery. Failure to get pre-certification may mean that the insurance company will refuse to pay for the services, or that they will pay only a portion of the charges. Be sure to follow the pre-certification rules to the best of your ability. Your policy will specify these requirements, so read the policy carefully.

Some policies have additional charges that you should ask about before purchasing. For example, some companies charge a one-time fee to cover the cost of the application process and/or administrative charges. The average amount for a one-time application fee may be in the \$50 range. If it is significantly higher, you may want to ask why.

ARE THERE OTHER LIMITATIONS THAT I SHOULD KNOW ABOUT?

Most policies include some limitations in coverage. Two of the most common limitations are waiting periods and coverage maximums.

A waiting period could be the 60- or 90-day period that applies to most employment-based coverage. Under this type of waiting period, a new employee must wait a specified time before coverage begins. Another type of waiting period is a “pre-existing condition exclusion waiting period.” (See following section for more information about exclusionary waiting periods.)

Coverage maximums define the maximum amount the policy will pay, either annually or over your lifetime. “Lifetime maximums” set the total amount the insurance company will pay for all covered medical services over the course of your lifetime. A lifetime maximum might be \$1,000,000 or \$2,000,000. A lifetime maximum may also be imposed on specific services. For instance, a policy might impose a lifetime maximum of a certain dollar amount for organ transplants.

“Annual maximums” define the total amount the insurance company will pay for covered medical services in a year. Annual maximums may apply to all services or just to certain services. It is not unusual for a policy to impose annual maximums on treatment of chemical dependency or durable medical equipment.

Many policies also exclude injury or illness that results from participation in a felony or illegal occupation; injury or illness related to alcohol abuse; acts of war; court-ordered examinations or care; custodial or maintenance care (such as care in adult care homes) or services provided solely for personal comfort, hygiene or convenience. Insurance companies may also exclude coverage for injuries or illnesses that are covered by another insurance plan, such as work-related injuries (which may be covered by workers compensation), or for services covered by Medicare or the Veterans Administration.

WHAT IF I HAVE A PRE-EXISTING CONDITION?

Under certain circumstances, health plans are allowed to limit coverage to people with pre-existing conditions. Pre-existing conditions are mental or physical conditions for which you sought medical advice, care or treatment within six months prior to your enrollment. Health plans, both HMOs and insurance companies, can limit coverage for up to 12 months for individuals who enroll in a health plan during a normal enrollment period. With certain exceptions, a person who enrolls late—after the normal enrollment period—can be excluded from coverage for pre-existing conditions for up to 18 months. However, individuals who enroll late because they lost other health insurance coverage are generally not considered “late” enrollees. Therefore, they can only be subject to a maximum of 12 months pre-existing condition limitation.

A patient who has a pre-existing condition may be excluded from coverage for the services needed to treat that condition. The health plan will cover other services that are unrelated to the pre-existing condition. For example, if a person has cancer or a heart condition, the health plan can exclude coverage for those conditions, but will still be required to pay for other health services unrelated to the heart condition or cancer. The reason that health plans are allowed to limit coverage for pre-existing conditions is to discourage individuals from waiting until they are sick before purchasing health insurance coverage.

Once you meet the 12- or 18-month pre-existing condition limitation period or are enrolled in a health plan for at least 12 months, you are given additional protections. You cannot be subject to a pre-existing coverage limitation if you later develop health problems. In addition, you will not be subject to a pre-existing coverage limitation if you change health plans and enroll in your new plan within 63 days of ending your prior health insurance coverage. If you met part of an exclusionary period, you must be given credit for that time when enrolling in a new health plan. For example, if you received health insurance through ABC insurance company, and met six months of a 12-month exclusionary period, you must be given credit for those six months if you enroll in XYZ insurance company within 63 days of leaving ABC.

Under certain circumstances, insurers that sell individual (non-group) policies may refuse to cover certain conditions at all. This is most likely to happen if a person has a pre-existing condition. This kind of exclusion is usually called a “rider.” A rider may exclude coverage for exactly the medical condition that you need coverage for the most. If you are shopping in the non-group market, be sure to check to see whether certain health conditions are excluded from coverage.

WHEN WILL MY COVERAGE END?

Health insurance coverage may end as a result of an action that you take, or by an action of the insurance company. You may cause the insurance policy to end by:

- ◆ Requesting to drop coverage, usually in writing
- ◆ Failing to pay the premium
- ◆ Reaching a certain age (some policies specify that when you reach a certain age, your coverage automatically ends)
- ◆ Making fraudulent misstatements. If you intentionally provide false information on an insurance application and subsequently file a claim for benefits, the insurance company may uncover the truth in the course of processing your claim. Under such circumstances, your policy may be canceled as if the coverage was never in force, you may be subject to a pre-existing condition exclusion, or your coverage may be reduced.

The insurance company may also cancel the policy in certain circumstances. For example, the company may decide to terminate the entire line of business. As a

general rule, the company cannot cancel your policy if you continue to pay premiums, if the company continues to offer the same type of policy to others in North Carolina.

WHAT HAPPENS IF I CANCEL MY CURRENT POLICY AND BUY A NEW ONE?

Depending on your type of coverage, new conditions of coverage may be applied to you. For example, if you are shopping in the individual (non-group) market, you may need to give information about your health status. Coverage may be more difficult to obtain if your health declined after you bought the original policy. In some instances, you may be subject to a new pre-existing condition waiting period. In general, it is not wise to cancel one policy before obtaining coverage from another company.

WHAT SHOULD I REPORT ON MY APPLICATION?

You should try to answer all of the insurance questions completely and honestly. Omissions could be interpreted as fraudulent misstatements, which can result in significant penalties or even in the cancellation of your policy. Fraudulent misstatements (that is, statements made with the intent to deceive) that are discovered within the first two years of the policy's life will almost always result in the insurance company rescinding your coverage and refunding your premiums.

HOW SHOULD I COMPARE POLICIES?

Not everyone has a choice of health plans. However, if you are offered a choice of different health plans, you may want to consider the following factors:

Health Care Providers: If you are considering a managed care product (HMO, POS, or PPO), find out if your doctor is part of the managed care network. You should also check to see what specialists, hospitals, specialized treatment centers, and other practitioners are included in the network. This is especially important if you have chronic or special health problems. For example, if you have a child with special health needs you may be interested in finding what pediatricians are included in the network. You may also want to know whether the provider network includes pediatric specialists that can address your child's health condition. If you want to continue your care with a provider who is not in the network, you may want to consider enrolling in a preferred provider organization (PPO) or a point-of-service plan (POS) if given that choice.

Services: Check to see what services are covered or excluded under the plan. You will be given a Summary of Benefits or Plan Summary that summarizes the covered services. If you have a special health need, ask to see the Evidence of Coverage that lists the covered and excluded services in more detail. It also lists any limitations in services. For example, many plans limit the number of physical or occupational therapy sessions, or how often a patient can have durable medical equipment replaced. Check the Evidence of Coverage for more specific information about the

limitations in covered services. Also check to see where the services are offered and whether they are available in your area of the state. If you have a choice of plans, you may want to talk with your provider to determine which service package best meets your needs.

Treatment of Certain Health Conditions: If you have special health needs, you may want to find out how the insurance company or HMO typically treats other people with the same health condition. New state laws give you a right to request certain information from an insurer before you choose to join. You can ask the insurer or other managed care company for:

- ◆ An explanation of the *criteria* or *clinical treatment protocols* that the health plan uses in deciding what types of services or treatments are appropriate. For example, you might want to find out what services the insurer would authorize to treat patients with sickle cell anemia, inflammatory bowel disease, infertility, autism or severe mental illness.
- ◆ Information about the *health plan's referral process*. You should check the insurer's prior authorization and referral process, especially if you have a health condition that requires you to see your specialist frequently.
- ◆ Information about *Centers of Excellence*. Some health plans contract with "Centers of Excellence" for certain services such as transplant care. You may be required to travel to other cities or states to obtain those services. It is important to find out where the services are provided, as well as whether the health plan will pay for transportation and lodging costs if the service is outside your immediate area. Check whether the plan will also pay the transportation and lodging costs of a parent if a child is required to travel outside the service area for care.
- ◆ *Case management protocol*. You may want to see if the insurer has someone who can help you or your family member coordinate all the needed health care services. It is important to realize that a health plan's case manager is not necessarily the same as a patient advocate. A case manager who is employed by the health plan may help you obtain and coordinate health care services, but may also have a responsibility to the insurer to try to reduce health care costs.
- ◆ *The drug formulary*, a listing of medications that the insurer will cover. Health plans often have different medications to treat hypertension, depression, ulcers, or schizophrenia. Find out if your specific medication is covered on the health plan's formulary. If it is not, you may be able to get an exception to the formulary, but that might require more work.

Quality: The NC Department of Insurance collects significant information to use in comparing HMOs and sometimes PPOs. However, it is difficult to determine the quality of a traditional insurance company. Some of the factors to consider include:

- ◆ Whether the health plan has been accredited by a national accreditation organization. (Note: managed care organizations are more likely to be accredited than traditional insurance companies.)

- ◆ How the plan compares to other plans on certain performance data (such as the percentage of women who receive recommended mammograms or pap smears, or diabetics who receive yearly eye examinations).
- ◆ Whether large numbers of enrollees or groups are leaving the plan, or whether doctors are withdrawing in large numbers.
- ◆ Information about member satisfaction with the plan. This information is gathered as a result of yearly HMO consumer satisfaction surveys.
- ◆ How often the plan reviews requests for medical services (“utilization review”) and how often these reviews are denied and appealed.
- ◆ Other complaints that members have with the plan (grievance reports).

Most of these measures are limited to managed care arrangements (either HMOs, PPOs, or POS). However, the Department of Insurance also keeps a record of complaints that it receives from consumers against health insurers or managed care organizations. This information can be obtained from the Department of Insurance, Consumer Services Division.

Costs: Find out the costs of the different health plans, including monthly premiums and out-of-pocket costs in the form of deductibles, coinsurance or co-payments and annual or lifetime limits. An HMO with a higher monthly premium may cost less money on a yearly basis after considering deductibles and coinsurance.

Example: Mary Jones is given a choice to enroll in Insurance Company A or HMO B. Insurance Company A charges \$185 a month in premiums. The plan has a \$250 deductible, after which it will pay 80 percent of all other health care services. HMO B charges \$200 a month in premiums, but only requires a \$10 co-payment per visit to the doctor. Mary’s annual health care costs will depend on her use of health services and the costs incurred. Even though Insurance Company A’s premiums are less expensive, Mary may spend more money on a yearly basis if she has multiple visits to the doctor. For example, it would be less expensive for Mary to join the HMO, if she sees the doctor three times a year, assuming an average cost of \$100 a visit. She would have to pay \$2,480 for Insurance Company A (\$2,220 premium costs, plus a \$250 deductible, plus \$10 for the 20 percent coinsurance). It would cost \$2,430 for HMO B (\$2,400 premium costs, plus \$10 co-payments).

Remember, your best protection is being an alert consumer. It is important to read the insurance or HMO policy cover to cover before you purchase. Don’t be a afraid to question your agent, the insurance company, or the Department of Insurance before purchasing insurance.

FOR MORE INFORMATION

Consumer Services Division

N.C. Department of Insurance

(800) JIM LONG (546-5664) outside the Raleigh area
(919) 733-2032

The Consumer Services Division can answer questions about your insurance policy either before purchase or after you have obtained coverage.

Independent Insurance Agents, N.C. Chapter

Bob Byrd, Executive Vice President
PO Box 1165
Cary, NC 27512
Phone: (919) 828-4371

North Carolina Association of Health Underwriters

Carol Matznick, Executive Director
P.O. Box 38905
Greensboro, NC 27438
Carol4ncahu@aol.com
Phone: (336) 605-9108
Fax: (336) 605-9103

NC Association of Insurance Financial Advisors

Cletis Wooton, President
P.O. Box 827
Statesville, NC 28687
Phone: (704) 838-0837
Fax: (704) 873-0215

PART II

INSURANCE FOR INDIVIDUALS

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INDIVIDUAL (NON-GROUP) POLICIES

What are they?

An individual health insurance policy is one that is purchased outside a group setting. (Most employment-based insurance is group insurance.) For this reason individual policies are also called “non-group” policies. Individual policies are often more expensive than group plans with comparable coverage. They may also offer less coverage than group policies.

Who are they for?

Individual policies are usually written for people who are unable to purchase health insurance through a group. Individual policies can, however, be issued to people who have group coverage available to them. For instance, some people choose to purchase individual policies to supplement their group plan. Others may purchase non-group policies so that their health insurance coverage is not dependent on their employment.

Non-group policies can be written for individuals or families — a policy written for more than one member of a family doesn’t make it a group policy. The difference is that an individual policy, whether written for one person or for a family, is not part of a master policy issued to a group.

How to obtain coverage

Individual policies can be purchased through insurance agents. Please see the information on choosing an agent in “How to shop for health insurance,” Chapter 2 of this guide. Bear in mind that there are literally thousands of insurance policies being offered for sale in North Carolina. You should be prepared to spend some time shopping for a policy that meets your needs.

INTRODUCTION

With some exceptions, almost anyone can purchase an individual health insurance policy. As a rule, non-group policies are written for individuals or families who do not qualify for group coverage. However, some people who are eligible for group coverage choose to purchase individual policies — just being eligible for a group policy does not make you ineligible to purchase an individual policy. Individual policies often have much higher administrative expenses, making the premiums more expensive than similar coverage for groups. In addition, some people may be excluded from coverage based on their health status.

Non-group plans come in a variety of types. Some of the plans are more comprehensive than others in covering a wide range of medical services. Non-group coverage falls into the following broad categories.

Managed Care Plans: In a managed care plan, you will generally get your medical care from a set list of medical providers approved by the plan (“network”). These plans often emphasize preventive health services. They also offer comprehensive coverage of other medical services (for example, physician visits and hospital stays). Managed care plans include Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO), or Point-of-Service plans (POS). HMOs generally limit coverage to network providers. PPOs and POS plans allow you to choose a medical provider outside the network, but the plan will cover a smaller portion of a medical bill from an out-of-network provider. HMOs and POS plans are usually limited to employment-based group insurance plans. PPOs, however, may be offered to people purchasing non-group insurance.

Major medical insurance policies: Major medical insurance provides broad coverage for outpatient expenses (such as doctor visits) and hospital stays. Major medical policies have some limitations but they usually provide high maximum benefit amounts.

Catastrophic policies: Catastrophic policies have large deductibles (\$5,000 or \$10,000 a year). After you meet this large deductible — usually because of a devastating accident, a major illness, or a prolonged hospital stay — the catastrophic policy begins to provide coverage. Because of the large deductible, this type of plan ordinarily offers little or no coverage of primary or preventive services, but its coverage of catastrophic illnesses or accidents is quite comprehensive.

Indemnity insurance policies: Indemnity insurance provides a specified dollar amount for a given medical service. For instance, an indemnity policy would pay a set dollar amount (not a percentage of the actual charges) for each day of a hospital stay.

Dread disease policies: Dread disease policies provide benefits solely for the treatment of a disease named in the policy — most typically cancer or heart disease. As with indemnity insurance, described above, these policies usually pay a fixed dollar amount for specific items outlined in the policy. For instance, a “dread disease” policy covering cancer might guarantee the payment of X dollars for radiation treatment. This type of policy often offers substantial maximum benefits; that is, it will pay a large amount over a person’s lifetime for treatment of the covered condition. But this type of coverage is otherwise very limited. A “dread disease” policy covering cancer, for instance, would provide no benefits for the treatment of an injury or any medical condition other than cancer. A “dread disease” policy should only be considered a supplement to other insurance.

BENEFITS

With some exceptions, health insurance policies sold in North Carolina must provide coverage of certain mandated benefits. Mandated benefits are listed in Chapter 22 of this book, “Consumer Protections.” Individual policies must provide these mandated benefits, but they are not required to cover any other specific services. So, for instance, an individual policy may cover an annual physical, but it is not required to — an annual physical exam is not a mandated benefit.

One exception is a “dread disease” policy. This type of policy is not required to cover mandated benefits. However, the non-discrimination provisions in the state’s insurance laws do apply to all health policies, including dread disease plans.

ELIGIBILITY

People who are not covered by a group insurance policy are eligible, at least in theory, to purchase an individual policy. For example, if your spouse receives health insurance through her employer, but her employer does not offer family coverage, you may want to purchase an individual policy for yourself. However, individual policies usually involve “medical underwriting” — that is, the insurance company can ask about your medical history and can refuse to offer you coverage because of it.

If you have been refused coverage because of a medical condition, you may be eligible for the Access Program of Blue Cross and Blue Shield of North Carolina. Please see Chapter 4 of this book for more information.

LIMITATIONS AND EXCLUSIONS

People who are considered high-risk, or who have a history of medical problems, may not be able to purchase a regular non-group policy at all. However, insurers may not refuse to cover some individuals because of their health status. To qualify for this special protection, you must meet the following criteria:

- ◆ You must have had prior health insurance coverage for at least 18 months, through an employer-based group health plan, governmental plan, or church plan
- ◆ You must not be eligible for health insurance under a group health plan, Medicare or Medicaid, and may not have other health insurance coverage
- ◆ You did not have your health insurance coverage terminated because of non-payment of premiums or fraud
- ◆ You elected COBRA continuation coverage if offered
- ◆ You exhausted your COBRA continuation coverage (if applicable)

Insurers that market health insurance in the non-group market must offer coverage to any individual who meets the criteria set out above. Further, they may not impose

a pre-existing condition exclusion. They must offer the two most popular non-group policies to these qualified individuals. (Generally, one of the policies must have comprehensive coverage, and the other may be more limited.) However, there is no limit on what the insurer can charge. So effectively, insurers can set their premium prices high enough to discourage most people with pre-existing medical conditions from purchasing insurance.

Individuals who do not meet the criteria above may be denied a non-group policy based on their health status. If you have been denied insurance because of a medical condition, you may be eligible for the Access Program of Blue Cross and Blue Shield of North Carolina.

Insurers may impose pre-existing condition exclusions on the policy if you are offered health insurance coverage, but do not meet the criteria above. Insurers are permitted to impose a waiting period of up to 12 months before they will begin paying benefits on certain pre-existing conditions. For instance, if you were treated for migraine headaches within six months before purchasing your individual policy, it might not pay any benefits for treatment of migraines until you have had the policy for 12 months. After the waiting period is over, however, the condition must be covered.

Individual policies may also contain “riders.” If you have a policy with a rider, you may have comprehensive coverage of every condition except the one named in the rider. If, for instance, you were treated for epilepsy before you purchased an individual policy, a rider may deny coverage of any epilepsy treatment for as long as you hold the policy.

NOTICE

When you buy an individual policy, the company must furnish you the official policy (not just a brochure or summary). The policy outlines your rights, benefits, and responsibilities under the plan. If material changes are made to the plan, you must be provided information about these changes. Proposed changes must also be filed with the Commissioner of Insurance. The Commissioner has the authority to approve or deny proposed changes in a policy’s coverage.

RENEWABILITY

Individual policies may be sold as either guaranteed renewable, conditionally renewable, or optionally renewable. Guaranteed renewable policies must be continued, as long as the covered individual pays the premium. Conditionally renewable policies are generally renewable, until the covered individual reaches a certain age that was specified in the policy (at which point, the insured individual is no longer eligible for benefits). Optionally renewable policies may be discontinued by the insurer, but only if the insurer discontinues the whole block of business. In other words, the insurer cannot single out and discontinue coverage for specific individuals (if they continue to pay the premium).

While you cannot be terminated because of your health status or use of health services, you can be denied continued coverage for the following reasons:

- ◆ Non-payment of premiums
- ◆ Fraud
- ◆ The health insurer stops offering health insurance in the individual market
- ◆ You move outside the insurer's coverage area

An insurer must provide at least 90 days notice before discontinuing a particular type of insurance coverage offered in the individual market; and at least 180 days prior to discontinuing all non-group insurance coverage. If an insurer chooses to stop providing a specific type of policy, it must offer the individuals covered under the non-group policy the option to purchase any of its other non-group policies.

PREMIUMS

Insurance carriers must file information on non-group premium rates with the North Carolina Department of Insurance. The Commissioner of Insurance has the authority to determine if a proposed rate increase is justified or not. This determination is made on the basis of established guidelines. The Commissioner uses a mathematical formula (called a "minimum loss ratio") to calculate how much of the premium dollar is being spent to pay for medical services and how much goes to company profits or overhead expenses. A large rate increase may be approved if the insurance company can show that it has paid out large medical claims under the plan.

If the Department of Insurance approves a rate increase, then the insurance company may raise the premium rates. However, the rate increase must apply to everyone with the same "policy form" (i.e., type of health insurance policy). You cannot be singled out individually for a premium increase.

If you have an individual policy, you are entitled to 45 days written prior notice of a proposed increase in your premium rates.

ADMINISTRATION

The North Carolina Department of Insurance has the legal authority and responsibility to regulate insurance carriers and HMOs. The Department's oversight of insurance includes seeing that the plans are financially solvent, meet certain quality standards, and have certain procedural safeguards. If you have questions about the administration of your insurance coverage, you may contact the Consumer Services Division of the Department of Insurance.

SOURCES OF LAW

State law(s): N.C.G.S. 58-51-1 *et. seq.*, 58-68-60 *et. seq.*

State regulation(s): 11 N.C.A.C. 12.0300 *et. seq.*
11 N.C.A.C. 12.0500 *et. seq.*

FOR MORE INFORMATION

Consumer Services Division
N.C. Department of Insurance
PO Box 26387
Raleigh, NC 27611
(800) 546-5664 outside Raleigh
(919) 733-2032

BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA ACCESS PROGRAM

What is it?

The Access Program, offered by Blue Cross and Blue Shield of North Carolina (BCBSNC), makes health coverage available to individuals who are not able to obtain health coverage because of pre-existing medical conditions. The program was established in 1991.

Who is it for?

The Access Program is for persons who have been denied health coverage by private insurance plans because of pre-existing physical or mental health conditions (i.e., conditions which existed prior to the attempt to purchase insurance).

To be eligible for the Access Program, an applicant must meet the following criteria:

- ◆ Must be under age 65
- ◆ Must have been a resident of North Carolina for at least six months
- ◆ Cannot be eligible for Medicare or Medicaid
- ◆ Must have been denied coverage by Blue Cross and Blue Shield of North Carolina or another private insurer

People with a pre-existing medical condition often find it difficult to purchase health insurance, or find that the only coverage they can purchase excludes the pre-existing condition. The Access Program does not deny coverage because of a pre-existing condition, and, except for a six-month waiting period, it does not exclude coverage of the pre-existing condition. However, because people with pre-existing conditions often require frequent and/or extensive medical attention, costs associated with their care may be high. As a result, the cost of Access Program premiums is considerably higher than many other insurance premiums.

How to obtain coverage

Detailed information about the Access Program is available in the company's main office in Durham, N.C. You can get information about application procedures by calling the toll-free Subscriber Services number at Blue Cross and Blue Shield of North Carolina: (800) 324-4973.

COVERAGE

As with many insurance policies, the Access Program begins to pay for services only after the covered person meets a deductible. The Access Program offers two deductible options: \$500 (Access 500) and \$1,000 (Access 1000). After an individual meets the deductible, the plans pay 80% of the covered services. The following benefits offered by the Access Program are paid at 80% of the provider's reasonable charge. Coverage is provided up to a lifetime maximum of \$500,000.

- ◆ Inpatient and hospital care (bed, board, and general nursing services, including services rendered in an intensive care or cardiac care unit)
- ◆ Surgical and medical care
- ◆ Ambulance services and care for accidents and emergencies
- ◆ Ancillary services provided in a hospital (prescribed drugs; blood; anesthesia; therapy; diagnostic services; and operating, delivery, and treatment rooms)
- ◆ Ambulatory surgery (performed in a doctor's office, clinic, or outpatient department of a hospital)
- ◆ Maternity services (normal pregnancy, interruptions of pregnancy, and nursery care)
- ◆ Inpatient and outpatient psychiatric care (There is a lifetime limit of \$10,000 in total benefits for psychiatric care, whether received on an inpatient or outpatient basis. Unlike other services, Access will pay only 50% towards outpatient psychiatric care, and is limited to a \$4,000 per benefit period.)
- ◆ Private duty nursing (up to \$3,000 per benefit period)
- ◆ Skilled nursing facility care (up to 120 days per benefit period)
- ◆ Home health care (up to 270 visits per benefit period)
- ◆ Physical therapy (limited to 60 days per illness or injury)

In addition, Access covers dental care related to an accidental injury, durable medical equipment, prosthetics, orthotics, medical supplies, and prescription drugs.

All benefits are subject to some limitations and exclusions. Call Blue Cross and Blue Shield for information.

What about Pre-Existing Conditions?

There is a six-month waiting period for coverage of pre-existing conditions. If you have been involuntarily terminated from another health care plan for any reason other than nonpayment of premiums, and you apply for Access within 63 days of the termination date, the pre-existing condition waiting period will be waived to the extent it was fulfilled under your old program. In other words, if under your old policy you fulfilled four months of a six-month waiting period, under the Access

Program you will have to meet only a two-month waiting period before the pre-existing condition will be covered.

LIMITATIONS

Benefits for maternity services are available only under a policy covering the subscriber and spouse. Maternity benefits are not covered for dependent children.

The Access program also excludes the following services:

- ◆ Services received or hospitalization that started before the effective date of coverage
- ◆ Services not ordered by a doctor or not medically necessary as determined by Blue Cross and Blue Shield of North Carolina
- ◆ Services that are investigational in nature
- ◆ Custodial care
- ◆ Routine physical exams, immunizations, and well-baby care (except for Pap smears, mammography, and prostate-specific antigen tests, which are covered)
- ◆ Reversal of sterilization
- ◆ Prescription drugs for the purpose of contraception; artificial conception; treatment related to transsexualism, sex changes or modifications; and treatment of sexual dysfunction not related to organic diseases
- ◆ Hearing aids, eye exams, and eyeglass or contact lens fittings
- ◆ Dental services (except those related to an accidental injury)
- ◆ Long-term therapy or long-term rehabilitation
- ◆ Organ transplants
- ◆ Allergy testing, treatment for weight control (except morbid obesity)
- ◆ Cosmetic surgery

Additional limitations and exclusions may apply to this coverage.

FOR MORE INFORMATION

Blue Cross and Blue Shield of North Carolina Access Program

P.O. Box 2291
Durham, NC 27702
(800) 324-4973

CONTINUATION AND CONVERSION POLICIES

What are they?

Continuation and conversion policies are for certain people who lose their group health insurance coverage. People who lose coverage may be entitled to continue their group health insurance coverage for a certain length of time (“continuation” policy). After this time has run out, they may be able to convert their group plan into an individual non-group policy (“conversion” policy). Both state and federal laws govern continuation and conversion policies; however, federal laws are limited to employers with 20 or more employees.

Who are they for?

Some people who lose their group health insurance are entitled to continuation and conversion coverage. Typically, these are individuals who had group employment-based health insurance coverage. The most common examples of people who qualify for continuation and conversion coverage are those who:

- ◆ Have had their hours reduced so they no longer qualify for health insurance coverage
- ◆ Have been fired from or have quit a job
- ◆ Lose employer-based health insurance due to divorce, legal separation, or the death of the covered employee
- ◆ Are children who have aged out of dependent coverage

How to obtain coverage

You are entitled to written notice of continuation and conversion options. Different rules apply as to when the notice must be given and to whom, depending on whether the situation is governed by federal or state law. You also must be given a set amount of time to choose this type of coverage. Most employers do not pay for continuation coverage. If you elect to take the coverage, you probably will have to pay the premiums yourself.

INTRODUCTION

North Carolina enacted continuation and conversion laws in 1981. The federal government enacted similar laws in 1986. The federal laws are commonly called COBRA (for the Consolidated Omnibus Budget Reconciliation Act, in which these provisions are found).

Federal COBRA laws govern most situations. COBRA gives beneficiaries greater rights than state law to continuation policies and some rights to conversion policies, but it applies only to those who had group health insurance coverage from an employer with 20 or more employees. An employee who had health insurance coverage from a smaller firm would be covered under the North Carolina continuation and conversion laws.

COBRA requires certain employers to offer employees and former employees and their spouses and dependents the opportunity to continue their group health insurance coverage if they lose coverage because of what is called a “qualifying event.” After the time for being covered by a continuation policy has run out, COBRA requires certain insurers to give you the right to convert your group health insurance into an individual (non-group) policy. However, federal law does not give much guidance on conversion policies. State law provides the terms of coverage for conversion policies. Thus, with certain limited exceptions, conversion policies will be discussed in the state section, not in the COBRA section.

FEDERAL CONTINUATION POLICIES (COBRA)

Introduction

COBRA does not apply to all employers. It is limited to employers who employed 20 or more employees on a typical business day during the preceding calendar year and who were already providing a group health plan to their employees. COBRA does not apply to plans provided by the federal government or by church-related organizations. Also, COBRA does not require employers to begin providing coverage if they weren't already doing so. If an employer ends its group health plan for all of its employees, it is not required to provide continuation or conversion insurance options to any employee, former employee, or qualified beneficiary.

Benefits

Continuation insurance must be identical to the plan it provides to current employees. When the employer modifies the plan for current employees, coverage must be similarly modified for those receiving continuation benefits. So, for instance, if your employer's health insurance for employees is a major medical plan, the continuation insurance offered to you cannot be just a catastrophic plan. And, if your former employer adds benefits for current employees, the same benefits must be added to continuation plans.

Eligibility

Employees, former employees, the spouse or surviving spouse of an employee, and dependent children who were previously covered under an employer's health plan may qualify to have their group health insurance continue. (In other words, if your family members are not covered under your employment-based plan, you can't purchase insurance for them under your continuation insurance.) These individuals

may qualify for continuation policies if one of the following things (called “qualifying events”) happens:

- ◆ The covered employee dies
- ◆ The covered employee loses health insurance because he or she was fired, quit the job, or no longer qualifies because of reduced hours
- ◆ The covered employee is legally separated or divorced from his or her spouse
- ◆ The covered employee becomes entitled to Medicare benefits
- ◆ A dependent child ceases to be a dependent

In general, COBRA permits you to have continuation coverage for up to 18 months (longer in some special cases). If you have not become covered by a new group plan at the end of the maximum time, COBRA requires that you be offered conversion insurance. Information about your right to purchase a conversion policy should be in your original policy.

You are not entitled to a conversion policy, however, if:

- ◆ The employer ceases to provide any group health plan to any employee
- ◆ You fail to pay a required premium
- ◆ You become covered by another plan or by Medicare
- ◆ You are covered by a self-funded plan

Limitations and exclusions

Continuation plans are not allowed to require medical underwriting. That is, the coverage cannot be limited because of a person’s health history or the potential need for health services. Anyone who received benefits prior to a “qualifying event” cannot be denied coverage because he or she falls into a particular risk group, or fails to meet certain health requirements. In addition, conditions that were covered before the qualifying event took place must continue to be covered.

Continuation plans are not permitted to impose new pre-existing condition exclusions. They may, however, contain the same provisions as those in the plan available to the company’s current employees. Thus, with continuation coverage, you may be required to serve out any waiting period that you have not yet satisfied under your employer-based coverage. For example, if you have already met ten months of a twelve-month waiting period while employed, you might be subject to a two-month waiting period under the continuation policy.

Notice

An employee and spouse must receive written notice of their rights to continuation coverage when their coverage under a group plan begins (i.e., when the employee first is covered by the employer’s health insurance plan). Notice about rights to continuation coverage must be given again after a qualifying event.

The employer has the responsibility of notifying the insurance company if an employee dies, is fired, has his or her hours reduced, or becomes eligible for Medicare. If one of these events occurs, notice must be given to the insurance company, HMO, or plan administrator within 30 days of the qualifying event.

The employee or qualified beneficiary is responsible for notifying the health plan if the qualifying event is divorce or separation, or if a dependent “ages out” of coverage. In these instances, notice must be given to the health plan within 60 days of the event.

After the insurance company, HMO or plan administrator receives notice of the qualifying event, it has 14 days to notify you of your right to continuation insurance.

Federal COBRA law states that when an employer is obligated to provide conversion insurance, they must provide notice of this option in the 180-day period before continuation coverage expires. The COBRA conversion option is not available if you discontinue your continuation coverage before your eligibility expires (usually 18 months), or if the plan is self-funded.

Enrollment

You must be given at least 60 days after receiving notice of eligibility to elect continuation coverage (though an insurance company may give you more than 60 days). The coverage is then retroactive to the date of the qualifying event. Thus, once you elect continuation coverage, you are covered for all health services that were rendered during the 60-day “election period.” Each qualified beneficiary may make an independent election. So, for instance, you might elect continuation coverage after losing your job, and your spouse (who was covered by your insurance but could get coverage through his or her job) might choose not to take the coverage.

Length of coverage

People who elect coverage are ordinarily entitled to continue their group health insurance for at least 18 months. Coverage begins as soon as the group plan’s coverage expires, and not when continuation coverage is elected or when the first premium is paid. Once continuation coverage is elected, the coverage is retroactive to the date that employer-based group health coverage ended.

The normal 18-month period can be extended under certain circumstances. For example, the period of coverage is 36 months when the qualifying event is:

- ◆ Divorce or legal separation (which would otherwise result in the employee’s spouse losing coverage)
- ◆ Death of the employee
- ◆ A dependent child reaching the age of maturity
- ◆ The employee becoming entitled to Medicare

The period of coverage can be extended for 11 months (up to 29 months) for some qualified beneficiaries who are disabled at the time of the qualifying event (or within 60 days thereafter). To be eligible for the additional 11 months coverage, the individual must provide information of a Social Security disability determination within 60 days of the date of the determination and before the expiration of the initial 18-month period.

Coverage can be discontinued at any time, if:

- ◆ The employer stops providing group health coverage to all employees.
- ◆ A premium payment is not made on time. (Note: payments are considered timely if they are made within 30 days of their due date, although employers may allow a longer grace period).
- ◆ The qualified beneficiary becomes covered under another group health plan (as long as he or she is not subject to a pre-existing condition exclusion).
- ◆ The qualified beneficiary becomes covered by Medicare. In that event, the person who is covered by Medicare will be ineligible for continuation coverage, but his or her dependents and/or spouse may continue to receive continuation coverage.

Premiums

Employers can, and usually do, require the former employee or qualified beneficiary to pay a premium for continuation coverage. However, the premium cannot exceed 102% of the cost of insurance for a similarly situated beneficiary who is still receiving the employer-sponsored health insurance coverage. So, for instance, if your employer-based coverage costs \$200 a month, your continuation coverage may cost you up to \$204. If a former employee is provided with extended disability coverage, then the premium can be increased to 150% of the cost of insurance after the initial 18 months of coverage.

Other provisions

Under COBRA, you cannot be required to make your first continuation premium payment until 45 days after you elect continuation coverage. (State law, by contrast, requires your first payment before employer-based coverage ends.)

Even if you become covered under a new group health plan, continuation coverage cannot be discontinued if the new group coverage is substantially less comprehensive than your old policy.

STATE CONTINUATION AND CONVERSION POLICIES

Introduction

North Carolina's continuation and conversion privileges apply to all former employees who were continuously covered under an employer's insurance policy for three months prior to termination of coverage. As long as that requirement is met, continuation coverage is available, regardless of the circumstances involving loss of employment. The state's continuation coverage also applies to employers with fewer than 20 employees. The state's continuation and conversion privileges do not apply to self-funded (ERISA) plans. In addition to employees who lose employment-based group health insurance plans, members who lose coverage under other group plans (for example, association plans), can also qualify for continuation coverage. As noted previously, state law provides most of the guidance for conversion policies.

State Continuation Policies

Benefits

North Carolina continuation laws do not require the continuation plan to be identical to the plan offered other employees or members covered under the group plan. For example, continuation plans are not required to include dental, vision care, or prescription drug benefits, even if current employees receive coverage for these services. In general, the state continuation laws require only that group continuation plans include hospital, surgical, or major medical plans.

Eligibility

In addition to the COBRA eligibility requirements listed above, state law requires that, in order to be eligible for continuation coverage, an employee or member must have been continuously insured under the group health plan for three consecutive months before losing coverage.

Limitations and exclusions

Insurers are not permitted to impose new exclusions or waiting periods under the state's continuation law.

Notice and enrollment

Notification of the continuation privilege must be included in each certificate of coverage. In addition, employers must give employees notice of the option to continue coverage on insurance identification cards, or orally or in writing as part of the employment exit process (for example, in an exit interview).

Length of coverage

State continuation policies must be provided for 18 months from the date the employee or member's insurance ended. However, the policy may be discontinued earlier, if:

- ◆ The employee or member stops paying premiums
- ◆ The employee or member becomes eligible to be covered for similar group health insurance benefits
- ◆ The employer stops providing coverage to all employees. Note: in these instances, the employee or member has the right to convert the policy to an individual policy (see conversion section, below).

If an employer changes group health insurance policies, the employee is entitled to continue his or her conversion policy under the successor group policy for the remainder of the continuation policy period.

Premiums

North Carolina laws require you to make your first premium payment for continuation coverage before your employer-based insurance expires. North Carolina law also allows insurance companies to require payment at the beginning of the month that service is provided (that is, you may have to pay your January premium by January 1, not by February 1). Premiums for continuation coverage cannot be more than the 102% of the premiums charged to others under the insurance plan, but the employee is responsible for the total cost of the premiums.

State Conversion Policies

Benefits

Generally, conversion policies will not be as comprehensive as the coverage offered through the original employer plan. Insurers have the option to offer conversion coverage through individual or group policies.

Eligibility

Conversion policies are available to individuals who exhaust the 18-month continuation period. Coverage must be provided to both the employee (or member) and his or her eligible dependents who were covered under the group policy on the date that the insurance coverage ended. However, certain individuals are not eligible for conversion policies. These include:

- ◆ Individuals who were not eligible for continuation or who failed to elect continuation coverage
- ◆ Individuals who failed to make timely premium payments
- ◆ Individuals who failed to keep the continuation policy for the entire 18 month period, unless the reason that the individuals failed to continue the insurance coverage was because the employer changed health insurance policies within the continuation period. In these instances, the original group insurer must provide eligible individuals options to convert the policy to individual policies. Alternatively, the individual can continue with the continuation policy under the new group insurer, for any remaining time that he or she was entitled to continuation coverage.

- ◆ Individuals who are or could be covered by Medicare
- ◆ Individuals who are or could be covered by another group health insurance plan
- ◆ Individuals who were terminated from a health maintenance organization (HMO) for cause

If an employer ceases to provide health insurance coverage to all of its employees, the insurer must then make a conversion policy available to covered beneficiaries.

Limitations and exclusions

The insurer must continue to cover all the conditions that were previously covered under the continuation policy. The insurer may not exclude people from conversion coverage based on their health conditions or need for health services.

As with continuation policies, conversion policies may not require individuals to meet certain health tests in order to obtain coverage. Health plans or insurance companies cannot exclude an individual from coverage for a conversion policy based on their medical history or potential need for medical services. Similarly, the plans may not impose new pre-existing condition exclusions.

Notice and enrollment

Notice of the conversion option must be included in each certificate of coverage. Notice need not be given at any other time, unless a new certificate of coverage is issued. For many people, the only notice they will be given of the conversion option is with the original certificate of coverage when they first entered the plan, or on plan anniversary dates if changes were made to the plan and new certificates or booklets were issued.

Written applications for conversion insurance and the payment of the first premium must be made within 31 days of the termination of continuation coverage.

Length of coverage

A converted policy must be renewed annually. The insurer can refuse to renew the policy only if:

- ◆ Having the conversion policy would cause the beneficiary to be overinsured according to the insurer's standards of overinsurance (usually because the beneficiary is or could be covered by another plan)
- ◆ The beneficiary engaged in fraud or material misrepresentation in applying for the benefits
- ◆ The beneficiary becomes eligible for Medicare or other state or federal benefits substantially similar to those under the converted policy

In addition, subscribers to an HMO may lose their HMO-based conversion coverage "for cause." HMO policies should state explicitly what "for cause" means.

Premiums

People who elect conversion policies can be charged non-group rates for their health insurance coverage. Ordinarily, conversion rates are much more expensive than other non-group policies, and insurers have some leeway to increase the amount of premiums charged under a conversion policy. However, all premiums must be “reasonable” and must be determined according to certain specified standards (based on the age and class of risk of the covered individual, and the amount of insurance offered).

Administration

COBRA provisions are federal. The COBRA notification and disclosure provisions are administered by the Pension and Welfare Benefits Administration Office of the U.S. Department of Labor. The Internal Revenue Service oversees the other aspects of the COBRA continuation laws.

State continuation and conversion laws are administered by the N.C. Department of Insurance. Questions about state continuation and conversion requirements can be directed to the Department’s Consumer Services Division.

SOURCES OF LAW

Federal statute(s):	26 U.S.C. § 162(k) (Internal Revenue Code) 42 U.S.C. § 1395c (Medicare Act) 29 U.S.C. §§ 1002, 1161-1168 (Employee Retirement Income Security Act) 42 U.S.C. § 300bb-1 (Public Health Service Act)
State statute(s):	N.C.G.S. §§ 58-53-1 through 58-53-115

FOR MORE INFORMATION

Pension and Welfare Benefits Administration

Office of Enforcement

U.S. Department of Labor

61 Forsyth Street, SW, Suite 7B54

Atlanta, GA 30303

Employee Hotline: (866) 275-7922

Consumer Services Division

N.C. Department of Insurance

P.O. Box 26387

Raleigh, NC 27611

(800) 662-7777 outside Raleigh

(919) 733-2032

MEDICARE SUPPLEMENT (“MEDIGAP”) POLICIES

What are they?

Medicare supplement (“Medigap”) policies help fill in the gaps in coverage under the Medicare program. (For information on Medicare coverage, see Chapter 14.) Generally, Medigap policies are designed to offset some of the cost-sharing requirements of the Medicare program. For instance, a Medigap policy may pay the Medicare deductible that a patient would otherwise pay out of pocket. Some Medigap policies also cover services not otherwise covered by Medicare, such as prescription drugs.

Who are they for?

Medigap policies are available only to people who are eligible for Medicare. There are different rules governing Medigap policies for older adults and for those who are eligible for Medicare based on disability. In general, people who receive Medicare based on disability may find it more difficult to purchase a Medigap policy. Each state may have different laws for disabled people to purchase Medigap policies.

Not everyone purchases Medigap insurance — it is not a mandatory program. These policies may seem expensive for people on a fixed or limited income. In deciding whether to purchase a Medigap policy, you should consider the gaps in traditional Medicare coverage and other coverage options available. Medicare also imposes deductibles (an amount you pay before Medicare benefits begin to be paid) and requires cost-sharing (an amount you are required to pay out of pocket when you use certain medical services). It is estimated that Medicare actually covers only about half of a covered person’s medical costs. People on Medicare who are also covered by Medicaid, an employer’s health plan for retirees, or under a Medicare + Choice plan (described below) may feel that they do not need a Medigap policy.

How to obtain coverage

Close to 30 companies offer Medigap insurance in North Carolina. The North Carolina Department of Insurance offers the Seniors’ Health Insurance Information Program (SHIIP) which provides free information and advice on Medigap policies (as well as other insurance issues for seniors). SHIIP’s phone number and website are listed at the end of this chapter. They can send you their “Medicare Supplement Comparison Guide,” which gives comprehensive information on Medigap, companies offering these policies, and the different premiums charged. Alternatively, you may want to speak to a reputable insurance agent who can help you understand the difference between the plans offered and the companies selling Medigap coverage in North Carolina.

INTRODUCTION

In 1990, Congress enacted laws to regulate the sale of Medicare supplement policies. The new laws were designed to standardize these policies, making it easier for people on Medicare to understand what they were purchasing. The federal laws also provide significant consumer protections to older individuals.

There are ten standard Medigap plans available in North Carolina. If you purchased a Medigap policy before January of 1992, you are entitled to continue your coverage under that policy as long as you pay the premiums. Anyone who purchases a policy after that date must choose from among the ten standard plans.

BENEFITS

All ten of the Medigap policies provide the following core benefits:

- ◆ \$210/day for Part A copayment for days 61–90 of a hospital stay
- ◆ \$420/day for Part A copayment for days 91–150 of a hospital stay
- ◆ All approved costs not paid by Medicare after day 150 to a total of 365 hospital days lifetime
- ◆ Charges for the first three pints of blood not covered by Medicare
- ◆ Part B coinsurance for medical services. (Note: A Medigap policy pays only 20% of Medicare's approved charges for medical services.)

In addition to the core benefits, the plans provide the following additional benefits:

Plan A

Plan A is the core benefits policy. No additional benefits are covered if you purchase Plan A.

Plan B

All core benefits plus:

- ◆ \$840 Part A hospital deductible per benefit period

Plan C

All core benefits plus:

- ◆ \$840 Part A hospital deductible per benefit period
- ◆ \$105/day for Part A copayment for days 21–100 of skilled nursing facility care
- ◆ \$100 Part B deductible/year

- ◆ Coverage for medically necessary emergency care in a foreign country. (Note: this benefit is subject to a \$250 deductible. After the deductible is met, then the plan will pay 80% of the billed charges for Medicare-eligible expenses, provided the illness or injury begins during the first 60 consecutive days of each trip. This is subject to a \$50,000 lifetime maximum.)

Plan D

All core benefits plus:

- ◆ \$840 Part A hospital deductible per benefit period
- ◆ \$105/day for Part A copayment for days 21–100 of skilled nursing facility care
- ◆ Foreign travel emergency care as in Plan C
- ◆ At-home recovery. (Note: this benefit provides coverage for up to \$1,600 per year for short-term, at-home assistance with activities of daily living, such as bathing, dressing, personal hygiene, eating, etc., for those recovering from illness, injury, or surgery. The total number of visits may not exceed the number of Medicare-approved home health visits and each visit will pay a maximum of \$40. A patient may receive up to seven visits per week.)

Plan E

All core benefits plus:

- ◆ \$840 Part A hospital deductible per benefit period
- ◆ \$105/day for Part A copayment for days 21–100 of skilled nursing facility care
- ◆ Foreign travel emergency care as in Plan C
- ◆ Preventive medical care. (Note: this may include any of the following: fecal occult blood test, digital rectal exam, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, flu shot, tetanus and diphtheria booster. This benefit is limited to \$120/year.)

Plan F

All core benefits plus:

- ◆ \$840 Part A hospital deductible per benefit period
- ◆ \$105/day for Part A copayment for days 21–100 of skilled nursing facility care
- ◆ \$100 Part B deductible/year
- ◆ 100% of Part B excess charges (i.e., the difference between what Medicare approves and the 15% additional amount a physician can charge if he or she does not accept Medicare assignment.)
- ◆ Foreign travel emergency care as in Plan C

Plan G

All core benefits plus:

- ◆ \$840 Part A hospital deductible per benefit period
- ◆ \$105/day for Part A copayment for days 21–100 of skilled nursing facility care
- ◆ 80% of Part B excess charges (i.e., the difference between what Medicare approves and the 15% additional amount a physician can charge if he or she does not accept Medicare assignment.)
- ◆ Foreign travel emergency care as in Plan C
- ◆ At-home recovery as in Plan D

Plan H

All core benefits plus:

- ◆ \$840 Part A hospital deductible per benefit period
- ◆ \$105/day for Part A copayment for days 21–100 of skilled nursing facility care
- ◆ Foreign travel emergency care as in Plan C
- ◆ A “basic” prescription drug benefit. The basic drug benefit has a \$250 annual deductible and a maximum annual benefit of \$1,250. People with Plan H pay 50% coinsurance on prescription drugs.

Plan I

All core benefits plus:

- ◆ \$840 Part A hospital deductible per benefit period
- ◆ \$105/day for Part A copayment for days 21–100 of skilled nursing facility care
- ◆ 100% of Part B excess charges (i.e., the difference between what Medicare approves and the 15% additional amount a physician can charge if he or she does not accept Medicare assignment.)
- ◆ Foreign travel emergency care as in Plan C
- ◆ At-home recovery as in Plan D
- ◆ The basic prescription drug benefit as in Plan H

Plan J

All core benefits plus:

- ◆ \$840 Part A hospital deductible per benefit period
- ◆ \$105/day for Part A copayment for days 21–100 of skilled nursing facility care
- ◆ 100% of Part B excess charges (i.e., the difference between what Medicare approves and the 15% additional amount a physician can charge if he or she does not accept Medicare assignment.)
- ◆ Foreign travel emergency care as in Plan C
- ◆ At-home recovery as in Plan D
- ◆ Preventive medical care as in Plan E
- ◆ Extended prescription drug benefits. People with Plan J pay a \$250 annual deductible and 50% coinsurance as in Plans H and I. However, under Plan J, the annual maximum benefit is \$3,000.

Note: The amount of the deductible and copayment which the plans will pay is based on the Medicare cost-sharing amounts. They are revised on January 1st of each year. The amounts listed in this chapter are current as of January 1, 2003.

Insurance companies are not required to offer all ten plans in North Carolina. However, if they offer any plan, they must offer Plan A.

ELIGIBILITY

Anyone who is eligible for Medicare may purchase a Medicare supplement policy. Medicare beneficiaries who are age 65 and older may purchase a Medigap policy any time after becoming eligible for Medicare. If you purchase your Medigap policy during the first six months after enrolling in Medicare Part B (the “open enrollment” period), you are guaranteed coverage. That is, the insurance company may not deny you coverage or charge you a higher premium based on your health status. If you do not purchase during this special enrollment period, or if you qualify for Medicare because of a disability, different rules apply.

Older adults who do not purchase a Medigap policy during the open enrollment period may be subject to medical underwriting. That is, the insurance company will look at their prior health history and at the likelihood of future use of medical services before deciding whether to offer health insurance coverage.

As of October 1, 2001, persons receiving Medicare due to a disability may purchase Medigap plans A, C, and J during the open enrollment period (the first six months after qualifying for Medicare). After the period of open enrollment, there is no requirement to provide supplemental insurance to the disabled. This law also guarantees the right to purchase insurance for disabled individuals who were enrolled in a Medicare managed care plan that discontinued its coverage, for 63 days after the

termination. In either case, companies may still develop premiums specific to the disabled population, so premiums may be higher than those for people over age 65. Contact SHIP for more information.

As with other insurance policies, with Medigap policies you are entitled to a “free-look” period. Medicare supplement policies offer a 30-day “free-look” period. During that time you may review the policy and, if you are not satisfied with it, you may return it to the insurance company for a full refund. The 30-day period begins the day you receive the certificate or policy — not the day you first apply for coverage.

LIMITATIONS AND EXCLUSIONS

People who enroll during the open enrollment period may still be subject to a waiting period of up to six months for coverage of pre-existing conditions (“pre-existing condition exclusion”). During this period, Medicare supplement policies will cover all conditions except the pre-existing condition. Once you have met the requirements of a pre-existing condition waiting period, you are not subject to another waiting period, even if you later change your insurance plan and/or company. Medigap policies are not allowed to impose “riders”—that is, they cannot refuse to cover specific conditions. Pre-existing conditions are waived if you have prior creditable coverage and do not have a gap in health insurance coverage for more than 63 days.

RENEWABILITY

All Medicare supplement policies are guaranteed renewable. That is, an insurance company may not cancel a Medigap policy even if the person covered later becomes very ill. This is also true for people with disabilities who are able to purchase a Medigap policy.

PREMIUMS

In general, the more extensive the benefits, the more expensive the premiums. So, for instance, Plan G is generally more expensive than Plan B. You should note, however, that there are wide variations in premiums even among these standardized plans:

- ◆ Different companies charge different rates for the same plan. So, for instance, Insurance Company #1 might charge \$100 a month for Plan A while Insurance Company #2 charges \$120 for Plan A. Differences in charges have to do with factors other than benefits: remember, all Plan As have the same benefits. So, although \$100 a month sounds like a better bargain than \$120, check to see if there are drawbacks.
- ◆ In addition, companies may charge more if you first purchase a policy when you are older. Company #3 may charge \$110 a month for Plan A if you purchase it

when you are first eligible for Medicare (age 65), and \$120 a month for the same plan if you purchase it when you are 68.

- ◆ Some policies increase your premiums as you age (you pay \$110 a month for Plan A when you are 65 and \$120 when you are 69). Others do not — your age doesn't make the premium increase automatically.
- ◆ You should also note that some companies charge more depending on where you live. Others do not.

Before purchasing a Medigap policy, you should study the differences carefully and be sure that you understand the details. SHIIP or an insurance agent can help.

Insurance companies must file proposed rate increases with the Commissioner of Insurance. The Commissioner decides whether a rate increase is justified based on a set mathematical formula.

SOURCES OF LAW

Federal law(s):	42 U.S.C. § 1395ss
State law(s):	N.C.G.S. §§ 58-54-1 through 58-54-40
State regulation(s):	11 N.C.A.C. § 12.0800 <i>et seq.</i>

FOR MORE INFORMATION

Seniors Health Insurance Information Program (SHIIP)

N.C. Department of Insurance

P.O. Box 26387
Raleigh, NC 27611
919-733-0111
800-443-9354

<http://www.ncshiip.com>

SHIIP provides information and advice on Medicare, Medicare supplement insurance, Medicare managed care, claims, and long-term care insurance. SHIIP has easy-to-understand printed materials on comparing different Medigap policies, including differences in premiums, as well as other publications. SHIIP also provides personal, free health insurance counseling. SHIIP has trained volunteers in all 100 counties in North Carolina.

LONG-TERM CARE INSURANCE

What are they?

A long-term care policy covers the services you need if you are unable to care for yourself because of a prolonged illness or disability. These services can range from help with daily activities at home, like bathing and dressing, to skilled care in a nursing home. Long-term care can involve a variety of providers, including home health care agencies, assisted living facilities, adult day care centers, traditional nursing homes, and continuing care retirement communities.

Neither Medicare nor Medicare supplement (“Medigap”) insurance will pay for most long-term care expenses. Most health insurance policies provided by employers also exclude long-term care. Some employers, however, offer long-term care policies as a benefit that an employee may purchase separate from a traditional health insurance policy. Also, Medicaid, a government-sponsored health insurance program that covers certain low and moderate-income people, provides coverage for long-term care services. (See Chapter 12.)

Who are they for?

Long-term care policies may be a part of a person’s overall planning for retirement. However, everyone may not be able to afford a long-term care insurance policy. Factors to consider in determining whether or not to purchase a long-term care policy include age, health status, overall retirement objectives, and income.

Many people buy long-term care insurance in order to protect their assets. Long-term care insurance may not be the best option, depending on the value of your assets. Some financial planners discourage purchasing long-term care insurance for people with less than \$100,000 in assets, excluding their home.

ABOUT LONG-TERM CARE INSURANCE

How to obtain coverage

Private insurance companies sell long-term care policies. They may sell policies to individuals through agents, or by mail without the use of agents. Some companies sell coverage through senior citizen organizations, fraternal societies, or other similar groups. In addition, some employers now offer their employees and retirees the opportunity to purchase long-term care policies.

The Health Insurance Portability and Accountability Act (HIPAA) of 1997 changed some rules regarding long-term insurance. These changes include:

- ◆ Benefits from qualified policies are received on a tax-free basis
- ◆ Expenses not covered by the policy are tax-deductible as medical expenses

North Carolina also provides an income tax credit of 15% (up to a maximum of \$350) for long-term care insurance premiums. This credit can only be taken if you do not take a federal tax deduction for the premiums. This credit expires January 1, 2004.

What is covered?

Benefits covered by long-term care policies vary. Some offer very limited benefits—others offer more comprehensive coverage. Since it is impossible to know in advance what types of long-term services may be needed, it is important to purchase a reasonably comprehensive policy that covers both nursing home and home care. In general, the more extensive the coverage, the more expensive the policy.

Nursing home coverage usually means that the policy will pay for all three types of nursing home care: skilled, intermediate, and custodial. By contrast, a policy that covers home care may restrict what services are covered, or what types of health care personnel can be reimbursed for providing the services. Some policies pay only for skilled nursing care performed in the home by registered nurses, licensed practical nurses, or occupational, speech or physical therapists. Other policies offer broader home care coverage, including the services of home health aides employed by licensed home care agencies. Policies sold after September 1992 that offer coverage for home health care must also offer adult day care benefits. A careful reading of the policy will help determine what services are covered.

Policies have different criteria for when coverage will begin. In some cases, coverage begins when the care is deemed medically necessary. In other cases, coverage is triggered if an individual is unable to perform activities of daily living (ADLs). ADLs include eating, bathing, dressing, getting to the toilet, moving from place to place, and going outside and walking. Certain long-term care plans may require that the beneficiary be unable to perform certain ADLs for a certain period of time before coverage will begin. Again, a careful reading of the policy can help determine coverage.

What is not covered?

Generally, long-term care policies do not pay benefits if services are needed for:

- ◆ Mental and nervous disorders or disease, other than Alzheimer's disease
- ◆ Alcoholism and drug addiction
- ◆ Illness caused by an act of war
- ◆ Treatment already paid for by the government
- ◆ Attempted suicide or intentionally self-inflicted injuries

Although all long-term care policies must cover Alzheimer's disease, a policyholder who has the disease may still be denied benefits if he or she is physically able to perform the activities of daily living specified in the policy.

What other requirements are there for policies?

Consumers are granted certain protections under North Carolina law, including the following:

- ◆ All policies must offer meaningful inflation protection, which protects an individual as the cost of services increases over time. A consumer may reject the inflation protection, but it must be in writing.
- ◆ All policies must provide a 30-day “free look” to allow the consumer to review the policy.
- ◆ The waiting period before coverage of pre-existing conditions is limited to six months.
- ◆ All policies must be guaranteed renewable, meaning that coverage must continue and policy provisions cannot be changed as long as the premiums are paid.

SOURCES OF LAW

State statute(s): N.C.G.S. § 58-55-1 *et seq.*

FOR MORE INFORMATION

Seniors Health Insurance Information Program (SHIIP)

N.C. Department of Insurance

P.O. Box 26387
Raleigh, NC 27611
919-733-0111
800-443-9354

The SHIIP website provides a great deal of useful information about long-term care insurance, as well as other insurance:

<http://www.ncshiip.com>

Division of Aging

N.C. Department of Human Resources

693 Palmer Drive
2101 Mail Service Center
Raleigh, NC 27699-2101
919-733-3983

PART III

GROUP INSURANCE

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HEALTH INSURANCE FOR SMALL BUSINESSES

What is it?

The North Carolina General Assembly enacted special laws that make it easier for small employers to purchase health insurance for their employees. Any insurance carrier or health maintenance organization (HMO) that markets small group health insurance in North Carolina must offer all of its small group plans to small employers with between 2 and 50 employees. Insurers are required to offer employers with only one person (self-employed) a choice of two standardized benefits plans, called the “Standard” and “Basic” plans (described more fully in this chapter). These insurance products are available to any small employer who requests them and agrees to make the required premium payments and to satisfy the other requirements of the plan.

Who is it for?

These laws provide protections to “small employers.” A small employer includes any self-employed individual or any business with 50 or fewer employees for more than 50% of its working days in the preceding calendar quarter. Any small employer offering health insurance must offer it to all eligible employees, defined as employees who work at least 30 hours a week on a full-time basis. Insurance companies that provide policies to the small-employer market must offer coverage to all eligible employees and their dependents.

INTRODUCTION

Many small employers do not offer health insurance coverage because of the cost — premiums for small employers are generally more expensive than a large employer’s premiums for a similar benefits package. In addition, in the past some small employers were unable to purchase coverage for their employees because of the health status of one or more of their employees.

The North Carolina General Assembly and Congress changed the laws to make it easier for small employers to purchase health insurance. All insurance carriers and HMOs that market small-group health insurance in North Carolina must make all their small group plans available to any small employer with two or more employees on a guaranteed-issue basis. That means no small group can be turned down because of the health status or use of health services of any of its employees. Self-employed individuals (with only one employee) must be offered two plans: a Standard Benefit Plan and a lower-cost Basic Benefit Plan.

In addition to guaranteed issue, the law guarantees renewability. That means that insurers must generally renew coverage for small groups, regardless of the claims experience of that small employer group. The law also limits the ability of insurance companies to charge differential premium rates to different types of employers.

BENEFITS

Insurers that offer health coverage in the small group market must offer the standard and basic benefit plan, in addition to any other plans they choose to offer. The standard and basic plans are described below.

Standard Benefit Plan

The Standard Benefit Plan is a major medical plan providing coverage for both hospitalizations and outpatient care. Coverage may be offered through a traditional major medical plan or through an HMO. Under the Standard major medical plan, benefits begin to be paid after a deductible of \$500 per individual (\$1,500 per family) is met. After the annual deductible is met, the plan generally pays for 80% of eligible medical expenses and the person insured pays 20% (although some services, like outpatient mental health and substance abuse, have more limited coverage). There is an annual out-of-pocket limit of \$2,000 per individual (\$4,000 per family) — that is, after you spend \$2,000 out of your own pocket in one year (not counting your deductible) on medical expenses, all other expenses are fully covered. The Standard indemnity plan has a lifetime limit for all services of \$1,000,000. Coverage of mental health and substance abuse services is generally limited to \$10,000 over the insured's lifetime. Coverage of specific types of therapy services, such as physical therapy, mental health, substance abuse or chiropractic, is limited to a certain number of visits per year.

The standard HMO plan does not have an annual deductible or lifetime limit for medical services. Instead, it has different levels of co-pays that must be paid for health services, such as \$15 for an office visit or \$250 for a hospital admission. While the standard HMO plan does not have specific annual or lifetime limits, coverage of mental health, substance abuse, and some therapy services is limited to a specified number of visits.

Basic Benefit Plan

The Basic benefit plan offers fewer benefits, but it is less expensive. It has a higher annual deductible, higher co-payments, and less coverage of preventive services. As with the standard plan, it may be offered through a traditional major medical plan or through an HMO.

Under the Basic indemnity plan, benefits begin to be paid after a deductible of \$1,000 per individual (or a maximum of \$3,000 for a family) is met. After the deductible is met, the plan generally pays 60% for covered medical services and the insured person pays 40% (although some services, like mental health and substance

abuse, have more limited coverage). There is a maximum out-of-pocket limit of \$3,000 per covered person (not counting the deductible), with no family maximum. The Basic indemnity plan offers an annual maximum benefit of \$100,000 per insured person, or \$1,000,000 lifetime maximum. Coverage of mental health and substance abuse services has a lifetime limit of \$10,000. As with the standard plan and basic HMO plans, there are visit limits for certain therapy services.

The Basic HMO plan does not have an annual deductible or lifetime limit for medical services. Instead, it has different levels of co-payment that must be paid for health services. Generally, the required co-payments that the patient must pay are higher in the Basic HMO plan than under the Standard HMO plan. While the Basic HMO plan does not have specific annual or lifetime limits, coverage of mental health, substance abuse, and some therapy services is limited to a specified number of visits.

ELIGIBILITY

In order for a person to be eligible for small-group health insurance, two conditions must be met. First, the person's employer must meet the law's definition of a small business. Then, the employee must be eligible for coverage.

A "small business" includes any self-employed individual or any business with 50 or fewer employees for over 50% of the working days of the business in the preceding calendar quarter. A person must be self-employed to qualify as an individual.

In order for an employee to qualify for coverage under a small-group plan, the employee must work for the small employer on a full-time basis, with a normal work schedule of 30 or more hours per week. Employees who work on a part-time, temporary, or substitute basis are not eligible for coverage.

An insurance company or HMO that offers insurance in the small-group market must offer coverage to all eligible employees and their dependents. Upon request, insurers must also provide small employers a description of all the plans they actively market to small employers, along with a description of the coverage and a quote.

ENROLLMENT

An eligible employee must be given a 30-day period (called an "open enrollment" period) in which to enroll in the plan. If the employer has a probationary period, the employee must be provided the opportunity to enroll within 90 days of the first day of employment. Eligible dependents of the employee also have a 30-day enrollment period.

There are special rules applicable to "late enrollees." Late enrollees are eligible employees or dependents who request health insurance coverage after the initial open enrollment period. Late enrollees may be subject to longer waiting periods and more far-reaching limitations on coverage than those who sign up during an open

enrollment period. More information on limitations applicable to late enrollees is included in the section on limitations and exclusions below. In general, it is better to enroll during an open enrollment period than as a late enrollee.

In any one of the following situations, however, you would not be considered a late enrollee:

- ◆ You were covered under another health benefit plan with comparable coverage at the time you were eligible to enroll with the small-business plan. Note that in order for this protection to apply, you must state at the time of open enrollment that you are declining coverage because you are covered under another employer's health plan. If you later lose that coverage (through the death of a spouse or divorce, or because the other employer stops offering health insurance, or because you lose the other job through which you had coverage), you can enroll with the small-business plan under the terms of the open enrollment period — that is, allowing you to avoid the limitations of a late enrollment. However, you must request enrollment within 30 days of the time you lose your other coverage.
- ◆ Your small-business employer offers the Standard or Basic plan and other plans, and you had previously chosen to be covered under one of the other plans during an open enrollment period. If you later want to switch to the Standard or Basic plan, you are not considered a late enrollee.
- ◆ You elect enrollment within 30 days of becoming an employee of a small employer.
- ◆ A court of law has ordered that coverage must be provided for a spouse or minor dependent child and the request for enrollment is made within 30 days of the court order.
- ◆ You have a newborn or adopted child, and the child is covered within 30 days of the child's birth or adoption.

GUARANTEED ISSUANCE AND RENEWABILITY

Insurance companies and HMOs (“small-employer carriers”) that offer plans in the small-group market must guarantee all plans to all small employers willing to pay the necessary premium. This is called “guaranteed issue.” Under guaranteed-issue protections, the small-employer carrier cannot exclude the coverage of any small employer or of any of its eligible employees or dependents based on their health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability. The only thing the employer must do is to pay the premium and meet the participation and contribution requirements of the small-employer carrier. Individual employees and their dependents cannot be charged more because of their health status.

Similarly, with limited exceptions, the insurance company must renew coverage for all small employers that are policy-holders (“guaranteed renewability”). Some of the exceptions include nonpayment of the premiums; fraud or misrepresentation of the

policy-holder; and noncompliance with certain plan provisions. Renewability is also not guaranteed when the number of enrollees covered under the plan is less than the number or percentage of people insured that the plan requires, or when the small-employer carrier stops writing new business in the small-employer market.

LIMITATIONS AND EXCLUSIONS

Small-employer carriers, like other insurers, may exclude coverage for pre-existing conditions for an insured individual for up to twelve months from the person's initial effective date of coverage. While insurers can exclude people from coverage based on pre-existing conditions, they are not required to do so. Often, the decision about whether to impose a pre-existing condition exclusion is one that is negotiated between the employer and the insurer.

A "pre-existing condition" is defined in North Carolina law as a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period immediately before a person's health insurance coverage becomes effective. That means that the insurance company cannot exclude coverage of a condition for which you were treated, if you received treatment more than six months before the date your coverage became effective. Under state and federal law, pregnancy can never be considered a pre-existing condition. Thus, insurance companies that normally cover pregnancy-related services, cannot exclude coverage for pregnancy even if you started receiving services in the six months before you obtained health insurance coverage.

If you did receive treatment for a health condition within the six months prior to obtaining health insurance coverage, the insurance company may exclude coverage of that condition for up to twelve months. Once you meet the terms of the exclusionary waiting period, you generally cannot be subject to another exclusion as long as you stay continuously insured. To be continuously insured, you cannot have a break in your insurance coverage for more than 63 days. However, you need not maintain coverage with the same insurer to be continuously insured. Thus, you may not be subject to another pre-existing condition exclusion if you change jobs or if your employer changes carriers, as long as you don't have a gap in insurance coverage for more than 63 days.

If you met part of a pre-existing condition exclusion, you must be given credit for that time spent. If, for example, you meet 10 months of a 12-month exclusionary period and then change jobs, you cannot be subject to more than a two-month exclusionary period. Anytime you leave a job that provided health insurance coverage, your employer must give you a certificate that identifies the amount of time you spent under a pre-existing waiting period (if any). This certification will help the new insurer know how much time to give you in credit towards your new pre-existing condition exclusionary period.

Late enrollees may be subject to additional limitations in coverage. If you are a late enrollee, you may be denied all coverage for up to 18 months (a waiting period

before any benefits will be paid), or you may be subject to an 18-month pre-existing condition exclusion (a waiting period before benefits for pre-existing conditions are paid). The total length of all exclusions, however, cannot exceed 18 months. Thus, for example, the insurance company could impose a six-month waiting period for all benefits plus a 12-month exclusion of pre-existing conditions. Once this waiting period is met, you must be covered just like other insured individuals. You cannot then be subjected to an additional pre-existing condition waiting period. Note: you will not be considered a late enrollee if you meet one of the exceptions listed above.

PREMIUMS

Small-employer carriers must use an adjusted community rating system to set premiums for each small employer. In determining premiums for small employers, the insurer can consider the age and gender of all the enrollees; the number of family members covered (an insurance company can charge more for large families than for single individuals); and the geographic area in which the enrollees live. Insurers may also vary the rates charged to small employers with similar characteristics by 20%, based on differences in administrative costs and claims experience. For example, if the average premium for one small employer is \$100/month, the insurer has the flexibility to vary the premiums for other similar small employers from \$80-\$120, based on the employers' claims experience, health status, or other reasons.

Insurers are not allowed to modify the premium rate for a small employer for 12 months from the initial issue date or renewal date, unless the composition of the group has changed by 20% or more, or unless benefits are changed.

ADMINISTRATION

Small business insurance laws are regulated by the North Carolina Department of Insurance.

SOURCES OF LAW

State law(s):	N.C.G.S. § 58-50-100 <i>et seq.</i> (laws on small employer insurance) N.C.G.S. § 58-68-1 <i>et seq.</i> (Health Insurance Portability and Accountability)
State regulation(s):	11 N.C.A.C. §§ 12.1301 through 12.1309

FOR MORE INFORMATION

Small Group Health Insurance Information Hotline
N.C. Department of Insurance
(800) SMALLGP (762-5547)

MULTIPLE EMPLOYER WELFARE ARRANGEMENTS (MEWAs)

What are they?

Multiple employer welfare arrangements (MEWAs) are arrangements that allow a group of employers collectively to offer health insurance coverage to their employees. MEWAs are most often found among employer groups belonging to a common trade or industry association or professional association.

Who are they for?

MEWA plans are generally available to the employees (and sometimes their dependents) of the employers who are part of the arrangement. People who do not have an employment connection to the group cannot obtain coverage through the MEWA plan. MEWA plans cannot be sold generally to the public.

INTRODUCTION

MEWA plans are usually established by trade, industry, or professional associations. To qualify as a MEWA, the organization must be nonprofit, in existence for at least five years, and created for purposes other than that of obtaining health insurance coverage. In other words, employers cannot group together solely for the purpose of offering health insurance. However, employers that have already grouped together for another common purpose (for example, a trade association) may also offer health insurance coverage to their member employers.

Occasionally, MEWA plans may qualify as ERISA Single Employer plans. Employees covered by ERISA Single Employer MEWAs have fewer protections than do those who obtain coverage through a regulated insurance company or HMO. For more information on ERISA, see Chapter 11.

In general, most MEWAs do not qualify as ERISA Single Employer plans and are therefore subject to all of the state's other insurance laws (including all the consumer protections and mandated benefits listed in Chapter 24). MEWA plans that claim to qualify as ERISA plans must provide certain information to the NC Department of Insurance in order to demonstrate exemption from state insurance laws. The Department of Insurance collects information on each MEWA operating in North Carolina to determine if it does qualify as an ERISA plan or is subject to state insurance requirements.

Certain employer arrangements are specifically excluded from the definition of MEWAs. These include plans maintained pursuant to collective bargaining

agreements (subject to Taft-Hartley laws), Rural Electric Cooperatives, and Rural Telephone Cooperative Associations. These plans are subject to other laws.

BENEFITS

MEWA plans are required to offer most of the same mandated benefits as other regulated insurance or HMO products. Except for those mandatory benefits, MEWA plans are not required to provide coverage of any other specific health service. ERISA Single Employer MEWAs, like other employer self-funded plans, are not subject to the North Carolina mandated benefits provisions, and thus are not required to offer any specific coverage in their plans unless mandated under federal law.

ELIGIBILITY

MEWA plans are covered by either small-group or large-group eligibility requirements, depending on the size of the plan. If the employers in the MEWA generally employ 50 or fewer people, then small-group eligibility requirements apply. If the employers generally have more than 50 employees, then the large-group eligibility requirements apply.

LIMITATIONS AND EXCLUSIONS

In general, MEWAs can impose a pre-existing condition waiting period of only 12 months (18 months for late enrollees). See the section on small and large group plans.

NOTICE AND ENROLLMENT

All plans, including ERISA Single Employer plans, must furnish participants and beneficiaries with a description of the plan, including rights, benefits, and responsibilities under the plan. If material changes are made to the plan, information about these provisions must also be provided.

PREMIUMS

The state-regulated MEWA must satisfy minimum capital and reserve requirements, much like traditional insurance carriers. These requirements, along with the claims experience of the MEWA, will affect the premiums paid by all participating employers. The actual amount paid by the employee can differ among the participating employers, because the employer determines its contribution toward the premium cost and may require the insured employee to share the premium cost.

ADMINISTRATION

The Managed Care and Health Benefits Division of the NC Department of Insurance has responsibility to ensure the financial solvency of all MEWAs and to oversee all aspects of state-regulated MEWA plans, as long as one or more of the employer members of the MEWA is domiciled in the state or has its principal headquarters in North Carolina.

MEWA plans that qualify as ERISA Single Employer plans are subject to oversight and enforcement by the US Department of Labor.

SOURCES OF LAW

Federal statutes:	29 U.S.C. § 1002 <i>et seq.</i> (Employee Retirement Income Security Act)
State statutes:	N.C.G.S. § 58-49-1 through 58-49-65.
State regulations:	11 N.C.A.C. § 18.0000 <i>et seq.</i>

FOR MORE INFORMATION

Managed Care and Health Benefits Division
NC Department of Insurance
101 Seaboard Avenue
Raleigh, NC 27604
(919) 715-0526

Pension and Welfare Benefits Administration
Administrative Office of Enforcement
US Department of Labor
1371 Peachtree St. NE, Room 205
Atlanta, GA 30367
Employee Hotline: (866) 275-7922

HEALTH INSURANCE FOR LARGE BUSINESSES

What is it?

The North Carolina General Assembly has enacted special insurance laws that apply to large employers that offer health insurance to their employees. These laws give certain protections to employees who work for these large employers. A large employer is defined in state law as having 51 or more employees.

Who is it for?

These laws are for employees of large employers who purchase health insurance or HMO plans for their employees. This chapter does not apply to self-funded (ERISA) plans. For information on ERISA, see the next chapter.

A large employer that offers health insurance to any employee must offer it to all eligible employees. An “eligible employee” is a worker with a normal workweek of 30 or more hours. Eligible employees do not include part-time, temporary, or seasonal workers, or those who have been hired on a substitute basis. Employers can choose to offer health insurance coverage to these other employees, but are not required under state law to do so.

BENEFITS

The health insurance plans of large employers must cover the mandated benefits listed in Chapter 24, “Consumer Protections.” Except for these mandated benefits, large employers are not required to offer any specific benefits in their plans.

ELIGIBILITY

A large employer offering health insurance to any employee must offer it to all eligible employees. An eligible employee is defined as a non-seasonal, full-time worker with a normal workweek of 30 or more hours. Employees must be added to the group coverage no later than 90 days after the first date of employment [N.C.G.S. § 58-51-80(c)].

GUARANTEED ISSUANCE AND RENEWABILITY

Insurance companies are not required to offer policies to large businesses. Thus, unlike small employers, large employers have no legally guaranteed right to obtain insurance coverage. As a practical matter, however, large employers generally do not have problems finding insurers or HMOs that will provide coverage. If large employers do not offer their employees health insurance, it is usually not because they can't find a company to offer insurance coverage; it is more likely because they can't find affordable insurance.

While insurers are not required to initially offer health insurance to a large group, they are generally required to renew coverage once an employer purchases coverage. Insurers must continue to provide coverage at the employer's option, unless the employer fails to pay premiums, commits fraud, or meets one of the other limited exceptions to the guaranteed renewability rules.

LIMITATIONS AND EXCLUSIONS

Health insurers cannot “medically underwrite” — that is, exclude you from coverage or charge you a higher premium based on your health status, medical condition, claims experience, genetic information, disability, or perceived health risk — if you sign up for your employer's health plan within the open-enrollment time period (often 30 or 31 days after you first become eligible).

Thus, for example, insurers cannot deny your health insurance coverage or charge a higher premium if you have cancer, a mental illness, or have been a victim of domestic violence. However, if you are a late enrollee — that is, you turn down coverage at first and later sign up for your employer's health plan — you can be subject to medical underwriting. Also, if you purchase an individual policy to supplement your employment-based policy, the supplemental policy can be subject to medical underwriting.

Even if you elect your employer's health plan when you are first eligible, the plan may refuse to pay benefits for pre-existing conditions for up to twelve months. (Pre-existing conditions are defined as “a condition, whether physical or mental...for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date.”) [N.C.G.S. § 58-68-30(a)(1)]. However, if you are a late enrollee, plans can impose pre-existing condition limitations of up to 18 months.

Once you have met the requirements of the pre-existing condition waiting period, the insurance company cannot impose a new waiting period, even if your employer changes insurance carriers or you change jobs, as long as you had health insurance within 63 days of the time your new coverage begins. If you met only part of the pre-existing waiting period under a prior health insurance plan, you will be given credit for that time as long as you change plans and have less than a 63-day break in coverage. Note: Prior health insurance plans include health insurance offered

through small or large employers, ERISA plans, individual health insurance coverage, Medicare, Medicaid, NC Health Choice, or a medical care program of the Indian Health Services. Individuals who were previously covered by one of these plans for at least 12 months, and who obtained new coverage within 63 days of when the prior coverage ended, cannot be subject to a pre-existing condition exclusion—even if the prior coverage did not have any exclusionary periods.

Additional protections apply for newborns, children who were adopted, and pregnant women. Insurers may not impose pre-existing condition exclusions on newborns if they are insured within 30 days of birth. Similarly, insurers cannot impose pre-existing condition exclusions on children who were placed for adoption, if they are insured within 30 days after the date of the adoption. In addition, insurers may not impose pre-existing condition exclusions on pregnancy, regardless of whether the woman was previously covered by insurance. In other words, if an insurer normally covers the medical costs associated with pregnancy and delivery, then the insurers must cover the pregnancy-related costs of all new enrollees, whether or not the pregnant women had health insurance coverage in the past.

NOTICE AND ENROLLMENT

In general, all insurance companies and HMOs must furnish participants and beneficiaries with a description of the health insurance plan, which includes their rights, benefits, and responsibilities under the plan. If material changes are made to the plan, information about these provisions must also be provided.

PREMIUMS

The NC Department of Insurance has no authority to regulate large-group insurance rates. Typically, insurers can adjust the premiums only once at the end of a year of the first year of coverage, and then not more frequently than once every six months. The new rates will not become effective unless the insurer has given the enrollees at least 45 days advance notice [N.C.G.S. § 58-51-80(g)].

ADMINISTRATION

The NC Department of Insurance has the legal authority to regulate insurance carriers and Health Maintenance Organizations (HMOs). In general, the Department insures that the plans are financially solvent, meet certain quality standards, and have certain procedural safeguards.

SOURCES OF LAW

State law:	N.C.G.S. § 58-51-80, 58-68-25 <i>et seq.</i> (governs health insurance portability)
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FOR MORE INFORMATION

**Consumer Services Division
NC Department of Insurance**

PO Box 26387

Raleigh, NC 27611

(800) 546-5664

(919) 733-2032

<http://www.ncdoi.com/>

ERISA PLANS

What is it?

ERISA, the federal Employee Retirement and Income Security Act, was enacted in 1974, largely to regulate employee pension funds. Although the law was originally enacted to protect employee pension funds, it also affects employer-sponsored health insurance. ERISA prevents states from directly regulating employee welfare benefits, including employer-sponsored health plans.

Who is it for?

The federal ERISA laws govern employer-sponsored health plans, except those offered by a church or a governmental entity for its employees. Health insurance that is offered by a church or a governmental entity is not governed by ERISA. Neither are publicly-subsidized health insurance plans (such as Medicaid, NC Health Choice, or Medicare), or private health insurance bought in the non-group market.

INTRODUCTION

Congress enacted ERISA to create a uniform federal system of laws to govern employee welfare benefit plans. ERISA restricts the ability of states to enact laws that relate to employee welfare benefits, including employer-sponsored health insurance coverage. Under ERISA, states retain the authority to regulate insurance carriers and health maintenance organizations (HMOs). If an employer purchases a traditional health insurance product or HMO for its employees, then the employees get the benefit of many of the state law protections. However, employers that choose to “self-fund” are not subject to traditional state insurance laws. Under “self-funded” or “self-insured” plans, the employer is actually responsible for paying most of the health bills—not just the insurance premiums. Nationally, about half of insured employees are covered by these self-funded or self-insured plans.

Note: It is often difficult to know whether your employer is operating an ERISA plan or buying a traditional insurance plan or HMO coverage. You may get an insurance card that looks like you are enrolled directly in an HMO or insurance company, even though your employer is still retaining the financial risk for paying for all the health care claims. The easiest way to find out whether you are enrolled in a self-funded ERISA plan or whether you are enrolled directly in the state-regulated HMO or insurance company is to ask your employer.

BENEFITS

Self-insured ERISA plans are not required to provide coverage for *state*-mandated benefits, such as coverage of mammograms or Pap smears. However, there are certain *federally*-mandated benefits that do apply to ERISA self-funded health plans. For example, ERISA plans must cover the following:

- ◆ Breast reconstruction in connection with a mastectomy
- ◆ 48-hour hospital stay following childbirth (or 96 hours in the case of a cesarean section)

At the time of this writing, Congress was considering adding consumer protections and mandated benefits to ERISA plans. For example, Congress was considering an extension of the Mental Health Parity Act (which expired September 30, 2001). Congress was also considering enacting a Patient Protection Act, which would provide additional managed care consumer protections and coverage of clinical trials.

ELIGIBILITY

Employers are not required to offer health insurance coverage to any of their employees. However, an employer offering health insurance coverage may not discriminate against certain employees on the basis of health status or disability. Employers may still exclude employees who do not otherwise qualify for coverage (for example, because they are part-time or temporary employees).

Different federal laws prohibit employers from discriminating against lower wage employees in eligibility or covered services, if the company wants to deduct health contributions from its federal taxes. Note: this non-discrimination provision is complicated, and may require the advice of an attorney or accountant to determine an employer's compliance with the law.

LIMITATIONS AND EXCLUSIONS

Employers may exclude coverage for pre-existing conditions for an insured individual for up to 12 months from the person's initial effective date of coverage. The 12-month pre-existing exclusion period applies if a person seeks coverage when they first qualify (for example, during an open-enrollment period, or when coverage is first offered on the job). Employers can impose an 18-month pre-existing condition exclusion period for late-enrollees.

A "pre-existing condition" is a condition "for which medical advice, diagnosis, care, or treatment [is] recommended or received" in the six months immediately before a person becomes eligible for the employer's health plan. Thus, you could be excluded from coverage for a pre-existing condition for which you received care three months before qualifying for the employer's health plan, but not for the same condition if the last time you received treatment was 12 months earlier.

Generally, once you meet any pre-existing condition waiting period, you cannot be subject to another exclusion. This protection applies if you stay continuously insured—even if you change jobs or your employer offers new insurance coverage. The exception to this rule is if you have a gap in health insurance coverage for more than 63 days. If you have a gap in insurance coverage for more than 63 days, then you can be subject to a new pre-existing condition waiting period.

Late enrollees may be subject to longer pre-existing condition waiting periods. Late enrollees are people who failed to enroll when they were first eligible. If you are a late enrollee, you may be subject to an 18-month pre-existing condition exclusion. Once this waiting period is met, you must be covered just like other insured individuals.

You will not be considered a late enrollee if any of the following conditions are met:

- ◆ You were covered under another health benefit plan with comparable coverage at the time you were eligible to enroll with the employer's plan. In order for this protection to apply, you must state at the time of open enrollment that you are declining coverage because you are covered under another health plan. If you later lose that coverage (through the death of a spouse or divorce, because you lose the other job through which you had coverage, or because the employer that offered the other coverage stopped offering health insurance), you can enroll with the ERISA plan under the terms of the open enrollment period. However, you must request enrollment within 30 days of the time you lose your other coverage.
- ◆ If a court of law has ordered that coverage must be provided for a spouse or minor dependent child and the request for enrollment is made within 30 days of the court order.
- ◆ You have a newborn or adopted child, and the child is covered within 30 days of the child's birth or adoption.

NOTICE AND ENROLLMENT

All employer-sponsored health insurance plans (including both self-funded and traditional insurance or HMO coverage) must furnish participants and beneficiaries with a description of the plan. This written document is called a Summary Plan Description (SPD), and must include rights, benefits, and responsibilities under the plan. For example, the SPD should include information about the following:

- ◆ Cost-sharing provisions, including premiums, deductibles, coinsurance, and copayment amounts
- ◆ Annual or lifetime limits or other limitations in the plan
- ◆ The extent to which preventive services are covered under the plan
- ◆ The extent of drug coverage, if any, under the plan
- ◆ The extent of coverage, if any, for medical tests, devices, and procedures

- ◆ Provider networks, and whether individuals must use providers in the network
- ◆ Coverage for out-of-network services
- ◆ Whether the covered individual must select a primary care provider, and how to access specialists
- ◆ Coverage for emergency medical care
- ◆ The preauthorization or utilization review requirements
- ◆ An individual's appeal rights if coverage or services are denied

Plans must provide covered individuals information about any material changes within 60 days of when the changes are made.

PREMIUMS

There are no limits on the premiums that ERISA plans can impose, or on the amount of cost sharing required of people covered under the plan.

APPEALS

ERISA provides appeal rights for *all* employer-sponsored health plans (including both self-funded and traditional insurance or HMO coverage). Covered employees (or their dependents) can appeal denials of services that are normally covered under the plan. For example, a covered individual can appeal if the employer or health insurer denies coverage for a service because they determine the service is not "medically necessary." The appeals must be decided within certain specified timeframes. Urgent cases must be decided within 72 hours. However, the health plan has 60 days to decide appeals when the services have already been provided and the only outstanding dispute is whether the services should be covered under the plan. If the covered individual disagrees with the final appeal decision or if the plan fails to make a timely decision, then he or she can file a suit in federal court to obtain coverage.

ADMINISTRATION

ERISA plans are subject to oversight and enforcement by the U.S. Department of Labor.

SOURCES OF LAW

Federal statute(s): 29 U.S.C. § 1001 *et seq.* (Employee Retirement Income Security Act); 26 U.S.C. § 105 (IRS Non-Discrimination Provisions)

Federal regulation(s): 29 C.F.R. §§ 1021-1031; 1101-1114; 1131-1145; 2520.101 *et seq.*; 2560.503-1 (Employee Retirement Income Security Act)

FOR MORE INFORMATION

Pension and Welfare Benefits
Administrative Office of Enforcement
U.S. Department of Labor
Atlanta Regional Office
61 Forsyth Street SW
Suite 7B54
Atlanta, GA 30303
(404) 562-2156

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MEDICAID

What is it?

Medicaid is a governmental health insurance program that pays for medical services for certain low- and moderate-income people. In North Carolina, Medicaid is financed jointly between the federal, state and county governments.

Who is it for?

Only certain “categories” of people can qualify for Medicaid: families with dependent children, children under the age of 21, pregnant women, older adults (65 and older), and persons with disabilities or certain visual impairments (blindness). A potential recipient must first fit into one of the “categories” to qualify, and then must meet certain income and resource qualifications.

Where are applications taken?

All county Departments of Social Services (DSS) take Medicaid applications. You may also apply at some public health departments, hospitals, and community, migrant, and rural health centers.

INTRODUCTION

Medicaid is a governmental health insurance program that provides assistance with medical costs to certain low- and moderate-income individuals and families. The federal government sets the broad guidelines for the program. A state is then given considerable latitude to establish eligibility criteria and to determine what services will be covered for that state’s Medicaid recipients.

In North Carolina, you may be eligible for Medicaid if you fit into one of the categories listed above. People within the categories must then meet certain criteria regarding their income and resources (assets). These criteria are different for each category. The medical services covered may also differ.

This chapter begins with general information about Medicaid. Each “category” is then discussed separately. You can find information on the different programs as follows:

- **Families receiving Work First or Transitional Medicaid benefits**
- **Families with dependent children**
- **Pregnant women**
- **Infants and children under Age 19**
- **Breast and cervical cancer**

- **Aged, blind, or disabled persons**
- **Medicare savings programs**
- **Medically needy**

GENERAL INFORMATION ABOUT MEDICAID

Introduction

Several general rules apply to all types of Medicaid programs, regardless of the category a person qualifies under. The following information applies to all Medicaid programs (unless noted otherwise). Requirements that are unique to a program are outlined in each program section.

Benefits

Medicaid will pay for the following services:

- ◆ *Inpatient and outpatient hospital care*, including specialty hospitals
- ◆ *Physician services and other professional services*, such as podiatrists, osteopaths, chiropractors, and optometrists (limited to 24 visits per year unless life-threatening circumstances exist)
- ◆ *Clinic services* (including services at rural health centers, migrant health clinics, county health departments, and other services which are furnished by or under the direction of a physician or dentist — limited to 24 visits per year)
- ◆ *Prescription drugs and insulin* (limited to six prescriptions per month for certain individuals unless life-threatening circumstances exist)
- ◆ *“Health Check,”* a program of early and periodic screening, diagnosis, and treatment for children under the age of 21 (includes periodic physicals; hearing, dental and vision screenings; immunizations; and all the follow-up treatment identified by the provider)
- ◆ *Family planning services*
- ◆ *Laboratory and X-ray services*
- ◆ *Nurse midwife services*
- ◆ *Case management services* (available only for pregnant women, children under age five with special needs, people with mental illness, chronic substance abusers, and people with HIV)
- ◆ *Dental care* (there are a number of service limitations on dental services, except for children)
- ◆ *Mental health care* is limited to 24 visits per year for adults unless care is provided through an area mental health program (also referred to as a Local Management Entity) or authorized by Value Options. Children are not limited to the 24 visits per year limit. Medicaid will cover individualized treatment plans authorized by

psychiatrists. Treatment in a state psychiatric hospital or a freestanding psychiatric hospital is not covered for persons between the ages of 22 and 64.

- ◆ *Eyeglasses* and related services
- ◆ *Medically necessary Medicaid transportation* services and ambulance services (ambulance services are only available if other means of transportation would endanger the patient's health)
- ◆ *Adult screening* for early detection of physical and mental health problems and certain preventive health services such as mammograms or Pap smears (limited to 24 visits per year)
- ◆ *Home- and community-based services*, including: home health services and personal care services such as assistance with dressing, feeding, household tasks, transportation, and monitoring self-administered medication. Medicaid will also pay for private duty nursing in limited situations. Note: more extensive services, called Community Alternatives Programs (CAP), are available for people who would otherwise need to be placed in an institution (see below).
- ◆ *Nursing home care* (including intermediate care facilities for the mentally retarded)
- ◆ *Hospice care*
- ◆ *Durable medical equipment*
- ◆ *Hearing aids* (for children under age 21 only)
- ◆ *Home infusion therapy services*
- ◆ *Nurse practitioners*
- ◆ *Prepaid health plan services* (HMO coverage is an available option in certain parts of the state)
- ◆ *Prosthetics and orthotics* (for children under age 21 only)
- ◆ *Audiologists, occupational therapists, physical therapists, and respiratory therapists*
- ◆ *Speech and language pathologists* (for children under age 21 only)

Community Alternatives Programs (CAP)

The state offers several different CAP programs, which are designed to provide additional assistance to individuals who would otherwise need to be institutionalized. Different eligibility requirements apply to these programs. If eligible, the person is entitled to the full range of Medicaid benefits, and may receive additional services not otherwise offered to Medicaid-eligible individuals.

- ◆ *Community Alternatives Program for Children (CAP/C)*, which provides medically fragile children with a cost-effective home care alternative to institutional care.

To be eligible, the child must have a medical condition that places them at risk of needing nursing facility or long-term hospital care. The child must reside in a private residence. Children who are eligible for CAP/C may receive case management, home mobility aids, certain supplies, personal care services, respite care, and hourly nursing services. The total cost of home care must be within a monthly cost limit. There is a limit on the total number of children who may participate each year. For more information about CAP/C services, contact the Home Care Initiatives Unit in the Division of Medical Assistance at: (919) 857-4021 or the CARELINE at (800) 662-7030.

- ◆ *Community Alternatives Program for Disabled Adults (CAP/DA)*. CAP/DA is available to older adults or people with disabilities who would otherwise need nursing facility level of care. The individual must reside in a private residence. The program covers the cost of case management, adult day health care, in-home aide services, home mobility aids, respite care, telephone alert, home-delivered meals, and medical supplies. The total cost of home care must be within a monthly cost limit. There is a limit on the total number of people who may participate each year. For more information about this program, contact the CAP Unit in the Division of Medical Assistance at: (919) 857-4021 or the CARELINE at: (800) 662-7030.
- ◆ *Community Alternatives Program for Children and Adults with Mental Retardation or Developmental Disabilities (CAP-MR/DD)*. This program is available for children and adults who need the care of an Intermediate Care Facility for the Mentally Retarded or Developmentally Disabled (ICF-MR/DD). CAP-MR/DD clients are entitled to a full range of Medicaid-covered medical services. In addition, Medicaid can also be used to pay for augmentative communication devices, case management services, crisis stabilization, developmental day care, environmental accessibility adaptation, family training, personal care services, personal emergency response systems, respite care, vehicle adaptation, and other services, supplies, and equipment, up to a maximum monthly amount. The state currently limits the number of people it serves through CAP-MR/DD. Children and adults may apply for this program at local area mental health, developmental disability and substance abuse agencies. For more information about CAP/MR-DD services, contact the Division of Mental Health, Developmental Disabilities and Substance Abuse Services at: (919) 571-4980.
- ◆ *Community Alternative Program for Persons with AIDS (CAP/AIDS)*. This program is an alternative to nursing facility care for persons with AIDS as well as children who are HIV-positive and meet other criteria. The person must live in a private residence. The program covers the cost of case management, adult day health care, in-home aide services, home mobility aids, respite care, personal emergency response systems, home-delivered meals, and certain medical supplies. The total cost of home care must be within a monthly cost limit. There is a limit on the total number of individuals who may participate each year. CAP/AIDS is a cooperative effort with the AIDS Care Unit in the Division of Public Health. For more information about CAP/AIDS, contact the AIDS Care Unit at: (919) 715-3122, the Department of Medical Assistance Community Care Section at: (919) 857-4021 or the CARELINE at: (800) 662-7030.

Cost Sharing

Some Medicaid recipients are required to make a small payment — called a copayment — for some of their health services. These include chiropractic visits (\$1 per visit), prescription drugs (\$1 per prescription for generic drugs, and \$3 for brand-name drugs), optometrist visits (\$2 per visit), physician visits (\$3 per visit), and hospital outpatient visits (\$3 per visit).

The following services do not require any copayment from the patient:

- ◆ Family planning services
- ◆ Pregnancy-related services
- ◆ Services to residents in nursing facilities, mental hospitals, and intermediate care facilities for the mentally retarded (ICF-MR)
- ◆ Hospital emergency room services
- ◆ Community Alternatives Program (CAP) services
- ◆ Services provided at rural health clinics
- ◆ Non-hospital dialysis
- ◆ Services covered by both Medicaid and Medicare
- ◆ Any services provided to children under the age of 21

Eligibility

To qualify, individuals and families must be in one of the categories of individuals/families covered. In addition, the individuals or families must also meet personal and financial eligibility restrictions.

Personal eligibility

To qualify for Medicaid, an applicant must:

- ◆ Be a US citizen or eligible immigrant (see below)
- ◆ Be a resident of North Carolina
- ◆ Have a Social Security number, or have applied for one
- ◆ Provide verification of any health insurance
- ◆ Assign to the state the right to payment for health care from any third parties
- ◆ Not be in a public institution. (In other words, Medicaid will not pay for someone in prison or a non-elderly adult in a state psychiatric hospital. Medicaid will, however, pay for children under age 21 or adults age 65 or older who are receiving in-patient psychiatric service, or people age 21–65 who are in the medical/surgical unit of a state mental hospital.)

- ◆ Not be receiving Medicaid through any other source (for example, in another county or state)

Citizenship/Immigration Status

Citizens are eligible for assistance under the Medicaid program if they meet other programmatic rules. Most immigrants are ineligible for Medicaid, although they can receive Medicaid for emergency services. However, legal permanent residents (LPR) are eligible for assistance if admitted on or before August 22, 1996. If the person was admitted after August 22, 1996, he or she is ineligible for five years from the date of entry (unless he or she meets one of the exceptions listed below).

The five-year ban on receiving assistance does not apply to certain lawful permanent residents, including:

- ◆ Refugees, asylum-seekers, persons granted withholding of deportation, Cuban and Haitian entrants, and Amerasians can obtain benefits immediately but can only receive assistance during their first seven years. (Note: they can continue to receive assistance after seven years if they change their immigration status to another permanent status.)
- ◆ Veterans and active duty service members and their spouses and unmarried children under 21 can obtain benefits immediately, and continue to receive these benefits as long as they meet the programmatic rules.
- ◆ Immigrants who are receiving SSI can continue to receive Medicaid for as long as they continue to receive SSI.

Children born in the United States are US citizens, even if born to undocumented immigrants. The children are eligible for benefits, as long as they meet other programmatic rules. Parents who apply on behalf of their citizen child are not required to produce their own Social Security number or to provide information about their own immigration status. Applying for Medicaid will not normally affect their ability to later qualify for permanent residence.

Note: undocumented immigrants will not qualify for regular Medicaid coverage regardless of their length of time in the United States. However, all immigrants (including undocumented immigrants) can qualify for emergency Medicaid if they meet other program rules (e.g., categorical eligibility, residency, income and assets). Emergency Medicaid is available to help pay for medical conditions (including labor and delivery) with acute symptoms that could place the person's health in serious jeopardy, result in serious impairment to bodily functions, or cause serious dysfunction in any bodily organ or part. Emergency Medicaid will only pay for services necessary to stabilize the patient, not for ongoing care.

Financial eligibility

The income and, for most Medicaid programs, the resources of the person applying for Medicaid will always be counted in determining Medicaid eligibility. In addition, federal law makes certain people financially responsible for other people. In these instances the income and, when applicable, the resources of both the person seeking assistance *and* the financially responsible person will be considered in determining eligibility. For example, under federal law, spouses are considered to have financial responsibility for each other as long as they are living in the same home. In most instances, the joint income and resources of both spouses are counted in determining eligibility for Medicaid. Similarly, parents are generally responsible for their children, so the income and resources of both the parents and children are usually counted in determining Medicaid eligibility.

Income eligibility

The income of the person applying for Medicaid will always be counted in determining Medicaid eligibility, but not all income is “countable.” Income that is not counted by Medicaid includes but is not limited to:

- ◆ Supplemental Security Income (SSI)
- ◆ Earned Income Tax Credit payments
- ◆ Income that is unpredictable, such as occasional yard work or baby-sitting
- ◆ Foster care payments equal to or below the maximum state rate for foster care
- ◆ Loans, if there is an agreed-upon plan for repayment
- ◆ HUD Section 8 benefits

In addition, Medicaid applicants are allowed certain income exemptions, disregards, and deductions. Each Medicaid category has slightly different rules about income exemptions, disregards, and deductions. Please see sections on specific Medicaid programs for information unique to each program.

Income must be verified by bringing in a copy of a source document, such as a paycheck stub or statement from the employer.

Resource eligibility

In most of the Medicaid program categories, most of a person’s assets or resources are counted in determining Medicaid eligibility. An applicant may have only a certain limited amount of resources in order to be found eligible for Medicaid. However, some resources are not “countable.” Assets that do not count towards the resource limit include, but are not limited to:

- ◆ Personal effects and household goods
- ◆ One essential motor vehicle (used to retain employment or to get to the doctor at least four times a year, or one that is specially equipped for the disabled)
- ◆ Partial interests in real property, such as life estates, remainder interests that cannot be sold, and interests held with others as tenants-in-common
- ◆ Income-producing real property, such as rental property, or land that is rented out for farming (the Medicaid program has special rules to determine if the property is producing enough income to be exempt from the resource consideration)
- ◆ Income-producing personal property, such as farm or business equipment
- ◆ Retirement accounts, unless they can be withdrawn as a lump sum

Most people applying for Medicaid are limited in the amount of resources (assets) they can own. In the past, some people who needed medical services but could not afford them — such as an older person who needed nursing home care — got rid of excess resources in order to become eligible for Medicaid.

PLEASE NOTE: people who attempt to qualify for Medicaid by getting rid of their excess resources may be disqualified from receiving Medicaid. If you are in a nursing home, receiving home- or community-based services through the Community Alternatives Program (CAP), or receiving personal care services while living at home and you transfer certain assets to another person for less than fair market value in the 36 months immediately before applying for Medicaid, you may be disqualified from Medicaid for a certain number of months, depending on the value of the assets transferred. Of course, you are free to sell off any assets, if you receive fair market value for them. You may also be subject to a disqualification period if you set up a trust with excess assets within 60 months of applying for Medicaid.

The rules about transferring assets are notoriously tricky. Many people who innocently transferred assets have later found themselves being temporarily disqualified for Medicaid. It is worth consulting with a lawyer or your local Department of Social Services before transferring any resources. Free legal advice may also be available. See Appendix B to locate a Legal Services office near you.

Applications

An individual or family can apply for Medicaid at their county's Department of Social Services office. (See Appendix B for the DSS office in your county). Some hospitals, public health departments, and community, rural, and migrant health centers also have DSS workers available to take applications.

You have a right to apply for Medicaid on the same day you seek assistance. DSS must determine your eligibility within 45 days of the date of your application. If you are applying for Medicaid on the basis of being disabled, DSS must determine your

eligibility within 90 days of the date of your application.

People can apply for all of the Medicaid programs for which they are eligible. For instance, a woman with a child may be eligible for Medicaid for Families with Dependent Children, and her child may be eligible for Medicaid for Children. DSS workers are supposed to determine eligibility for all of the programs for which an individual or family may be eligible.

You can apply for ongoing Medicaid coverage for the next six months (prospective coverage). You may also apply to have Medicaid cover your medical expenses for one, two, or three months prior to the date of application (retroactive coverage). You may also apply for both prospective and retroactive coverage.

Much of the information needed for a Medicaid application must be verified by documents or in some other way. You should not wait to apply, though, if you don't have these papers at hand. They can be produced later in the application process. In addition, you can ask DSS to help you obtain whatever documents are required. As a general rule, the following documents should be brought when applying for Medicaid:

- ◆ Proof of income, such as wage stubs or award letters from government agencies
- ◆ Proof of assets, such as bank books, financial statements, deeds, property tax statements, or insurance policies
- ◆ Social Security cards for all applicants. (Note: Parents applying on behalf of their child need not provide their own Social Security number, just that of the child.)
- ◆ Immigration papers for all non-citizen applicants
- ◆ Proof of disability for those applying on that basis, such as medical reports from physicians
- ◆ Birth certificates or other proof of age for all applicants

Appeals

Medicaid applicants or recipients have a right to appeal any decision by the county DSS that involves the granting, denying, terminating, or modifying of assistance, or the failure of the county DSS to act within a reasonable time. Generally, the person has 60 days to request a hearing on an adverse decision. The 60-day deadline is calculated from the date the notice of the decision is mailed. If the person is already receiving Medicaid, he or she can request that benefits be continued until the first appeal is completed. Coverage will continue in these instances only if the person requests continued benefits within 10 days of the date of the notice.

All Medicaid appeals except those involving disability are first heard by a local DSS official. If you disagree with the decision of the local DSS official, you may appeal the decision to the North Carolina Department of Health and Human Services (DHHS). You have 15 days to appeal to DHHS. The 15-day deadline is counted from the date the local official's decision was mailed to you. The case will then be

heard before a state hearing officer, who will issue a decision. You can appeal an adverse DHHS decision to Superior Court by filing a petition for judicial review in Superior Court. The petition for judicial review has to be filed within 30 days of the time you get notice of DHHS's decision.

Free legal advice may be available to help you appeal an adverse Medicaid decision. Legal Services offices can provide more information about Medicaid appeals and the assistance that may be available. Legal Services offices are listed in Appendix B.

ADMINISTRATION

Medicaid is administered on the federal level by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (US DHHS). The program is administered on the state level by the Division of Medical Assistance (DMA) of the North Carolina Department of Health and Human Services (DHHS), and locally through the county Departments of Social Services (DSS).

SOURCES OF LAW

Federal law(s): 42 U.S.C § 1396 *et seq.*
Federal regulation(s): 42 C.F.R. §430 *et seq.*
State law(s): N.C.G.S. 108A-54 *et seq.*
State regulation(s): 10 N.C.A.C. Chapters 26 and 50

There are also state policy manuals on the different Medicaid programs. All manuals are available at county DSS offices or are available on-line at:

<http://info.dhhs.state.nc.us/olm/manuals/>

FOR MORE INFORMATION

Division of Medical Assistance
N.C. Department of Health and Human Services
1985 Umstead Dr.
2501 Mail Service Center
Raleigh, NC 27626-2501
(919) 857-4011

DHHS also has a toll-free number for Medicaid information and referral. Call CARELINE at (800) 662-7030.

There is a special toll-free number for information about the Medicaid for Pregnant Women program. Call (800) FOR-BABY (367-2229).

MEDICAID FOR FAMILIES RECEIVING WORK FIRST PAYMENTS OR TRANSITIONAL MEDICAID BENEFITS

Medicaid coverage for families is available automatically for families receiving Work First payments. In order to qualify, a family with dependent children must also meet strict work, income, and resource eligibility criteria. The major advantage to this program category is that both the children and the parents (or caretaker relatives) can receive assistance. Families do not need to apply for Medicaid separately, as all of the family members automatically receive Medicaid when they are part of a family receiving Work First payments.

Up to 24 months of transitional Medicaid benefits are available to families who lose Work First cash payments due to the earnings of a parent or caretaker relative. To qualify, families must have received cash assistance during at least three of the six months prior to having their cash assistance terminated due to earnings.

MEDICAID FOR FAMILIES WHO WOULD HAVE QUALIFIED UNDER NORTH CAROLINA'S FORMER AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC) PROGRAM

Introduction

Medicaid coverage for families with dependent children is available to families with children under age 21 who have been deprived of the support of one or both parents because of death, absence from the home, physical or mental incapacity, or the unemployment or underemployment of the parent who is the principal wage earner. Families who do not qualify for Work First payments, for example, because the family fails to participate in the work programs, or after the two-year or five-year time limits expire, may nonetheless still qualify for Medicaid under the old AFDC program requirements. If a family applies for Work First and is not eligible, they will not be required to make a separate Medicaid application. The local DSS office will evaluate whether the family is eligible for other Medicaid programs, such as Medicaid for families that would have qualified under the state's former AFDC program. The chief advantage of this program category is that both the children and parents or caretaker relatives can receive assistance, in contrast to the program for Children under Age 19 where only the children can receive assistance.

Eligibility

Personal Eligibility

The general personal eligibility rules set out in the General Information section are applicable both to a child and to caretaker relatives. However, additional personal eligibility rules are also applicable to each.

To be eligible as a caretaker, the person must:

- ◆ Be living with and caring for a child under age 19 (including unborn children) who is deprived of the support of at least one parent because of death, absence from the home, incapacity, or unemployment
- ◆ Be either the child's parent or a specified relative (such as a grandparent, aunt, or uncle who is related by blood, marriage, or adoption)
- ◆ Cooperate with the local Child Support Enforcement Agency in establishing paternity and medical support for all dependent children in the family
- ◆ Meet financial need requirements

To be eligible as a child, a person must:

- ◆ Be under age 21
- ◆ Meet financial need requirements

Income Eligibility

Certain deductions from gross income are allowed in determining a family's countable income. These include:

- ◆ Any Earned Income Tax Credit included in wages
- ◆ 27.5% of earned income. This deduction covers work-related expenses and expenses for childcare or adult day care. (Note: if a family is unable to qualify for Work First because they make too much income, then DSS will evaluate their earnings using income deductions that used to be in effect under the old AFDC program. These include a \$90 deduction per wage earner for work-related expenses, and child care or adult care expenses of \$200 for each child under age two and \$175 for others).
- ◆ Court-ordered alimony or child support payments to someone outside the household
- ◆ Needs of any minor children who are not in the family (up to certain maximums)
- ◆ \$50 per month child support or military allotment
- ◆ The earned income of a child who is a student may be excluded. The earnings of full-time students are excluded regardless of whether they work full- or part-time, but the earnings of a part-time student are excluded only if he or she works part-time.
- ◆ In-kind shelter and utility contributions paid to the supplier

To be eligible for Medicaid under this program category, the family's countable *monthly* income minus allowable deductions may not exceed the following amounts:

<u>Family Size</u>	<u>Monthly Income Limit</u>
1	\$362
2	\$472
3	\$544
4	\$594
5	\$648
6	\$698
7	\$746
8	\$772

If the family's countable income exceeds the amounts listed above, the family is not eligible for this program (although it may still be eligible under the medically needy program category). In addition, the children may be eligible under the Medicaid for Infants and Children (MIC) program category, which has higher income eligibility requirements.

Resource Eligibility

Under this program category, families cannot have more than \$3,000 in countable resources, regardless of the size of the family. Certain resources are excluded in determining eligibility:

- ◆ All real property and life insurance are excluded

Benefits

Those receiving Medicaid under the Families with Dependent Children program are entitled to the full range of Medicaid services listed in the General Information section. Children are entitled to the services without the copayments. In addition, children are eligible for "Health Check," which includes routine screenings, immunizations, and any follow-up treatment identified in the screenings. Health Check visits and follow-up treatment are exempt from any coverage limitations (such as the limit of 24 physician visits per year, or the limit on prescription drugs).

MEDICAID FOR INFANTS AND CHILDREN UNDER AGE 19 (MIC)

Introduction

Children under 19 may be eligible for Medicaid if they meet certain income requirements. Under this program, only the children—not their parents or caretaker relatives—are eligible for Medicaid coverage. Children need not reside with their parents or with caretaker relatives in order to qualify for this program. Children who are between the ages of 19-21 can qualify on their own, but must meet the income and resource requirements listed in the Medicaid program for families who would have qualified under the former AFDC program.

Eligibility

Income Eligibility

Income eligibility is determined by the family's countable income, family size, and the child's age. Even though parents are not covered under this program, the income of the parent(s) is considered in determining the child's eligibility, if the parent lives in the same household as the child seeking coverage.

Certain deductions from gross income are allowed in determining the family's countable income. These include:

- ◆ Any Earned Income Tax Credit (EITC) included in wages
- ◆ Work-related expenses of \$90 per wage earner per month
- ◆ Child care or adult day care expenses, limited to \$200 for each child under age two and \$175 for others per month
- ◆ Court ordered alimony or child support paid to someone outside the household
- ◆ Needs of any minor children who are not in the family (up to certain maximums)
- ◆ \$50 per month child support or military allotment
- ◆ The earned income of a child who is a student may be excluded. The earnings of full-time students are excluded regardless of whether they work full or part-time, but the earnings of a part-time student are excluded only if he or she works part-time.
- ◆ In-kind shelter and utility contributions paid to the supplier

If the family's countable income exceeds the amounts listed below, the child is not eligible for this program (although he or she may still be eligible under the medically needy program category). These income guidelines are effective April 1, 2003, and are revised annually.

<u>Family Size</u>	<u>Children <1 (185% FPG)</u>	<u>Children 1-5 (133% FPG)</u>	<u>Children 6-18 (100% FPG)</u>
1	\$1,385	\$996	\$749
2	\$1,869	\$1,344	\$1,010
3	\$2,353	\$1,692	\$1,272
4	\$2,837	\$2,040	\$1,534
5	\$3,321	\$2,388	\$1,795
6	\$3,805	\$2,736	\$2,057
7	\$4,289	\$3,084	\$2,319
8	\$4,773	\$3,432	\$2,580
Each Additional Person	+ \$485	+ \$349	+ \$262

Resource Eligibility

There are no resource limits for children under age 19 if applying under the MIC program.

Benefits

Children are entitled to the full range of Medicaid covered services, which are listed in the General Information section, but limits on services available to other Medicaid recipients are not applied to children. For instance, to get some Medicaid services, recipients have to pay a small fee when they use the service (called a “copayment”). Children are entitled to services without copayments. As another example, an adult’s use of some Medicaid services is limited. In general Medicaid will pay for only 24 visits to a physician each year. But “Health Check” for children and any necessary follow-up treatment are excluded from the 24-visit limit.

MEDICAID FOR WOMEN DIAGNOSED WITH BREAST OR CERVICAL CANCER (BCCM)

In 2001, the NC General Assembly approved new Medicaid coverage for women who have been enrolled in and screened for breast or cervical cancer under the NC Breast and Cervical Cancer Control Program (See Chapter 15, State Health Programs). In order to qualify for this new coverage, the woman must:

- ◆ Have been enrolled in and screened for breast or cervical cancer under the North Carolina Breast and Cervical Cancer program (BCCCP)
- ◆ Need treatment for breast or cervical cancer, including pre-cancerous conditions and early stage cancer
- ◆ Be uninsured (have no major health insurance coverage including Medicaid or Medicare)
- ◆ Be age 18 through age 64
- ◆ Meet other Medicaid eligibility requirements (such as citizenship requirements, residency, etc.)

A BCCCP screening provider must complete the Medicaid application form. The application must include a medical form, completed by a physician, that gives the diagnosis and estimated length of treatment. There are no income or resource limits in this Medicaid program; however, only women with incomes equal to or less than 200% of the federal poverty guidelines are eligible for the NC Breast and Cervical Cancer Control program. So effectively, only women with incomes less than 200% of the federal poverty guidelines will qualify for this Breast and Cervical Cancer Medicaid coverage.

MEDICAID FOR PREGNANT WOMEN (MPW) OR BABY LOVE

Introduction

A pregnant woman or pregnant minor whose countable income is not more than 185% of federal poverty guidelines is eligible for Medicaid for Pregnant Women as soon as her pregnancy is medically verifiable. This program is also known as the “Baby Love” program. For pregnant minors, the income of the minor and her parents will be counted in determining eligibility. There is no resource test in this program. Medicaid coverage will continue throughout the pregnancy and for a certain length of time after the pregnancy ends. In general, pregnant women and minors receive Medicaid coverage until the end of the month containing the 60th day after the pregnancy ends. Coverage will continue for the full eligibility period, even if her personal finances improve and she no longer meets the income guidelines.

Financial Eligibility

Income eligibility

Pregnant women and minors must have family incomes of not more than 185% of the federal poverty guidelines to qualify for assistance. For adults, only the income of the pregnant woman and her spouse, if any, will be counted. For minors, DSS will also count the income of the pregnant teen’s parent(s) if the minor is living with her parents.

Eligibility is determined based on the number of people in the family. The family includes the pregnant woman, her unborn child(ren), the spouse, and parents (for a minor), and any other children residing with the family. However, if eligible, only the pregnant woman receives coverage.

Families are allowed certain deductions from gross income. These include:

- ◆ Any Earned Income Tax Credit included in wages
- ◆ Work-related expenses of \$90 per wage earner
- ◆ Child care or adult day care expenses, limited to \$200 for each child under age two and \$175 for others
- ◆ Court ordered alimony or child support paid to someone outside the household
- ◆ Needs of any minor children who are not in the family (up to certain maximums)
- ◆ \$50 per month child support or military allotment
- ◆ The earned income of a child who is a student may be excluded. The earnings of full-time students are excluded regardless of whether they work full or part-time, but the earnings of a part-time student are excluded only if he or she works part-time.
- ◆ In-kind shelter and utility contributions paid to the supplier

After subtracting the allowable deductions, the countable income of the family must be no more than 185% of the federal poverty guidelines. The following are the monthly income guidelines in effect from April 1, 2003 to March 31, 2004. These income guidelines are revised each April.

<u>Family Size</u>	<u>Pregnant Women (185% FPG)</u>
1	\$1,385
2	\$1,869
3	\$2,353
4	\$2,837
5	\$3,321
6	\$3,805
7	\$4,289
8	\$4,773
Each Additional Person	+ \$485

Resource Eligibility

There are no resource limits in this program.

Benefits

Pregnant women who qualify for Medicaid under the Medicaid for Pregnant Women program are eligible for *pregnancy-related services only*. Treatment of other conditions, such as pregnancy-induced diabetes, which might complicate the pregnancy is also covered. (Pregnant women may also qualify under the TANF-related or Families with Dependent Children coverage programs. If they qualify under these latter programs, they are eligible for the full range of Medicaid benefits).

Applications

Eligibility for Medicaid under this program can be determined “presumptively” — that is, staff at health departments, hospitals, or clinics can “presume” that a woman will be eligible for this coverage and begin providing care immediately, based on medical verification of the pregnancy and a verbal declaration by the applicant of her family income. If it appears that she will be eligible, coverage will begin immediately. Coverage while a woman is “presumptively eligible” is limited to ambulatory prenatal care.

In order to continue coverage, the applicant must file a formal application with the Department of Social Services by the last working day of the month following the “presumptive eligibility” determination. The final determination of eligibility will be made within 45 days of application.

MEDICAID FOR THE AGED, BLIND, AND DISABLED (ABD)

Introduction

Medicaid is also available to certain older adults, people with disabilities or visual impairments (blind). In order to qualify, an individual or couple must be:

- ◆ Age 65 or older
- ◆ Blind (corrected visual acuity of 20/200 or worse in the better eye, or tunnel vision)
- ◆ Disabled meeting the Social Security disability definition. (Note: There are two separate definitions of disability, one for children and one for adults. For adults, disability is defined as a physical or mental impairment that keeps a person from performing any "substantial" work and is expected to last 12 months or result in death. A child's impairment must result in "marked and severe functional limitations" and must be expected to last 12 months or result in death.)

In order for a couple to qualify under this program, both members of the couple must be 65 or older, blind, or disabled. So, for instance, a couple composed of a man aged 66 and a blind woman of 64 would qualify. A couple composed of a man aged 66 and a woman of 64 who is not blind or disabled would not qualify as a couple, although the husband could still qualify for Medicaid coverage for himself. Children who are blind or disabled may also qualify if they meet the income and resource requirements.

Benefits

People who are eligible for Medicaid under this program are entitled to all the medical services listed in the General Information section at the beginning of this chapter. Additional benefits are available to people with disabilities or older adults participating in one of the state's Community Alternatives Programs (CAP).

Financial Eligibility

Income eligibility

The following general information about income eligibility under this program applies to people who are living at home or in a private living arrangement (for instance, with a sibling or other family member). Different income eligibility rules apply to people who are living in a nursing home or who are in a CAP program. Information on these exceptions appears at the end of this section on income eligibility.

Income rules for people living at home or in a private living arrangement:

Individuals who receive Supplemental Security Income (SSI) payments will automatically receive Medicaid. Others may also qualify, if their income is not more than 100% of the federal poverty guidelines. Generally, the income of the individual

and his or her spouse will be counted. Children applying on the basis of disability or blindness may also have some of their parents' income counted.

As in the other program categories, there are certain allowable deductions from gross income. Countable income is determined by subtracting the following deductions from gross income:

- ◆ The first \$65 of earned income plus half the remaining earned income
- ◆ Work-related expenses for individuals who are visually impaired (At the time of this writing, the state was also considering adding a work-related expense deduction for other people with disabilities.)
- ◆ Child care or adult day care expenses
- ◆ The needs of minor children in the household not in the family (certain maximums apply)
- ◆ A \$20 standard deduction
- ◆ One third of child support is excluded for people who qualify under the Medicaid program for the aged, blind, and disabled

After subtracting the allowable deductions, the countable income of the individual, couple or family must be no more than 100% of the federal poverty guidelines.

The following are the *monthly* income guidelines in effect from April 1, 2003 to March 31, 2004. These income guidelines are revised each April.

<u>Family Size</u>	<u>Aged, Blind, and Disabled (100% FPG)</u>
1	\$749
2	\$1,010
3	\$1,272
4	\$1,534
5	\$1,795
6	\$2,057
7	\$2,319
8	\$2,580
Each Additional Person	+ \$262

Individuals who live with and are supported by others (not their parents or spouses) are subject to different income limits. For example, if someone is living rent-free in a sibling's home, then they will have reduced monthly income limits. The reduced monthly income limits are \$493 for an individual, or \$664 for a couple. These limits are changed January 1st of each year.

Some people who used to receive SSI but became ineligible because of Social Security cost of living increases, qualifying for Social Security widows or widowers benefits, or qualifying for Social Security Disabled Adult Children coverage, may still qualify for automatic Medicaid eligibility. If you have received SSI any time since 1977, it is worth contacting your local Department of Social Services to determine if you are eligible for automatic Medicaid eligibility.

Income rules for people in long-term care:

People in long-term care (nursing homes or the CAP/DA program) have different income rules. As a general rule, a person in long-term care is eligible for Medicaid if his or her countable monthly income is less than the monthly costs of the nursing home.

People in long-term care must usually use any income to pay the costs of nursing home care. A person in long-term care may keep a certain amount of his or her monthly income: \$30 a month for a “personal needs allowance” and enough to pay for any medical needs not covered by Medicaid (such as over-the-counter drugs, or prescription drugs that exceed the Medicaid limit). The remainder of his or her income must be used to pay as much of the nursing home bill as possible, and Medicaid will pay any balance.

Special rules apply to people in long-term care who have a spouse at home (called the “community spouse”). These rules are intended to ensure that the community spouse has sufficient income to meet his or her subsistence needs. The spouse in the nursing home can give some of his or her income to supplement the community spouse’s income so that the combined income reaches \$1,493 per month. (This amount became effective July 1, 2002 and is updated annually).

The income of the community spouse determines whether and how much income the institutionalized spouse may contribute. If the at-home spouse has a monthly income of more than \$1,493, nothing can be contributed. If the at-home spouse has a monthly income of \$1,000, the institutionalized spouse may contribute \$493 per month (the difference between the contribution limit and the at-home spouse’s income).

In addition to the contribution that the institutional spouse can make to the community spouse, the institutional spouse can make additional contributions for excess shelter costs and/or dependents:

- ◆ *Excess shelter expenses:* “Shelter expenses” are housing expenses (for instance, rent or mortgage) plus utilities. The institutionalized spouse may make an additional contribution for shelter expenses over \$448 (effective July 1, 2002). So, for instance, if the at-home spouse’s shelter expenses were \$748, the institutionalized spouse could contribute \$300. The total amount that an institutional spouse can contribute towards the community spouse for both the regular contribution and excess shelter expense is \$2,267. (This amount became effective Jan. 1, 2003 and is updated annually).

- ◆ *Dependent expenses:* The institutional spouse can contribute up to an additional \$498 per month for each dependent depending on the dependent's income. (This amount became effective July 1, 2002 and is updated annually).

Exceptions to these amounts may be authorized through an appeals process. These figures are revised annually. Check with your local DSS to determine current limits.

Resource Eligibility

The following general information on resource eligibility applies to people living at home or in another private living arrangement. People in long-term care have special resource rules that are described below.

Resource rules for people living at home or in private living arrangements:

The countable resource limit is \$2,000 for an individual and \$3,000 for a couple. Certain resources are excluded in determining eligibility:

- ◆ One vehicle used for any purpose
- ◆ The homesite plus all contiguous property
- ◆ Income-producing property is excluded only if there is \$6,000 or less in equity and it produces at least 6% of its equity annually
- ◆ \$1,500 in revocable burial funds for both the applicant and his or her spouse. (For example, this would include money in the bank that the person intended to use for burial funds.)
- ◆ Life insurance policies when the total face value of all policies that accrue cash value does not exceed \$10,000
- ◆ Irrevocable pre-need burial contracts

Resource rules for people in long-term care:

Usually, DSS examines the resources of both the applicant and his or her spouse in determining eligibility. However, if a Medicaid applicant is in a nursing home, certain exceptions are made to protect some of the couple's joint assets for the spouse at home. Typically, the community spouse is entitled to half of the couple's joint assets, but not less than \$18,132 or more than \$90,660 (these amounts are effective January 1, 2003 and updated annually). Thus, if the couple only has \$13,000 in countable assets, the community spouse can keep all of their joint resources. However, if the couple jointly owns \$200,000 of countable assets; the community spouse can only keep \$89,280.

Applications

People who receive a Supplemental Security Income (SSI) check do not need to file a separate application for Medicaid. They will receive Medicaid automatically upon being approved for SSI. SSI applications are taken at local Social Security offices.

If you are ineligible for SSI, you can make a separate application for Medicaid. The procedures are essentially the same as outlined above in the General Information section. Decisions on applications should be made within 45 days for aged and blind individuals and within 90 days when applying on the basis of a disability.

MEDICARE SAVINGS PROGRAMS

Introduction

Aged, blind, and disabled individuals who cannot qualify for full Medicaid coverage may be able to qualify for more limited coverage under the Medicare Qualified Beneficiaries (MQB-Q) program, also known as the “Medicare Savings” program. The MQB-Q program was established to help low-income people with some of the costs of the Medicare program. There are four different MQB programs that will be outlined separately below. To qualify for Medicaid under the MQB program, you must meet certain income and resource tests, and must be eligible for Part A Medicare coverage.

Income eligibility

Income limits are different for each of the three programs. The income amounts listed below are current as of April 1, 2002 and are adjusted on April 1st of each year.

MQB-Q

The MQB-Q program pays Medicare premiums, deductibles, and copayments. To be eligible for MQB-Q, you must:

- ◆ Be eligible for Medicare Part A coverage
- ◆ Have a monthly income of less than \$749 for an individual and \$1,010 for a couple

An MQB-Q applicant who receives support and maintenance from someone else, such as a person living free in a sibling’s home, must have income lower than that listed above. In this case, a single MQB-Q applicant must have a monthly income of no more than \$499, and a couple no more than \$674.

MQB-B and MQB-E

The MQB-B and MQB-E programs pay only Medicare’s Part B premiums. To be eligible for this program you must:

- ◆ Be eligible for Medicare Part A coverage

- ◆ Have a monthly income of no more than 135% of the federal poverty guidelines, currently \$1,011 for an individual and \$1,364 for a couple

As noted in the MQB-Q section above, an MQB-B or MQB-E applicant who receives support and maintenance from someone else must meet lower income standards. A single MQB-B/E applicant in this circumstance may have a monthly income of no more than \$674, and a couple no more than \$910.

M-WD

The M-WD program pays only Medicare's Part A premiums. This program is available to certain disabled people who are working. To be eligible, you must:

- ◆ Be disabled and working
- ◆ Be eligible for Medicare Part A
- ◆ Have a monthly income of no more than \$1,497 for an individual and \$2,020 for a couple

As in the other MQB programs, an M-WD applicant receiving support and maintenance from someone else must have less income than mentioned above. A single M-WD applicant in this situation must have monthly income of \$998 or less, and a couple of less than \$1,347.

Resource eligibility

The resource exclusions are generally the same as those listed in the General Information section. Under MQB, the resource limits are higher than in most other Medicaid programs. To qualify for MQB, a single person may have no more than \$4,000 in resources, and a married couple may have no more than \$6,000 in resources. As with most other Medicaid programs, if your resources are over the limit, you are not eligible for MQB coverage.

MEDICALLY NEEDED

Introduction

North Carolina also provides Medicaid coverage to "medically needy" individuals and families. An individual or family who would otherwise qualify for Medicaid under another program category, but who has too much income, may still qualify for Medicaid under the medically needy program. In general, an individual or family qualifies as medically needy because of large medical expenses. To qualify as medically needy, the individual or family must incur and be responsible for paying medical bills equaling the difference between their countable income and the medically needy income limits (see below). This difference is called a deductible or "spend-down."

Eligibility

Personal Eligibility

To qualify under the medically needy Medicaid program, the individual or family must meet the same personal eligibility requirements of the other Medicaid programs. Thus, if a child applies separately, the child must meet the personal eligibility requirements of the Medicaid program for infants and children under age 21, or for disabled children. If the whole family is applying under the medically needy program, then the family must meet the personal eligibility requirements of the Work First or former AFDC program. If an older adult or person with a disability applies, they must meet the personal eligibility requirements of the Aged, Blind and Disabled program (see preceding sections).

Income Eligibility

Individuals or families who cannot qualify for other programs because of excess income may still be able to qualify for Medicaid under the medically needy program with a deductible. The individual's or family's countable income is compared to the medically needy income limits and the difference is the monthly deductible or "spend-down."

<u>Family Size</u>	<u>Medically Needy Monthly Income Limit</u>
1	\$242
2	\$317
3	\$367
4	\$400
5	\$433
6	\$467
7	\$500
8	\$525

These figures were last revised January 1, 1990, and are subject to change by the North Carolina General Assembly.

Example: A family of four who has \$800 in countable monthly income.
\$800 – countable monthly income
- 400 – medically needy income limits
\$400 – monthly deductible or "spend-down"

If the family wants ongoing Medicaid coverage, the amount of the deductible is calculated on a six-month prospective basis. In the example outline above, the family would have to incur \$2,400 in medical bills (\$400 deductible ► 6 months = \$2,400). After the family meets the deductible, Medicaid will pay medical bills for covered services for the remaining of the six-month period.

Alternatively, families can request that the Medicaid coverage be retroactive—that is, that Medicaid cover medical bills incurred in the one-, two-, or three-month period prior to applying. The amount of the deductible would be calculated accordingly.

Note: the family need not actually pay the medical bills in order to qualify. They must, however, be responsible for paying those medical bills. Medical bills that will be paid by a third party (such as an insurance company) cannot be applied to the deductible. Medical bills that a family incurs to cover the cost of health insurance, medical services, over the counter medications, or products can be used in meeting a deductible.

Resource Eligibility

For families who qualify under “medically needy” requirements, there is a \$3,000 resource limit (regardless of family size). All real property is excluded if someone is applying as medically needy under any of the families with children program categories. For older adults and people with disabilities, the person’s homesite plus all contiguous property is excluded from the resource calculation.

Note: as with other Medicaid programs, if you exceed the resource limits, you are not eligible for Medicaid. Applicants should be wary, however, of transferring assets in order to qualify for Medicaid. Please see the information on page 93 about transferring assets.

NC HEALTH CHOICE FOR CHILDREN

What is it?

NC Health Choice is a free or reduced-cost health insurance program for uninsured children from birth through age 18.

Who is it for?

NC Health Choice is for children who have family incomes that are too high for Medicaid coverage, but equal to or less than 200% of the federal poverty guidelines (FPG).

Where are applications taken?

Applications are available through local departments of social services or public health departments. Applications may also be available through many pediatricians' offices, day care centers, schools and other non-profit agencies.

INTRODUCTION

Congress created a child health insurance program as part of the Balanced Budget Act of 1997. The child health insurance program, called NC Health Choice for Children in this state, provides comprehensive health benefits for certain uninsured children under age 19. To qualify, the child must be a resident of North Carolina, ineligible for Medicaid, and have a family income that is equal to or less than 200% of the FPG. To enroll, the child may not have other health insurance coverage. Children with family incomes in excess of 150% of the federal poverty guidelines have to pay a one-time enrollment fee, and co-payments for certain health services. There is no resource requirement in this program.

Once a child is determined to be eligible for the program, the child will continue to receive insurance coverage for 12 months, unless the child obtains other health insurance coverage. This program is not an entitlement program, so children may be put on waiting lists if the state exhausts its funding.

BENEFITS/SERVICES

Covered Benefits

Health Choice provides children with comprehensive health insurance that covers most of a child's health care needs. There are some cost-sharing requirements for families with incomes above 150% of the FPG (see below). The insurance covers:

- ◆ *Hospital care*—semiprivate room, medically necessary supplies, medications, laboratory tests, radiological services, operating and recovery rooms, and professional care
- ◆ *Outpatient care*—diagnostic services, therapies, laboratory services, x-rays, and outpatient services
- ◆ *Physician and clinic services*—office visits
- ◆ *Preventive services*—four well-baby visits up to age one, three visits for children between one and two years of age, one visit for children between the ages of 2 and 7, and one visit every three years for children between the ages of 7 and 19; immunizations are also covered. No co-payments are charged for preventive services, including preventive dental services.
- ◆ *Surgical services*—standard surgical procedures, related services, surgeon’s fees, and anesthesia; some surgical procedures require precertification
- ◆ *Clinic services*—services provided at health centers and other ambulatory health care facilities
- ◆ *Prescription drugs*
- ◆ *Laboratory and radiology services*
- ◆ *Prenatal care and childbirth*—not covered; children who become pregnant are eligible for Medicaid coverage (see Chapter 12 on Medicaid)
- ◆ *Inpatient mental health services*—requires precertification
- ◆ *Outpatient mental health services*—covers the first 26 outpatient visits/year; precertification required after 26 outpatient visits
- ◆ *Durable medical equipment and supplies*—such as wheelchairs, nebulizer or hospital bed which is medically necessary for the treatment of a specific illness or injury
- ◆ *Vision*—including a routine eye examination once every 12 months, eyeglass lenses or contact lenses once every 12 months, replacement of eyeglass frames once every 24 months, and optical supplies and solutions
- ◆ *Hearing*—including auditory diagnostic testing services and hearing aids and accessories; prior approval required for hearing aids and accessories
- ◆ *Home health care*—limited to patients who are homebound and need care that can be provided only by licensed health care professionals or when a physician certifies that the patient would otherwise be confined to a hospital or skilled nursing facility. Professional health care is covered; care provided by an unlicensed caregiver is not.
- ◆ *Nursing care*
- ◆ *Dental care*—including oral examinations, teeth cleaning, and scaling twice during a 12-month period, full mouth x-rays once every 60 months, bitewing x-rays of the back teeth once during a 12 month period and routine fillings

- ◆ *Inpatient substance abuse treatment and outpatient substance abuse treatment*—covered subject to the same limitations as mental health coverage
- ◆ *Therapy*—physical therapy, occupational therapy, and speech therapy
- ◆ *Case management and care coordination*
- ◆ *Hospice care*

Children with Special Needs

Children with special needs may receive services beyond these listed above, such as case management, if the services are medically necessary. To qualify, the child must have a birth defect, developmental disability, mental or behavioral disorder, chronic or complex illness that is likely to continue indefinitely, interferes with the child's daily routine, and requires extensive medical intervention or family management. Typically, a child will be evaluated to determine if he or she has a special health care need when a provider recommends services not normally covered by the NC Health Choice benefits package.

Children with special needs may receive the same services provided to Medicaid-eligible children, except that long-term care services are not covered and respite care is limited to emergency respite. In effect, children with special needs may receive additional therapy services, personal care services, or durable medical equipment not fully covered under the core Health Choice program. Children are not required to apply separately for additional services.

APPLICATIONS

The state has developed a simple application that families can use in applying for either the NC Health Choice program or Medicaid. Children will first be evaluated for Medicaid eligibility. If the family's income is too high, then the same form will be used to determine if the children are eligible for the NC Health Choice program. No additional information is usually required to determine NC Health Choice eligibility. *Note: children who are eligible for Medicaid cannot obtain NC Health Choice coverage.*

Families may apply using mail-in applications found at county departments of social services, health departments, many health care providers, and other human service agencies. Applications are also available on the Internet at: <http://www.dhhs.state.nc.us/dma/cpcont.htm#app>. In addition, the family may also file an application directly at the department of social services. Assistance is available in filling out the application through local social services offices and at specially designated outstations (such as community, migrant and rural health centers and local health departments).

Applicants will be required to submit income verification (such as wage stubs or tax returns) and social security numbers for the children. Before children can be enrolled, families with incomes above 150% of the FPG must pay an enrollment

fee of \$50 for one child or \$100 for two or more children to the county department of social services (see below).

During the eleventh month of eligibility, the family will be sent a mail-in application form to renew coverage for their children. Families must provide income verification for the month preceding the re-enrollment. Families with incomes in excess of 150% of the FPG must also pay the required enrollment fee.

ELIGIBILITY REQUIREMENTS

To be eligible, a child must be a resident of North Carolina, uninsured, and have a family income within certain specified limits. Immigrants are subject to the same exclusions as in the Medicaid program (see Chapter 12). There are no resource eligibility requirements for this program.

Uninsured

NC Health Choice is targeted to uninsured children who meet the eligibility requirements. Because of the limited funding and federal requirements of this program, eligible children with existing private health insurance coverage may not enroll until the child's other health insurance coverage has ended. Once coverage has ended, the eligible child will be enrolled the first of the following month.

Income Eligibility

The income eligibility limits vary, depending on the number of people in the family's household, and the age of the child. To qualify, the family's *monthly income* must fall within the ranges listed below. Children in families with incomes below these limits will qualify for Medicaid (see Medicaid chapter). *Note: families with more than one child should look at the income guidelines for each child separately. Some families will have some children who qualify for Medicaid and some children who qualify for NC Health Choice.*

Age of Child

Family Size	Under age 1		1-5		5-18	
	Medicaid	NC Health Choice	Medicaid	NC Health Choice	Medicaid	NC Health Choice
1	\$1,385	\$1385 - 1497	\$996	\$996 - 1497	\$749	\$749 - 1497
2	\$1,869	1869 - 2020	\$1,344	1344 - 2020	\$1,010	1010 - 2020
3	\$2,353	2353 - 2544	\$1,692	1692 - 2544	\$1,272	1272 - 2544
4	\$2,837	2837 - 3067	\$2,040	2040 - 3067	\$1,534	1534 - 3067
5	\$3,321	3321 - 3590	\$2,388	2388 - 3590	\$1,795	1795 - 3590
6	\$3,805	3805 - 4114	\$2,736	2736 - 4114	\$2,057	2057 - 4114
7	\$4,289	4289 - 4637	\$3,084	3084 - 4637	\$2,319	2319 - 4637
8	\$4,773	4773 - 5160	\$3,432	3432 - 5160	\$2,580	2580 - 5160
Each add'l child	+ \$485	485 - 524	+ \$349	349 - 524	+ \$262	262 - 524

These income guidelines are effective April 1, 2003 and are updated annually.

Example: A family of four with two children (ages six months and 7) with a countable monthly income of \$2,100 would have one child eligible for Medicaid (because the family income for a family of four with a child under the age of one is less than \$2,837), and one child eligible for NC Health Choice. The younger child will maintain Medicaid eligibility until he or she turns one, and then will qualify for NC Health Choice if the family remains income eligible.

Fees

Families with incomes above 150% of the FPG will be required to pay an annual enrollment fee, plus certain co-payments. There are no fees or co-payments for families with lower incomes.

Enrollment fee:

The enrollment fee is \$50 for one child, or \$100 for two or more children. The enrollment fee must be paid before a child can obtain coverage. There are no monthly premiums in this program.

Co-payments:

- ◆ \$5 for each physician visit, clinic visit, dental, or optometry visit, except that there are no co-payments for preventive services (screenings or immunizations)
- ◆ \$5 for each outpatient hospital visit
- ◆ \$6 for each prescription
- ◆ \$20 for unnecessary use of the emergency room

150% of the federal poverty guidelines (FPG):

Only families with incomes in excess of 150% of the FPG are required to pay the annual enrollment fee or co-payments:

<u>Family Size</u>	<u>150% of FPG Monthly limits (2003)</u>
1	\$1,123
2	\$1,515
3	\$1,908
4	\$2,300
5	\$2,693
6	\$3,085
7	\$3,478
8	\$3,870
Each additional person	\$393

These income guidelines are effective April 1, 2003 and are updated annually.

Purchasing NC Health Choice

Children who were enrolled in NC Health Choice for one year and no longer qualify for NC Health Choice because of a slight increase in family income may purchase NC Health Choice coverage for up to one-year after their eligibility ends. To qualify, families may have income no greater than 225% of the FPG, and they must pay a premium equal to the per member per month cost of the program -currently \$120.84 per child (2002). The coverage is purchased directly from Blue Cross Blue Shield of North Carolina. There is no government subsidy for this coverage.

<u>Family Size</u>	<u>225% of FPG Monthly limits (2003)</u>
1	\$1,684
2	\$2,273
3	\$2,862
4	\$3,450
5	\$4,039
6	\$4,628
7	\$5,217
8	\$5,805
Each additional person	\$589

These income guidelines are effective April 1, 2003 and are updated annually.

PRIORITIZATION IF PROGRAM FUNDS ARE INSUFFICIENT TO SERVE ALL ELIGIBLES

In January 2001, the state ran out of money to serve new children. Eligible children who applied after that date were put on a waiting list. In July, the state started processing applications of children on the waiting list on a first-come, first-serve basis. The North Carolina General Assembly appropriated more money for the program and the waiting list was removed in October 2001. The waiting list did not affect children who were already in the program—just those who applied for the first time or who failed to reapply for NC Health Choice in a timely manner.

Note: Because the program has limited funds, it is important to apply for coverage when enrollment is open. It is equally important to renew coverage for your child at the end of the one-year eligibility period.

APPEAL RIGHTS

There are several different appeals processes, depending on whether the family is appealing eligibility determinations or service denials. Families who are appealing eligibility determinations have the same appeal rights afforded to Medicaid recipients (see Chapter 12 on Medicaid).

Issues that arise about whether a particular service should be covered are handled differently. Children or their families can appeal denials of covered service to the

Teachers and State Employees' Comprehensive Major Medical Plan ("State Employees' Health Plan"). If the family is dissatisfied with the outcome of this initial appeal, they can appeal further to the Board of Trustees of the State Employees' Health Plan. Questions about these appeals should be addressed to: (919) 733-9623.

Children with special needs who are denied coverage for additional services can appeal to the Children and Youth Section, Division of Women's and Children's Health, N.C. Department of Health and Human Services. Questions about these appeals should be addressed to: (919) 737-3028.

ADMINISTRATION

The program is administered through the N.C. Division of Medical Assistance. Claims are paid through the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan.

SOURCES OF LAW

Federal statute:	42 U.S.C. § 1397aa <i>et. seq.</i>
Federal regulations:	42 C.F.R. § 457.1 <i>et. seq.</i>
State statute:	N.C.G.S. § 108A-70.18 <i>et. seq.</i>

FOR MORE INFORMATION

Division of Medical Assistance
N.C. Department of Health and Human Services
1985 Umstead Dr.
P.O. Box 29529
Raleigh, NC 27626-0529
(800) 857-4262

<http://www.dhhs.state.nc.us/dma/cpcont.htm>

Toll-free hotline: (800) 367-2229

MEDICARE

What is it?

Medicare is a federal health insurance program that pays some of the costs of medical care, including hospital and doctors' charges, skilled nursing, home health, hospice, and outpatient care.

Who is it for?

People age 65 and older, certain people with disabilities, and people with end-stage renal disease.

Where are applications taken?

Applications are taken at the district offices of the Social Security Administration. These offices are listed in Appendix B. An applicant may call 800-772-1213 to begin the application process and arrange an appointment at the Social Security office.

INTRODUCTION

Medicare is a two-part federal program designed to provide health insurance for people 65 years of age and older, for people with certain disabilities, and for people with end-stage renal disease.

Medicare Part A provides some coverage of hospital and long-term care services; it is financed through Medicare payroll tax deductions. Almost everyone age 65 and older and certain people with disabilities are eligible for Part A without the payment of any additional premium.

Medicare Part B is a voluntary program that pays for the costs of professional medical services, outpatient care, and some medical equipment. It is financed by a combination of federal contributions and premiums paid by the individual. Anyone who is eligible for Medicare Part A is eligible for Medicare Part B, but some people do not purchase it.

Medicare is administered by the Social Security Administration. Payment problems with Part A coverage are handled by:

Medicare Part A Beneficiary Services
Palmetto GBA
Durham, NC
(800) 685-1512

<http://www.palmettogba.com>

Payment problems with Part B coverage are handled by:

CIGNA
High Point, NC
(800) 672-3071
(336) 882-4562 (Outside of North Carolina)

Unlike Medicaid, Medicare eligibility is not based on need. There are no income or resource (assets) limits.

BENEFITS

Medicare is not full health care coverage. Because of cost-sharing (deductibles, copayments, and coinsurance) and gaps in coverage, Medicare has been estimated to cover only about half of an enrollee's health care costs. Every year, Medicare cost-sharing increases.

People on Medicare have several ways of supplementing their Medicare coverage. Some low-income Medicare beneficiaries may be eligible for Medicaid. Depending on their income, low-income Medicare beneficiaries may be eligible for full Medicaid coverage (Medicaid for the Aged, Blind, or Disabled), or may be eligible for more limited Medicaid coverage (Medicare Savings programs). Medicare Savings programs pay some or all of the out-of-pocket costs (premiums, copayments, and deductibles) of Medicare. For information on the different Medicaid options, please see the section on Medicaid, Chapter 12.

Many insurance companies offer Medicare supplement (commonly called "Medigap") policies that are designed to cover medical costs not covered by Medicare. For information on "Medigap" policies, please see Chapter 6 of this book. In addition, some retirees are eligible for employer sponsored retirement benefits that supplement Medicare coverage.

Benefits under Part A

Medicare Part A covers inpatient hospital services. After a hospital stay, Part A will cover skilled nursing home care, and, if ordered by a doctor, home health services or hospice care. It does not cover custodial nursing care, private duty nurses, or personal convenience items that you request (for instance, television or telephone while in the hospital).

Note: The cost-sharing amounts listed in this chapter are for the 2003 calendar year. They are revised annually, effective January 1st.

Part A has an \$840 deductible per benefit period for inpatient hospital services. That is, a person on Medicare who is hospitalized must pay the first \$840 in hospital charges before Medicare will begin to pay benefits. A benefit period starts on the day of the hospital admission and ends 60 days after the date of discharge from the hospital or nursing home.

After the deductible is met, Medicare will pay 100% of the hospital charges for days 1 through 60 of a person's hospital stay. For days 61 through 90, the patient is responsible for paying a \$210 per day copayment.

People on Medicare also have what is called "lifetime reserve days" to cover extended hospital stays. A Medicare beneficiary has 60 "lifetime reserve days" during which Medicare will cover a portion of hospital care. For instance, if you are hospitalized for 91 days, Medicare pays 100% of the charges for days 1 through 60. You pay a \$210 per day copayment for days 61–90. Day 91 is charged against your 60 lifetime reserve days, and you have 59 lifetime reserve days left. For day 91 (and all lifetime reserve days), you pay a \$420 per day copayment.

Once your "lifetime reserve days" are exhausted, Medicare coverage for that benefit period ends. However, when a new benefit period begins, you are once again eligible for Medicare coverage of a hospital stay of up to 90 days. Once you exhaust your lifetime reserve days, you are no longer eligible for additional hospital coverage past 90 days each benefit period.

Coverage of skilled nursing home care is limited to 100 days per spell of illness. Skilled nursing home care is covered only if the following conditions are met:

- ◆ You must have been hospitalized for at least three days before entering a skilled nursing care facility
- ◆ You must be admitted to the skilled nursing care facility within 30 days of the hospitalization
- ◆ The care required must be rehabilitative in nature
- ◆ The condition that requires skilled nursing home care must be the same condition that required the hospitalization

If a doctor certifies that a patient needs skilled rehabilitative care, then Medicare will pay 100% of the first 20 days of nursing home care. The patient is responsible for a \$105 per day copayment for days 21 through 100.

Part A coverage of home health care is broader than that of nursing home services. (Note: Part B also covers home health services.) You can qualify for an unlimited number of home health visits if:

- ◆ You receive part-time or intermittent skilled nursing or physical, speech, or occupational therapy
- ◆ You are at least temporarily unable to leave your home
- ◆ The care is medically reasonable and necessary

In order for these services to be covered by Medicare, your physician needs to prescribe a home health treatment plan for you, and the home health agency that provides the services must be certified by Medicare. There are no copayments or deductibles for these services.

Medicare also covers hospice services. To qualify for hospice services, a patient must be terminally ill, with a prognosis of less than six months to live, and must have completed aggressive therapies. Agreeing to hospice services entitles a patient to medical and supportive services offered by an interdisciplinary team that includes the patient's physician and hospice personnel. Hospice services also cover durable medical equipment and drugs related to the terminal illness. Small copayments for inpatient respite care and outpatient drugs may be required.

When a patient signs on to hospice benefits, Medicare Part A coverage for the terminal illness is waived. However, Medicare Part A coverage remains in effect for other illnesses unrelated to the terminal illness. The patient may revoke the hospice benefit at any time.

Benefits under Part B

Medicare Part B covers:

- ◆ The medical services of doctors, nurse practitioners, and physician assistants
- ◆ Supplies and drugs that cannot be self-administered and are incidental to doctor care
- ◆ Outpatient services and diagnostic tests
- ◆ Rental or purchase of durable medical equipment (for instance, wheelchairs, prostheses, or braces)
- ◆ Prosthetic devices, including breast prosthesis after a mastectomy
- ◆ Ambulance services, when medically necessary
- ◆ Services provided in rural health clinics
- ◆ Outpatient physical, occupational, and speech therapy
- ◆ Outpatient dialysis for people with end-stage renal disease
- ◆ Outpatient mental health treatment (there is a 50% copayment for these services)
- ◆ The services of psychologists and mental health social workers
- ◆ Limited psychiatric hospitalization
- ◆ Immunosuppressive drugs
- ◆ Vaccines for pneumococcal pneumonia, hepatitis B, and flu
- ◆ Certain preventive screenings, such as: Pap smears, mammograms, colorectal cancer screening, glaucoma screenings, and prostate cancer screenings
- ◆ Diabetes glucose monitoring and diabetes education (for those with diabetes)

Medicare Part B does *not* cover such medical care as routine physicals, dental care (except dental surgery or emergency dental care), intermediate nursing home care, eyeglasses or vision care (except after cataract surgery or treatment for macular degeneration), hearing aids and hearing examinations, routine foot care and

orthopedic shoes (except where foot care is necessitated by diabetes), custodial care, homemaker services, private duty nurses, acupuncture, medical transportation (except for medically necessary ambulance services), immunizations (except as noted above), the first three pints of a blood transfusion, or most outpatient prescription drugs.

There is a \$100 Part B deductible each year. That is, for services covered by Part B, the patient must pay \$100 out of pocket, and Part B then pays 80% of the Medicare-approved payment level. Medicare sets pre-determined payment levels for medical procedures and services.

Some physicians accept Medicare “assignment” and some do not. It is important to find out if your doctor accepts Medicare assignment. If not, you may be required to pay more out of pocket for his or her medical services. Here is an example of the difference in what you might pay out of pocket, depending on whether your physician accepts Medicare assignment:

Assume that your physician recommends a certain minor surgical procedure for you. For that procedure, Medicare’s approved payment amount is \$100. If your doctor accepts Medicare assignment, Medicare will pay 80% of that amount (\$80) to the doctor, and the doctor is permitted to bill you only \$20 — the difference between the Medicare approved charge (\$100) and the Medicare payment (\$80). The doctor is paid a total of \$100 for procedure X, no matter what the “going rate” for that procedure is, and your out-of-pocket cost will be \$20.

If your doctor does not accept Medicare assignment, you may be responsible for paying up to 115% of the Medicare- approved charge—here, \$115. In this case, Medicare would pay \$80 (80% of its approved charge amount). Medicare’s payment is sent to you, and the doctor can bill you \$115. Your total out-of-pocket cost would be \$35.

Since Medicare’s approved charges are often lower than a physician’s usual fees, some physicians may limit the number of Medicare beneficiaries that they will take as patients, or may not accept Medicare assignment. It is therefore very important to find out whether your doctor accepts assignment.

Benefits under Medicare + Choice

In some areas of North Carolina, benefits may also be available through managed care plans. There are three Medicare Managed Care Plans operating in North Carolina:

Partners Medicare Choice

P. O. Box 24907
Winston-Salem, NC 27114-4907
800-668-8037
<http://www.partnershealth.com>

Counties served: Alamance, Alexander, Alleghany, Ashe, Cabarrus, Davidson, Davie, Forsyth, Gaston, Guilford, Iredell, Mecklenburg, Orange, Rockingham, Rowan, Stokes, Surry, Wake, Wilkes, and Yadkin

QualChoice Medicare Gold

100 Kimel Forest Drive
P. O. Box 340
Winston-Salem, NC 27102-0340
800-273-4115
<http://www.qualchoicenc.com>

Counties served: Alexander, Alleghany, Burke, Caldwell, Catawba, Davidson, Davie, Forsyth, Rowan, Stokes, Surry, Wilkes and Yadkin

United HealthCare of NC Medicare Complete

P. O. Box 26403
Greensboro, NC 27404
888-264-8761
(336) 851-8740

Counties served: Alamance, Chatham, Durham, Forsyth, Guilford, Mecklenburg, Orange, Randolph, Rockingham and Wake.

Enrollment into these plans is voluntary. Enrollees will receive all benefits available under Part A and Part B. They may also receive benefits not included under the original Medicare program, such as prescription drugs or preventive care. Enrollees must pay the Medicare Part B premium (\$54/month), although some plans may require additional premiums. There may also be copayments for certain services.

Members of managed care plans may have less choice of providers and less freedom to see specialists without prior approval from their plan. However, they may have less out-of-pocket payments and may be eligible for additional services.

Beginning in 2003, some insurers around the country will begin offering a Preferred Provider Organization (PPO) product to Medicare recipients. In North Carolina, only one company will offer a PPO product:

United Healthcare of North Carolina

P. O. Box 26403
Greensboro, NC 27404
888-264-8761
(336) 851-8740

Counties served: Alamance, Chatham, Durham, Forsyth, Guilford, Mecklenburg, Orange, Randolph, Rockingham and Wake.

Waiver of liability

When Medicare denies a claim for a medical service — for instance, because it was determined not to have been “medically necessary” — the patient may not be required to pay for the service. Medicare may agree to pay for the service if the patient follows a special waiver process. This procedure can be used for any claims denied under Part A. Under Part B, the waiver process is available only if the claim is denied for a service provided by a physician who accepts Medicare assignment.

Liability will be waived if it can be shown that the patient could not have been expected to know that the service would not be covered. Generally, it is presumed that a patient would not be able to know that a service would not be covered, unless the patient received advance written notice of noncoverage. When liability is waived, Medicare pays for the service even though the claim was denied.

PERSONAL ELIGIBILITY

Part A

Eligibility without a premium

The following people are eligible for Medicare Part A without the payment of any premium:

- ◆ Recipients of Social Security or Railroad Retirement benefits who are age 65 and older.
- ◆ Federal civil service employees age 65 and older who became eligible for federal retirement benefits after January 1, 1983.
- ◆ State and local government employees age 65 and older who were hired after April 1, 1986.
- ◆ People with disabilities under age 65 who have been entitled to Social Security disability or Railroad Retirement disability benefits for 24 months or more. (Note: there is a five-month waiting period before anyone can qualify for Social Security disability, so you would have to be disabled for at least 29 months before you could qualify for Medicare under this category.)
- ◆ Certain people who receive a kidney transplant or undergo hemodialysis. This is called end-stage renal disease, or ESRD. To qualify for Medicare under this

category, you must be under age 65 and fully or currently insured for Social Security, or you must be an employee covered by the Railroad Retirement Act. This type of Medicare coverage begins with the kidney transplant or three months after the hemodialysis begins, and ends 36 months after the transplant or 12 months after hemodialysis ends.

Eligibility with a premium

Certain older individuals who are not receiving Social Security or Railroad retirement payments may still be eligible to buy into Medicare Part A. To qualify for Part A with a premium, a person must be a resident of the U.S. (a citizen or a lawfully admitted alien who has resided in the United States for five consecutive years) who is age 65 or older and enrolled in Medicare Part B. Anyone who meets the following criteria may choose to enroll in Medicare Part A by paying the policy's premium. The 2003 premium is \$316 per month, but it may be reduced based on a person's past contributions to the Social Security system. Medicaid will pay this premium for some low-income individuals (see page 109).

Part B

Anyone entitled to participate in Medicare Part A may choose to participate in Part B upon the payment of a monthly premium. Effective January 1, 2003, the monthly premium is \$58.70. The premium amount is adjusted yearly. The monthly premium is usually deducted from a person's Social Security check. Medicaid will pay this premium for some low-income individuals (see page 109).

Medicare + Choice

All individuals who are eligible for Part A and Part B, except those eligibles with end stage renal disease, may enroll in a Medicare + Choice plan, provided that they live in an area where a plan is offered.

FINANCIAL ELIGIBILITY

Unlike Medicaid, eligibility for Medicare does not depend on financial need. Anyone who meets the personal eligibility requirements outlined above is eligible for Medicare, regardless of that person's income or resources.

APPLICATIONS

Applications are taken at district offices of the Social Security Administration, which are listed in Appendix B. Call 800-772-1213 for information about setting up an appointment.

Automatic enrollment for Part A and Part B

People who are entitled to Social Security or Railroad Retirement benefits will be automatically enrolled in Medicare when they turn 65. People who begin collecting Social Security disability benefits prior to age 65 are automatically enrolled once

turning 65. People who have received Social Security disability benefits for 24 months are also automatically enrolled. No separate application is required.

Applying for Part A and Part B

People who are eligible for but not receiving Social Security benefits must apply for Medicare benefits. In addition, people with end-stage renal disease and voluntary enrollees (those who are eligible for Medicare by paying a premium) do not receive Medicare automatically. They must file an application to become eligible for Medicare. Contact the Social Security Office to apply for Medicare.

Part B enrollment

People who are enrolled in Medicare Part A are automatically enrolled in Part B. However, you may “opt out” of Part B coverage.

If you are not automatically enrolled in Part A, you may enroll in Part B at certain times without any penalty. If you enroll late — that is, after the set enrollment periods — you may be charged as much as 10% more for your Part B premium than if you enrolled during the prescribed enrollment periods.

The “initial enrollment period” begins three months before a person becomes eligible for Medicare Part A and continues for seven months. If you are not automatically eligible for Medicare and wish to enroll, you should apply during this initial enrollment period.

There is also a “general enrollment period” for people who did not enroll during the initial enrollment period. The general enrollment period runs from January 1 to March 31 of each year. Coverage becomes effective July 1st.

“Special enrollment periods” are also available under certain circumstances. A person 65 or older who had health insurance from another source (for instance, through an employer’s health plan) and later loses that coverage may enroll during a special enrollment period. In this case, the special enrollment period is an eight-month period beginning when employment terminates or after the employer’s group plan ends. You are not charged a penalty if you enroll during a special enrollment period.

Medicare + Choice Enrollment

All Part C plans must participate in an “open enrollment” period during the month of November. Some plans may also accept members at other times during the year. In order to join one of the plans, you must contact the plan and obtain an enrollment form. Once you have completed the form and returned it to a plan representative, the plan will provide you with a letter stating the date that coverage will begin.

The plans may place restrictions on when members can disenroll in the + Choice plan. Beginning in 2002, beneficiaries may change plans only once during the first six months of the year.

APPEALS

If you are a Medicare beneficiary (or applying for Medicare), you may sometimes disagree with a Medicare decision — for example—about whether you are required to pay a Part A premium, the appropriate length of a hospital stay, or if Medicare denies payment for a medical procedure. The Medicare program has systems to appeal such decisions. The appeal process you need to use will depend on the type of Medicare decision you wish to appeal. If you do appeal a Medicare decision, you have a right to be represented by a lawyer. Legal Services offices may be able to assist some low-income people who need an attorney's assistance with a Medicare appeal. Legal Services offices are listed in Appendix B.

Appealing a decision about eligibility

Decisions about whether someone is eligible for Medicare (Parts A and B) are appealed to the Social Security Administration. If you receive notice that you are ineligible for Medicare and you want to appeal that decision, you have 60 days from the time you receive notice to file a written request for reconsideration.

The Medicare program may end, reduce, or suspend a person's Medicare benefits for a variety of reasons. If you wish to appeal a Medicare decision about termination, reduction, or suspension of benefits, you should file a request for reconsideration within 60 days of receiving notice of the decision. If you file your request for reconsideration within 10 days of receiving your notice, your Medicare benefits will continue while you are making your appeal. Unlike the Medicaid program, the Social Security Administration is not required to issue a decision on an appeal within a certain length of time.

If you disagree with the Social Security Administration's decision on your written request for reconsideration, you may continue your appeal. You have 60 days after receiving notice of SSA's decision to request a face-to-face hearing before an Administrative Law Judge (ALJ). The ALJ will issue a written decision and will mail it to you and your legal representative. The ALJ is not required to issue a decision within a certain length of time.

If you disagree with the ALJ's decision, you may request a review of your case by the Appeals Council. The request for review must be made within 60 days of receiving the ALJ's decision. The Appeals Council's written decision will be mailed to you and your legal representative. As with previous steps in the appeals process, the Appeals Council is not required to issue its decision within a certain length of time.

If you disagree with the Appeals Council's decision, you have 60 days to file an appeal in Federal District Court. The case is reviewed by a judge or a federal magistrate, who considers the evidence already submitted in the prior proceedings. This decision may be appealed to the U.S. Court of Appeals.

Appealing a decision about Part A hospital services

Decisions about Medicare's hospital services (such as preadmission certification, length of stay, and hospital procedures and care) are made by a group of doctors working for a Quality Improvement Organization (QIO, formerly called Peer Review Organization or PRO). In North Carolina, the QIO is Medical Review of North Carolina. If you disagree with the QIO decision, you may request a reconsideration within 60 days of the action or decision you wish to challenge. Your request is made to the QIO and is given an initial review by them. This is a "paper review" — that is, not a face-to-face hearing.

An expedited reconsideration process is available when time is of the essence. This is especially important if you are hospitalized and have been notified by Medicare that a continued stay or an anticipated procedure will not be covered. You must request the review within three days of getting the notice, and the QIO must respond within three days.

If the amount in question is at least \$200, a Medicare beneficiary has a right to appeal the QIO decision to an Administrative Law Judge (ALJ). If the amount in controversy is at least \$2,000, the ALJ's decision can be appealed to Federal District Court.

If you are a Medicare beneficiary and you are admitted to a hospital, you must be given a brochure called "An Important Message from Medicare." This brochure explains how to appeal a Medicare decision about Part A hospital services.

Appealing a decision about other Part A services

Appeals about other Part A services such as home health or hospice care are heard first by Palmetto-GBA. If you do not agree with their decision and the amount in dispute is at least \$100, you may appeal the decision to an Administrative Law Judge (ALJ). The ALJ's decision can be appealed to Federal District Court if the amount in controversy is at least \$1,000.

Appealing a decision about Part B services

If Medicare Part B denies payment for services, you will get a "Medicare Summary Notice" (MSN) which explains Medicare's decisions about Part B services and tells you how to appeal a decision. You have six months from the date of the MSN to request a review.

If Part B benefits are denied and the amount in question is at least \$100, you can request reconsideration of the denial and a hearing before CIGNA. You must make the request for reconsideration within six months of the denial. (The amount in dispute can be accumulated over the six-month period.) If the amount in controversy is at least \$500, you can appeal the reconsideration decision to an Administrative Law Judge (ALJ). If the amount in controversy is at least \$1,000, the ALJ's decision can be appealed to Federal District Court. You may also request a hearing if Medicare fails to respond to a request for payment.

Appeals process for members of Part C plans

The appeals process for Part C claims is divided into two categories: non-urgent and urgent.

Non-urgent

If a plan member files an appeal for a denied service that is not needed immediately, the plan has 30 days to respond. If the plan does not reverse its denial, it must send the member's appeal to the Center for Health Disputes and Resolution (CHDR). The CHDR has 30 days to review the appeal. If the CHDR agrees with the denial and the denied service costs more than \$100, the member can request that the appeal be heard by an administrative law judge. If the member does not agree with the ALJ's decision, the member can appeal the decision to a Federal District Court if the amount in controversy is at least \$1,000.

Urgent

If a denied service is needed immediately, a member can request an expedited decision from the plan. If the plan denies the request for an expedited decision, the member's doctor can request the expedited decision requiring the plan to consider the request within 72 hours.

If the member's doctor does not support the request for an expedited appeal, the plan will review the appeal according to the non-urgent appeals process. However, the member may also file a grievance with the plan if the member believes that the appeal was urgent. All grievances filed with the plan should also be sent to CMS and to the member's congressional representative.

SOURCES OF LAW

Federal statute(s):	42 U.S.C. §1395 <i>et seq.</i>
Federal regulations:	42 C.F.R. §§400-424, 460-498 C.F.R. §405 <i>et seq.</i>
Federal policy:	CMS Medicare Manuals

FOR MORE INFORMATION

Social Security Administration

800-772-1213

<http://www.ssa.gov>

The Social Security Administration publishes The Medicare Handbook each year. It is available free from SSA.

Medicare-Consumer Information

1-800-MEDICARE

<http://www.medicare.gov>

For Part A:

Medicare Part A Beneficiary Services

Palmetto GBA

Durham, NC

800-685-1512

Medical Review of North Carolina

(For appeals of hospital stays)

Raleigh, NC

800-722-0468

For Part B:

CIGNA

High Point, NC

(800) 672-3071

(336) 882-4562 (Outside of North Carolina)

STATE HEALTH PROGRAMS

What are they?

A variety of services are available through the public health system in the state. These services are generally targeted at specific health conditions or at certain populations at high risk for health problems.

Who are they for?

People who meet a variety of eligibility criteria. In most programs, people must have a specific medical condition and/or financial status to qualify.

Where are applications taken?

Usually at local health departments. Most programs are offered directly by local health departments, or by community health clinics or other medical providers who have contracted with the state to offer particular services. The local health department can provide a referral if the health department does not offer the service directly.

INTRODUCTION

The North Carolina Department of Health and Human Services (DHHS), through the Division of Public Health, administers a variety of health programs. Some are designed to prevent injuries or chronic diseases through education and screening services. Others provide treatment to people who already have chronic illnesses, such as cancer or kidney disease. Still others offer health services to people in particular populations, such as migrant workers or children.

Local health departments offer some of these health programs directly. Sometimes, the department has contracts or arrangements with health providers to carry out programs. Initial access to most of the programs is through local health departments. When the health department is not the direct provider of a particular health program, it is usually able to refer a patient to the appropriate provider.

Every area of the state is served by a local health department. Most health departments serve one county, although some serve a multi-county area. Each health department is independent, answering to its own local Board of Health.

Some of the state-funded programs are available throughout the state, but others are available only in certain locations. Some of the programs operate only for part of the year because funds are insufficient to meet all of the need. This chapter describes the major public health programs that provide direct clinical services to individuals throughout the state. The programs that focus mostly on education and health

promotion are not included, nor are programs that are available only in some counties. Your local health department is the best source of information about the programs available in your area. The addresses and phone numbers of all the local health departments in North Carolina are listed in Appendix B.

This chapter is divided into four sections. The first describes state health programs that provide assistance with specific diseases or conditions (AIDS, cancer, hemophilia). The programs are listed alphabetically. The second lists other health-related programs such as family planning and home health services. The third section outlines programs directed at specific populations such as children or refugees. Eligibility requirements are noted for each program. The final section notes services available to children through the school systems.

PROGRAMS FOR PEOPLE WITH SPECIFIC MEDICAL CONDITIONS

This section describes programs that assist people with specific medical conditions. Eligibility is given for each program. The programs are listed alphabetically by disease.

Cancer

Breast and Cervical Cancer Control Program

The Breast and Cervical Cancer Control Program (BCCCP) provides screening for breast cancer and cervical cancer for eligible women. Local health departments provide screening. Screening is also provided at some community health centers and at regional medical centers.

Services: The BCCCP provides screening and certain specific follow-up care only. This program does not assist with treatment costs, though some women may be eligible for assistance through the Medicaid program, discussed in Chapter 12.

Eligibility: The program focuses on women ages 50 to 64, with family incomes that are at or below 200% of the federal poverty guidelines (See Appendix A). To be eligible, women cannot be enrolled in Medicaid or Medicare Part B. There is a special emphasis on reaching women of ethnic or racial minorities. Women at or below 100% of the federal poverty guidelines are not charged; women between 100% and 200% of federal poverty guidelines may be charged on a sliding scale.

Sources of Law:

State Law: N.C.G.S. § 130A-205

State Regulations: 15A N.C.A.C. § 16A .1200 *et. seq.*

Contact:

Breast and Cervical Cancer Control Program

Cancer Prevention and Control Branch

North Carolina Division of Public Health

1915 Mail Service Center

Raleigh, NC 27699-1915

919-715-0123

or

Local health department (See listing in Appendix B)

or

CARELINE

1-800-622-7030

919-733-4261 (in Raleigh)

Cancer Control Program

This program focuses on the prevention, detection, diagnosis, and treatment of cancer. Local health departments have detection and screening clinics that test for breast and cervical cancer. In some counties, testing for skin, colorectal, prostate, testicular, mouth, and throat cancers may be available, either on site or through direct referral to a physician office. If an abnormality is found through the testing process, the health department will refer indigent patients for further diagnosis and, if necessary, treatment. Diagnosis and treatment for indigent patients is paid for by the state through this program.

Eligibility. To receive services in the Cancer Control Program, you must meet both medical and financial criteria. Coverage for treatment is limited to a maximum of eight inpatient days or 30 outpatient visits per year. Patients must be referred by their physicians.

Medical eligibility. For diagnostic services, the person must have a condition that the physician believes is indicative of cancer or might be cancer. There must be a need to perform diagnostic procedures to rule out cancer.

For treatment services, the patient must have cancer that has been confirmed by biopsy or other definitive method. Treatment may not be solely for palliative purposes; there must be at least a 25% chance of survival for at least five years.

Financial eligibility. In order to receive free services, the individual must have an annual gross family income no higher than 115% of the federal poverty guidelines (see Appendix A). If the income is higher, the individual may be able to get some free services after incurring a portion of the bill (called “spend-down”). The local health department and participating physician offices throughout the state can help you determine eligibility.

Sources of Law:

State Law: N.C.G.S. §§ 130A-205, 130A-206

State Regulations: 15A N.C.A.C. § 16A .1100 *et. seq.*

Contact:

Local Health Department (See listing in Appendix B)

or

Cancer Control Program

Cancer Prevention and Control Branch

Division of Public Health

Department of Health and Human Services

919-715-3148

or

CARELINE

1-800-622-7030

919-733-4261 (in Raleigh)

Epilepsy

Epilepsy and Neurological Disease Program

Limited funds are available to screen, diagnosis, and treat persons with epilepsy or suspected of having epilepsy. Indigent persons may receive free anticonvulsant medications, although sufficient funds are not available to pay for drugs for everyone who meets the eligibility criteria. Children are generally able to receive needed medications through Children's Special Health Services, so this program concentrates on adults.

Services are provided by seven regional project locations:

- ◆ Albermarle Regional Health District, Elizabeth City
- ◆ Cumberland County Health Department, Fayetteville
- ◆ Jackson County Health Department, Sylvania
- ◆ New Hanover County Health Department, Wilmington
- ◆ Pitt County Health Department, Greenville
- ◆ Carelina Medical Associates, Raleigh
- ◆ Wake Forest University School of Medicine, Winston-Salem

Medical eligibility. The individual must be diagnosed with epilepsy.

Financial eligibility. Clinical services and education services require only that an individual have a medical referral with a diagnosis of epilepsy; there are no financial eligibility requirements. In order to receive free medication, the individual must have an annual net family income no higher than 100% of the federal poverty guidelines

(See Appendix A). If the income is higher, the individual may be able to get some assistance after incurring a portion of the bill.

Sources of Law:

State Law: N.C.G.S. § 130A-223
State Regulations: 15A N.C.A.C. § 16A.0500

Contact:

Health Promotion and Disease Prevention Section
Division of Public Health
Department of Health and Human Services
919-715-3113

or

CARELINE
1-800-622-7030
919-733-4261 (in Raleigh)

HIV/ AIDS

HIV Prevention

Counseling, testing, and referral for HIV is available without charge at all local health departments. Testing is confidential, but those receiving tests must give their name and address. Individuals who test positive for HIV are required to notify their sexual and needle sharing partners. A partner notification program is available to assist HIV positive individuals notify their partners. Alternatively, the partner notification staff will notify partners regarding their HIV exposure, without revealing the infected individual's identity.

Eligibility. There are no financial eligibility requirements for the free HIV testing program at local health departments.

Sources of Law:

State Law: N.C.G.S. §§ 130A-133; 130A-144;
State Regulations: 15A N.C.A.C. § 19A .0202

Contact:

Local Health Department (See listing in Appendix B)

or

CARELINE
1-800-622-7030
919-733-4261 (in Raleigh)

AIDS Drug Assistance Program

The AIDS Drug Assistance Program (ADAP) is a joint state-federal program administered by DHHS through the HIV/ STD Prevention and Care Branch. Special oversight is delegated to the AIDS Care Unit (ACU). Funds are available to

purchase various drugs, including protease inhibitors, antiretroviral drugs, and prophylactic drugs such as antibiotics for persons who do not qualify for Medicaid and are not able to purchase the drug. Children with AIDS may be able to obtain additional assistance from the Children's Special Health Services program, described below, or Medicaid. Additionally, ADAP is available to documented immigrants, regardless of their citizenship.

Eligibility. To qualify for the AIDS Drug Program, an individual must be diagnosed with AIDS or be HIV-positive. He or she must also have an annual net income at or below 125% of the federal poverty guidelines based on family size (see Appendix A), be a resident of North Carolina, have no other insurance that pays for their medication (e.g., Medicaid), and have need of at least one of the medications included in the program's formulary.

Additional information about services available for people with AIDS can be obtained from the AIDS Care Unit.

Sources of Law:

State Law: N.C.G.S. § 130A-5(3)
State Regulations: 15A N.C.A.C. §§ 16A .1001-.1005

Contact:

HIV/ STD Prevention and Care Branch
919-715-3111

or

AIDS Care Unit
919-733-7301

or

CARELINE
1-800-622-7030
919-733-4261 (in Raleigh)

HIV Consortia and HIV Primary Medical and Dental Care Projects

HIV Care Consortia provide assistance to individuals who have HIV/AIDS. Each of the 12 North Carolina consortia helps coordinate care within a particular region. Each consortium must provide or assure the availability of, at a minimum, case management, transportation, primary medical and dental care, mental health and substance abuse services, benefits advocacy, and emergency assistance. Some consortia provide additional services, such as skilled nursing, medications, respite care, medical and dental care, and nutritional supplements.

Financial Eligibility: Anyone who is HIV positive is eligible to be served, with most clients having incomes that are at or below 125% of the federal poverty level. Clients with higher incomes may be charged a sliding fee scale for services provided.

Medical Eligibility: Individuals diagnosed with HIV and determined to have a need for services meet the medical eligibility criteria.

Sources of Law:

State Law: N.C.G.S. § 130A-223
State Regulations: 15A N.C.A.C. § § 16A .0901-.0912

Contact:

AIDS Care Unit
HIV/STD Prevention and Care Branch
Division of Public Health
1902 Mail Service Center
Raleigh, NC 27699-1902
919-733-7301

or

CARELINE
1-800-622-7030
919-733-4261 (in Raleigh)

HIV Community Alternatives Program (CAP/AIDS)

The HIV Community Alternatives Program is a Medicaid program for individuals with HIV/AIDS that require an institutional level of care. This program can provide in-home care as an alternative to nursing home care for those who qualify. Additional information about Medicaid and the Community Alternatives Programs can be found in the chapter on Medicaid.

Contact:

Division of Medical Assistance
2501 Mail Service Center
Raleigh, NC 27699-2501
919-857-4011

or

CARELINE
1-800-622-7030
919-733-4261 (in Raleigh)

Hemophilia

Hemophilia Assistance Plan

Through this program, adults and children with hemophilia may be able to get free blood factor replacement. The state allocates a sum of money to each of the following institutions:

- ◆ University of North Carolina Hospitals, Chapel Hill
- ◆ North Carolina Baptist Hospital, Winston-Salem
- ◆ Duke University Medical Center, Durham
- ◆ East Carolina University Medical Center, Greenville

◆ Carolinas Health Care System, Charlotte

Each of these institutions uses the money to provide blood replacement factor and other services to individuals until funds are exhausted. Individuals must give information about other third party payers, and funds can only be used for services not covered by other programs or insurance.

Eligibility: Individuals seeking assistance must be residents of North Carolina, diagnosed with hemophilia or another congenital bleeding disorder, and seek treatment at one of the above facilities.

Sources of Law:

State Law: N.C.G.S. § 130A-124

State Regulations: 15A N.C.A.C. § 21F .1101 *et. seq.*

Contact:

Children and Youth Branch (This program is run out of the Children and Youth Branch even though it also covers adults.)

Women's and Children's Health Section

Division of Public Health

Department of Health and Human Services

919-733-2815

or

CARELINE

1-800-622-7030

919-733-4261 (in Raleigh)

Kidney Disease

Kidney Program

This program provides financial assistance to persons suffering from end-stage renal disease (chronic kidney failure). The program ensures the availability of dialysis services and helps with the cost of drugs (up to \$300 per year), supplies, transportation, and other related necessities. Most people with end-stage renal disease are eligible for Medicare. This program pays the cost of items not covered by Medicare.

There are 110 dialysis agencies, half of which are funded to provide transportation assistance.

Eligibility: To receive services, an individual must meet medical and financial criteria.

Medical eligibility: The individual must be diagnosed with end-stage renal disease, have no other payer, be on a waiting list for a kidney transplant, or have had a kidney transplant.

Financial eligibility: The individual must not have an annual net family income in excess of the following limits to receive free services. People with higher incomes may still qualify after incurring some of the expenses themselves. In 2002, the income limits were:

<u>Family Size</u>	<u>Kidney Program</u>
1	\$6,400
2	8,000
3	9,600
4	11,000
5	12,000
6	12,800
7	13,600
8	14,400

Sources of Law:

State Law: N.C.G.S. § 130A-220

State Regulations: 15A N.C.A.C. § 16A.0301 *et. seq.*

Contact:

Chronic Disease Branch
Health Promotion and Disease Prevention Section
Division of Public Health
Department of Health and Human Services
919-715-3113

or

CARELINE
1-800-622-7030
919-733-4261 (in Raleigh)

Sexually Transmitted Disease

Sexually Transmitted Disease Control

Free examinations and treatment for sexually transmitted diseases, such as syphilis, gonorrhea, and chlamydia, are available from all local health departments. Drugs for treating these conditions are also available. Counseling and educational materials about these conditions may be obtained.

Eligibility: There are no financial eligibility criteria and no fees for the services.

Sources of Law:

State Law: N.C.G.S. §§ 130A-135, 130A-144

State Regulations: 15A N.C.A.C. § 19A .0204

Contact:

Local Health Department (See listing in Appendix B)

Sickle Cell Syndrome

Sickle Cell Syndrome Program

Through this program, individuals may be tested for the sickle cell trait. Counseling and referral are also available for those who test positive. Persons who meet financial eligibility guidelines can also receive financial assistance with the cost of certain medical services. Case management services help individuals with sickle cell disease obtain information about the condition and needed medical and social services.

Six clinics throughout the state receive referrals for medical care. They are:

- ◆ Wake Forest University School of Medicine, Winston-Salem
- ◆ Carolinas Medical Center, Charlotte
- ◆ Duke University Medical Center, Durham
- ◆ Brody School of Medicine, East Carolina University, Greenville
- ◆ North Carolina Memorial Hospital, Chapel Hill
- ◆ Presbyterian Hospital, Charlotte

Financial Eligibility: Local health departments provide sickle cell testing to all who request it.

Persons with both sickle cell disease and with income below the federal poverty guidelines are eligible for financial assistance with the cost of medical services.

Sources of Law:

State Law: N.C.G.S. § 130A-129

State Regulations: 15A N.C.A.C. § § 21H .0100, 21H.0200;
24A .0100

Contact:

Sickle Cell Syndrome Program
Women's and Children's Health Section
919-715-3411

or

Local health department for testing information (See listing in Appendix B)

or

CARELINE
1-800-622-7030
919-733-4261 (in Raleigh)

Tuberculosis

Tuberculosis Control

Outpatient services for tuberculosis patients and those suspected of having the disease are available at all local health departments. Services include physician and nursing care, X-rays, skin testing, anti-tuberculosis drugs, sputum testing, and drug monitoring.

Eligibility. Anyone in the state who has tuberculosis or is suspected of having the disease is eligible for services. There are no financial eligibility criteria and no fees for any of the services. If a patient is covered by Medicaid, Medicare, or private insurance, those sources may be billed for services.

Sources of Law:

State Law: N.C.G.S. § 130A-144

State Regulations: 15A N.C.A.C. § 19A.0205

Contact:

Tuberculosis Control
Division of Public Health
Department of Health and Human Services (DHHS)
1902 Mail Service Center
Raleigh NC 27699-1902
919-733-7286

or

Local health department (See listing in Appendix B)

or

CARELINE
1-800-622-7030
919-733-4261 (in Raleigh)

Vision

Medical Eye Care Program

The Medical Eye Care Program aims to reduce the incidence of blindness due to retinal disorders, cataracts, and glaucoma.

Services: The program provides screening and corrective services, including eye examinations, treatment, surgery, glaucoma screenings, children's vision screenings, correction of limited vision, and eye care education.

Eligibility: To qualify, services cannot be covered by Medicaid or other government program. Income limits for 2001-2003 are as follows:

<u>Family Size</u>	<u>Medical Eye Care- Adults</u>
1	\$4,860
2	5,940
3	6,204
4	7,284
5	7,281
6	8,220
7	8,772
8	9,312

Sources of Law:

State Law: S. §§ 111-8, 143B-157

State Regulations: 10 N.C.A.C. § 19H .0100

Contact:

Medical Eye Care Program
Division of Services for the Blind
Department of Health and Human Services
919-733-9744

or

CARELINE
1-800-622-7030
919-733-4261 (in Raleigh)

OTHER HEALTH SERVICES

This section describes other health programs. These programs provide certain types of services, but do not target individuals with specific diseases. Eligibility information is given for each program.

Family Planning Services

Local health departments offer a range of reproductive health services. Family planning services also help clients make informed choices about the number and spacing of their children. The program focuses its services on teenagers and low-income women, although some counseling and contraceptive services are available to men. Medical, educational, referral, and social services are included. Family planning services include:

- ◆ Clinical services including Pap smears, pelvic and breast exams
- ◆ Screening for gonorrhea, hypertension, anemia, and genetic disorders

- ◆ Lab tests and X-rays
- ◆ Counseling about pre-pregnancy health and planning, contraception, human sexuality, and other related subjects
- ◆ Referral to genetic counseling and other health and social resources
- ◆ A range of family planning methods, including oral contraceptives, condoms, diaphragms, and other devices

Abortions are not available through the family planning program.

Eligibility. Family planning services are available free to people with a family income of less than 100% of the federal poverty guidelines (see Appendix A). In most cases, a teenager will be considered a family of one, so her parents' income will not be counted in determining her financial eligibility. Services are available on a sliding fee scale to persons with a family income between 100% and 200% of the federal poverty guidelines.

Sources of Law:

State Law: N.C.G.S. § 130A-124

State Regulations: 15A N.C.A.C. § 21A

Contact:

Local Health Department (See listing in Appendix B)

or

CARELINE

1-800-622-7030

919-733-4261 (in Raleigh)

Genetic Health Care

Both children and adults can receive genetic screening, diagnosis, treatment, and follow-up support services through the state's four medical schools, Carolinas Health Care System in Charlotte, or community-based genetic satellite clinics. Evaluation, education, and consultation related to the identification of genetic diseases and the impact on health care outcomes is available for families and providers. The UNC Genetics contractor provides biochemical and metabolic genetic diagnoses, counseling, and management for children and pregnant women.

In addition, newborns are screened to detect phenylketonuria (PKU), hypothyroidism, galactosemia, sickle cell, congenital adrenal hyperplasia (CAH) and other metabolic disorders. Early identification of these conditions can help reduce morbidity and mortality.

Eligibility: Children and adults in families with an income at or below 100% of the federal poverty guidelines are eligible for free services (See Appendix A). Children and adults in families with higher income are

eligible on a sliding fee scale basis. No family is denied services because of an inability to pay.

Sources of Law:

State Law: N.C.G.S. § 130A-125
State Regulations: 15A N.C.A.C. § 21H .0300

Contact:

Genetic Health Care Unit
Children and Youth Branch
Women's and Children's Services Section
Division of Public Health
Department of Health and Human Services
1928 Mail Service Center
Raleigh, NC 27699-1928
919-733-2815

or

CARELINE
1-800-622-7030
919-733-4261 (in Raleigh)

Senior Care

Senior Care is a prescription drug assistance program is designed to assist older adults (age 65 or older) in paying for medication necessary for the treatment of cardiovascular disease, chronic obstructive pulmonary disease, and diabetes.

At the time of publication, the plan was undergoing some changes so assistance could be provided to more people. The information here is scheduled to be effective November 1, 2002. You should call to see if you are eligible.

Services: The program covers outpatient prescription drugs for cardiovascular diseases, chronic obstructive pulmonary disease (COPD), and diabetes with a copayment of 40% of the cost of the medications. The maximum state benefit per year is \$600.

Medical Eligibility: Individuals must be diagnosed with hypertension, angina, arrhythmia, heart failure, or diabetes mellitus. The program is limited to individuals over age 65 with one of these medical conditions.

Financial Eligibility: The program covers individuals up to 200% of the federal poverty guidelines, who are not eligible for full Medicaid benefits, and have no other coverage for prescription drugs.

Contact:
Prescription Drug Assistance Program
Division of Public Health
1915 Mail Service Center
Raleigh, NC 27699-1915
919-733-7081
or
CARELINE
1-800-622-7030
919-733-4261 (in Raleigh)

Maternity Care

Most local health departments offer a full range of prenatal care. In those few counties in which it is not available in the health department, local health providers provide the same care. Services include a physical examination, routine laboratory tests, a nutritional assessment and counseling, and regular check-ups throughout the pregnancy. Consultation from or referral to an obstetrician or high-risk maternity clinic is available if certain high-risk factors are observed. Delivery services are usually arranged through a referral to the private medical community.

All local health departments and some community health centers provide Maternity Care Coordination Services. Over 58 local health departments also provide Maternal Outreach Services for more comprehensive outreach, advocacy, and support services to Medicaid eligible pregnant women and mothers with infants up to age one. These individuals are also responsible for providing social support, reinforcement of education and outreach activities that may not be part of the health care system.

Eligibility. Pregnant women with a family income below 100% of the federal poverty guidelines are eligible for all of the services with no charge. Women with incomes above that level may be charged on a sliding fee scale. Note: Most pregnant women with incomes less than 185% of the federal poverty guidelines, with the exception of many immigrants, are eligible for Medicaid for Pregnant Women. Please see Chapter 12, "Medicaid." Women who apply at the health department for prenatal services are usually encouraged to apply for Medicaid. If they refuse or fail to do so, however, they are still eligible for services.

Sources of Law:

State Law: N.C.G.S. §§ 130A-124, 130A-127
State Regulations: 15A N.C.A.C. § 21C

Contact:
Local Health Department (See listing in Appendix B)

SERVICES TO SPECIAL POPULATIONS

This section provides information about programs available for specific groups of people, including children, migrants, and refugees. Eligibility information is given for each program.

Services for Children

Child Health Services

Some basic child health services are available in all local health departments. These services generally include periodic health assessments (including physical, developmental, and nutritional assessments), screening for early detection of disabilities, immunizations, anticipatory guidance for parents, and referrals as appropriate. Some health departments are also able to provide primary care including treatment for routine childhood illnesses.

Eligibility. Immunizations are available without charge to all children, regardless of financial need. Immunizations are available free both at health departments and at private doctors' offices. (Note: While the immunizations are free, doctors can charge a fee for administering the immunization. Please see the Immunization Program section on page 157.) Other child health services are available free to children whose family income does not exceed 100% of the federal poverty guidelines, and on a sliding fee scale to children in families with higher incomes. See Appendix A for information on federal poverty guidelines.

Sources of Law:

State Law: N.C.G.S. § 130A-9

State Regulations: 15A N.C.A.C. 21B, 21E, 21F, 21G

Contact:

Local Health Department (See listing in Appendix B)

or

CARELINE

1-800-622-7030

919-733-4261 (in Raleigh)

Child Service Coordination

Infants who are identified as being at high risk for developmental delays are tracked and referred for special services. The infant may be identified in the hospital newborn nursery or through local health departments, developmental evaluation centers, area mental health centers, primary care physicians, or other providers. Local health departments, developmental evaluation centers, sickle cell programs, and United Cerebral Palsy (UCP) agencies can provide the service coordination.

Families are assigned a care coordinator to help them identify their strengths and outstanding needs. An individualized service plan is created for each family. The

care coordinator may provide follow-up visits and contact as needed. The child may be referred to a Developmental Evaluation Center if that is appropriate (see below).

Eligibility: There are no financial eligibility criteria to receive this service. Children must be under age five. For children up to age three, the child must be at risk of developmental delay, chronic illness, or a social/emotional disorder. For children ages three to five, the child must have a diagnosed developmental, medical, environmental, or social/emotional disorder, or be considered at high risk of developing a disorder. A provider must complete a referral form indicating these needs in order to enroll the child into the program.

Sources of Law:

Federal Law: 20 U.S.C. § 1400 *et. seq.*, P.L. 105-17 (IDEA)

Contact:

Children and Youth Branch
Women's and Children's Health Section
Department of Health and Human Services
1928 Mail Service Center
Raleigh, NC 27699-1928
919-715-3814

or

Children with Special Needs Health Care Help Line
1-800-737-3028

or

CARELINE
1-800-622-7030
919-733-4261 (in Raleigh)

Children's Special Health Services

This program assists with the costs of medically necessary equipment and other services for children with special health care needs. The program services children under age 21 who have certain chronic medical problems that could keep them from growing and developing normally, and in certain limited instances, adults over the age of 21. The program has three primary components:

- ◆ Assistance for Medicaid eligible children (see Chapter 12) to obtain medically necessary equipment, supplies or pharmaceuticals that are not covered by Medicaid; for example, power wheel chairs or over the counter vitamins or formulas. These services are only covered if the child has exhausted all other sources of possible funding.
- ◆ Assistance for children enrolled in the state Early Intervention Program who are in need of adaptive and assistive devices necessary for optimal functioning.
- ◆ Assistance with costs of equipment, pharmaceuticals and other health care expenses for low-income adults with cystic fibrosis.

- ◆ Assistance with costs of equipment, pharmaceuticals and other health care expenses for low income adults with hemophilia or other congenital blood coagulation disorders.

In addition, state funds are used to support the provision of limited medical and subspecialty care in selected health departments and medical centers.

Eligibility. Eligibility varies by program. In general, children must be either Medicaid eligible or enrolled in the Early Intervention program to receive assistance.

Sources of Law:

State Law: N.C.G.S. § 130A-124

State Regulations: 15A N.C.A.C. § 21F

Contact:

NC Division of Public Health
Women's and Children's Health Section
Children and Youth Branch
1928 Mail Service Center
Raleigh, NC 27699-1928
919-715-3302, 919-733-2815

or

Children with Special Health Care Needs Help Line
1-800-737-3028

or

CARELINE
1-800-622-7030
919-733-4261 (in Raleigh)

Developmental Evaluation Centers Program (DEC)

There are eighteen DECs throughout the state with interdisciplinary staff that provide clinical evaluation, treatment, and case management services for children who have known or suspected developmental disabilities. DECs only serve children birth through age five. The DECs provide services as part of the Infant/Toddler program in Early Intervention Services.

Eligibility. There are no income requirements for a child's eligibility. Some services are available at no cost to families. Other services are subject to fees based on a sliding fee scale. No child is denied services because of inability to pay.

Sources of Law:

State Law: N.C.G.S. § 130A-124

State Regulations: 15A N.C.A.C. § 21G

Contact:
Women's and Children's Health Section
Division of Public Health
Department of Health and Human Services
1916 Mail Service Center
Raleigh, NC 27699-1916
919-733-7437
or
CARELINE
1-800-622-7030
919-733-4261 (in Raleigh)

Immunizations

The Universal Childhood Vaccine Distribution Program (UCVDP) provides certain childhood vaccines to health professionals at no charge. The covered immunizations include: Hepatitis B; Polio; Diphtheria, Tetanus, and acellular Pertussis (DTaP); Influenzae type b (Hib); Measles, Mumps, and Rubella (MMR); Pneumococcal Conjugate (PCV7); and Varicella (Chicken Pox). Children are eligible for immunization according to the schedule recommended by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices. Influenza and pneumococcal vaccines are also provided by UCVDP for high-risk children.

Eligibility: All children are eligible for the vaccines with the exception of pneumococcal conjugate. State-supplied pneumococcal conjugate vaccine is available through UCVDP for children who are Medicaid- eligible, uninsured, underinsured, American Native, or Alaskan Indian. Children who do not otherwise qualify for the state-supplied pneumococcal conjugate vaccine, can obtain this immunization from their private provider for a charge.

Children are not required to fill out application forms to receive the UCVDP covered immunizations. They can obtain the vaccinations from the local health department, community, migrant, and rural health centers, or the child's current provider, if participating. More than 92% of private physicians participate in the program. The vaccines are free, but private providers may charge an administration fee of \$13.71 for one vaccine, or \$27.42 for two or more vaccines.

Sources of Law:

State Law: N.C.G.S. § § 130A-152, 130A-153, 130A-433
State Regulations: 15A N.C.A.C. § § 19A .0400, 19A .0500

Contact:

Local health department (See listing in Appendix B) or child's physician
or

Immunization Branch
Women's and Children's Health Section
Division of Public Health
Department of Health and Human Services
1917 Mail Service Center
Raleigh, NC 27699-1917
919-733-7752
or
CARELINE
1-800-622-7030
919-733-4261 (in Raleigh)

Individuals with Disabilities Education Act (IDEA)/Early Intervention Program

The Early Intervention Program includes separate programs designed for infants and toddlers, preschool-aged children, and school-aged children. The primary intent of the program is to identify children with special needs early in life and provide needed services. Providing services to children as early in life as possible allows for the best treatment of a disability, and improves their development. The Infant/Toddler program is administered by DHHS, and discussed here. The preschool and school-aged programs are administered by the Department of Public Instruction, and are discussed in the section on school-based services.

Infant / Toddler Program:

The Infant/Toddler program will provide an evaluation of any child believed to have or be at risk of developing a disability. Children who are determined to be eligible for services are assigned a child service coordinator (see section in this chapter). An individualized treatment plan for the family is designed, drawing off of the available services. This is called an Individual Family Services Plan (IFSP).

Services: Services available in the Infant/Toddler Program include: assistive technology, audiology services, child service coordination, family training and counseling, health services to facilitate the early intervention, diagnostic and evaluative services, nursing, nutrition, psychological services, respite care, social work services, special instruction, therapy, transportation assistance, and vision services.

Medical Eligibility: Children must show a cognitive, physical, psychosocial, communication, and/or adaptive developmental delay. Children may also qualify on the basis of other significant atypical development. Additionally, infants and toddlers may qualify if they are at high risk of developing such delays.

Financial Eligibility: All children may receive an initial evaluation and child service coordination at no charge and without regard to family income. Other services may require fees, but they must be on a sliding scale, after considering the family's income, family size, and other circumstances. Additionally, no child is denied services because of an inability to pay.

Sources of Law:

Federal Law: 20 U.S.C. § 1400 *et. seq.*, P.L. 105-17 (IDEA)

State Law: N.C.G.S. § 122C

State Regulations: 10 N.C.A.C. § 14V .0900

Contact:

Early Intervention Branch
Women's and Children's Health Section
Division of Public Health
919-715-7500

or

Family Support Network
1-800-852-0042 or
www.fsnn.org

Women, Infants, and Children Program (WIC)

The WIC program, formally entitled the Special Supplemental Nutrition Program for Women, Infants and Children, provides breastfeeding support, food supplements and nutrition education for eligible individuals who are at nutritional risk. Because this is not considered an entitlement program, not all persons who meet the eligibility criteria will receive benefits.

Services: WIC provides two types of services—food supplements and nutrition education. Eligible individuals receive free food vouchers that can be redeemed at authorized grocery stores for special foods. A professional at the health department or community health center makes up an individual “food prescription” for each participant that is tailored to his or her nutritional needs. The vouchers are for a monthly allotment of the specified foods. Foods typically include formula, juice, and baby cereal for infants; milk, cheese, eggs, cereal, juice, dried beans or peanut butter for pregnant women and children. Women who are breastfeeding may also receive tuna and carrots.

Participants must usually pick up the vouchers from the WIC provider. Usually, three months of vouchers can be picked up at a time. The vouchers must be redeemed within the time period stamped on them.

Each local program must make available free nutrition education as well as specific counseling tailored to the individual's need. WIC participants who decline the nutrition education benefits of the program may not be denied food supplements. Nutrition education should be simple and take into account the cultural and personal preferences of the participants. Pregnant women must be given information on breastfeeding, bottle-feeding, and other aspects of infant feeding. Children should receive information geared to their level of understanding.

Eligibility: In order to qualify for WIC, patients must meet medical requirements as well as financial requirements.

Medical eligibility: Only pregnant or breastfeeding women, infants, and children up to age five qualify. In order to receive WIC, individuals must be considered at “nutritional risk.” The determination of whether an individual is at “nutritional risk” is a medical judgment. Examples of why an individual might qualify include anemia, abnormal weight, nutritionally related medical conditions, dietary deficiencies, or some other condition that makes an individual likely to have poor nutrition.

Financial eligibility: In order to qualify, individuals must have income below 185% of the federal poverty guidelines (see Appendix A.)

Sources of Law:

Federal Law: 42 U.S.C. § 1786 *et. seq.*
Federal Regulations: 7 C.F.R. § Part 246
State Regulations: 15A N.C.A.C. § 21D

Contact:

Nutrition Services
Division of Public Health
DHHS
1914 Mail Service Center
Raleigh, NC 27699-1914
(919) 715-1923
1-800-FOR BABY

or

CARELINE
1-800-622-7030
919-733-4261 (in Raleigh)

or

Local Health Department (See Appendix B)

Migrant and Seasonal Farmworkers

Migrant and Seasonal Farmworker Health Programs

There are three primary sources of health care for migrant and/or seasonal farmworkers: Community and migrant health centers (C/MHC), the North Carolina Farmworker Health Program (NCFHP), and the Migrant Fee-for-Service program. Health departments, rural health clinics, private practitioners, and hospitals are also sources of care for the migrant and seasonal farmworker community.

Community and migrant health centers, discussed in more detail in Chapter 18, are the largest providers of primary care to migrant and seasonal farmworkers. Four centers receive special federal funding to target migrant and seasonal farmworkers: Blue Ridge Community Health Center in Henderson County, Goshen in Duplin County, Greene County Health Care in Greene County, and Tri County Community Health Center in Sampson County.

The North Carolina Farmworker Health Program (NCFHP), within Office of Research, Demonstrations and Rural Health Development of the NC Department of Health and Human Services, receives federal migrant funding to expand the availability of primary and preventive health services to migrant and seasonal farmworkers. NCFHP currently contracts with 11 health care providers (four community health centers, four county health departments, two rural health centers and one Partnership for Children community-based organization) to develop and maintain a farmworker health program at these sites. The funds are used to pay for bilingual outreach workers who conduct health assessments and make referrals when necessary, provide health education and case management services, and coordinate evening clinics when needed. The nurse outreach coordinators also offer clinical services both in the field and at residences.

In addition to the federally subsidized programs for migrant and seasonal farmworkers, the state helps fund the NC Migrant Fee-for-Service Program, within the Division of Public Health. Funds are used to pay private doctors, dentists, pharmacists and hospital outpatient departments for services provided to migrant farmworkers across the state. This program does not serve seasonal farmworkers. Reimbursement is limited to \$150 per claim, and the patients are charged a co-pay. The state Migrant Fee-for-Service program generally runs out of money before the end of the fiscal year, leaving migrants without services from this source for the remainder of the fiscal year.

Eligibility: Most programs are available to migrant and seasonal farmworkers, although the Migrant Fee-for-Service program is limited to migrants. Migrants are defined as persons engaged primarily in agricultural work on a seasonal basis who set up temporary residences to accommodate their work. Anyone who has been a migrant farmworker in the past 24 months is eligible for assistance through the different migrant health programs. Seasonal farmworkers are employed in agriculture as their principal employment, but are not migratory.

There are no financial eligibility requirements for these programs, and no migrant or seasonal worker is denied service because of an inability to pay. However, funding for services for the Migrant Fee-for-Service program typically runs out before the end of the fiscal year. Minimum copayments and sliding fee scales exist at some of the clinics and health departments.

Sources of Law:

State Law: N.C.G.S. § 130A-223
State Regulations: 15A N.C.A.C. § 16A .0100

Contact:

Office of Research, Demonstrations, and Rural Health Development
2009 Mail Service Center
Raleigh, NC 27699-2009
919-733-2040

or

CARELINE
1-800-622-7030
919-733-4261 (in Raleigh)

Refugees

Refugee Health Program

The purpose of this program is to ensure that any health condition of public health concern or health condition that could impede the effective resettlement of refugees is promptly identified and treated. It provides health assessments of refugees shortly after their arrival, and attempts to acquaint them with the health care system and to integrate them into existing follow-up services as necessary. The primary health departments offering services to refugees are in the four urban areas where most refugees settle. In other parts of the state, the local health department can either perform the assessment or refer the refugee to a health care provider for that service. The program works with other public and private groups to arrange for interpretation, transportation, and other related services.

Eligibility: All persons who are refugees as determined by the U.S. Immigration and Naturalization Service are eligible for most services covered by this program, without regard to financial status. Reimbursement for the health assessment is through Refugee Medical Assistance or Medicaid. Note: Medicaid is generally available to refugees who otherwise meet the personal and financial eligibility requirements. See the chapter on Medicaid in this book for further details.

Sources of Law:

State Law: N.C.G.S. § 143B-153
State Regulations: 10 N.C.A.C. § 35B .0100

Contact:

State Refugee Health Coordinator
919-715-3119

or

Local County Department of Social Services

or

CARELINE
1-800-622-7030
919-733-4261 (in Raleigh)

SCHOOL BASED HEALTH SERVICES

Individuals with Disabilities Education Act (IDEA)

Two programs are administered by the Department of Public Instruction to address the needs of children with disabilities in the school system. The preschool program provides services to children prior to kindergarten, and the school-aged program

addresses the needs of older children. The goal is to improve the functional abilities for school-aged children by beginning services at an early age.

Pre-School Program

Designed for children ages three to five, the Preschool Program is designed to help meet the special education needs of this age group.

Services: Many of the services are similar to that of the Infant/Toddler Program, except children in the Preschool Program are evaluated to create an Individualized Education Plan (IEP) to meet their special education needs.

Medical Eligibility: The criteria for eligibility are generally more stringent for preschoolers than for infants. Children must show a disability that requires special education assistance. Some conditions that meet the criteria include: autism, delayed or atypical development, hearing impairment, orthopedic impairment, speech or language impairment, visual impairment, traumatic brain injury, and other impairments.

Financial Eligibility: Same as the Infant/Toddler Program. Some services may require a fee that is based on a sliding scale. No child may be denied services due to an inability to pay.

Sources of Law:

Federal Law: 20 U.S.C. § 1400 *et. seq.*, P.L. 105-17 (IDEA)

State Law: N.C.G.S. §§ 143B-139.6A, 179.5 *et. seq.* (Early Intervention for children birth through five)

State Regulations: 16 N.C.A.C. § 6H

Contact:

Preschool Program Coordinator
Exceptional Children Division
Department of Public Instruction
919-715-1598

or

CARELINE
1-800-622-7030
919-733-4261 (in Raleigh)

School Age Program

This program provides services for school-aged children with disabilities. This includes children with permanent or temporary mental, physical, or developmental disabilities.

Services: A wide variety of services are available if needed to help secure an appropriate education for the child. Children are evaluated to develop an

Individualized Education Plan (IEP). Children should be served in the least restrictive environment, and every effort is made to educate them with children who are not disabled. Available services include:

- ◆ Special education services provided within a regular classroom, with or without additional services outside the classroom
- ◆ Self-contained special education classes
- ◆ Separate public or private school facilities
- ◆ Public or private residential facilities
- ◆ Hospital or homebound education services

Medical Eligibility: Children must be diagnosed with a mental, physical, or developmental disability that requires special services. Diagnoses that may qualify for these services include: autism, behavioral or emotional disability, deafness or blindness, hearing impairment, mental disability, multiple handicaps, orthopedic impairment, specific learning disability, speech-language impairment, traumatic brain injury, and visual impairment.

Financial Eligibility: There are no financial eligibility requirements. All children deemed medically eligible for services are entitled to them.

Sources of Law:

Federal Law:	20 U.S.C. § 1400 <i>et. seq.</i> , P.L. 105-17 (IDEA)
State Law:	N.C.G.S. §§ 143B-139.6A, 179.5 <i>et. seq.</i> (Early Intervention for children birth through five); N.C.G.S. § 115C-106 <i>et. seq.</i> (Special Education Services for older children)
State regulations:	16 N.C.A.C. § 6H

Contact:

Child's School
or
Exceptional Children Division
Department of Public Instruction
919-807-3300
or
CARELINE
1-800-622-7030
919-733-4261 (in Raleigh)

School-Based Health Centers

Some North Carolina Public Schools have school-based health centers (SBHC), which provide comprehensive primary and preventive care for students. These centers provide services such as comprehensive health assessments, diagnosis and treatment of illness, immunizations, laboratory tests, health education, nutrition services, and mental health services. In some areas, where a need has been shown, the clinic may also offer services to the children of students. North Carolina has

provided funding for approximately 50 SBHCs, primarily located in middle schools and high schools. See Appendix B for schools in your county that have a school-based health center.

Eligibility: Children enrolled in the school who have consent forms from parents or guardians may receive services. Most school-based health centers will file third party insurance or assist students in enrolling in Medicaid or NC Health Choice, if eligible. The clinics may charge fees as appropriate, but no child will be denied services because of an inability to pay.

Contact:

Children and Youth Branch
Women's and Children's Health
Division of Public Health
Department of Health and Human Services
1928 Mail Service Center
Raleigh, NC 27699-1928
919-733-2815

or

Contact the child's school to inquire about availability

or

CARELINE
1-800-622-7030
919-733-4261 (in Raleigh)

Dental Care

A variety of dental services are provided through the school system. The programs are targeted to schools with high-risk populations. Dental services include screenings to identify tooth decay, education on good oral hygiene, and fluoride mouth rinses to prevent tooth decay. Children with dental caries are referred to dentists for treatment. Children without dental insurance or another source of payment may be referred to a local health department or non-profit community dental clinic that provides dental services to low-income or uninsured people.

Sources of Law:

State Regulations: 15A N.C.A.C. §§ 17A, 17B

Contact:

Child's school

or

Oral Health Section
Division of Public Health
Department of Health and Human Services
1910 Mail Service Center
Raleigh, NC 27699-1910
919-733-3853
or
CARELINE
1-800-622-7030
919-733-4261 (in Raleigh)

Social Workers

Social workers in schools offer a range of services to students, including needs assessment, advocacy, service coordination, and direct service to students. Social workers can address some needs of students who are experiencing social-emotional or behavioral problems, and can assist them in finding additional help.

Considerable variability exists in the availability of school social workers; some counties do not have any social workers, and others have several. Also, a social worker's role varies from school to school.

Contact:
The child's school.

School Counselors

All North Carolina schools, from elementary school through high school, should have at least one school counselor. The role of school counselors is to address the developmental needs of students. One of their functions is to provide direct counseling services to students individually or in small groups. Although counselors do provide services to help students with educational, social, or personal concerns, they also often consult with families to find appropriate help for students needing long-term treatment.

In general, however, most school counselors have limited time for such interactions. About half report spending less than 20% of their time in direct services to students. Counselors are encouraged to consult with children they feel may be experiencing adjustment difficulties and refer them for further treatment if it is considered necessary.

Contact:
The child's school.

School Nurses

School nurses provide some basic health services to students. Services may include health screenings, identification of illness or special needs and appropriate referrals, dispensing medications, and providing emergency care if needed. Some schools have

full-time nurses on staff; others share school nurses between schools. The availability of school health nursing services varies by school.

Contact:
The child's school.

CONTACT INFORMATION

Local Public Health Departments are listed in Appendix B.

N.C. Department of Health and Human Services

Care Line: 1-800-662-7030

Division of Public Health, Women's and Children's Health Section

919-733-3816

Division of Public Health, Oral Health Section

919-733-3853

Division of Public Health, Epidemiology

919-733-3421

Division of Public Health, Department of Health Promotion and Disease Prevention

919-733-7081

MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES

What are they?

Publicly funded mental health, developmental disability, and substance abuse services are offered through local management entities (LMEs), previously referred to as area programs, and by state institutions. Services may include outpatient and inpatient treatment, case management, group and independent living situations, developmental day care, day treatment, residential treatment, supported employment, family intervention and supports, and other habilitation/rehabilitation services.

Note: At the time this chapter was being written, North Carolina was in the midst of a major restructuring of its mental health, developmental disability and substance abuse system. It is important for anyone seeking these services to check with their local LME (formerly called area program) to determine if the system has changed further.

Who are they for?

Any resident of North Carolina with serious emotional disturbance (children), mental illness, a developmental disability, or a substance abuse problem is eligible for services. However, there are insufficient resources to provide all services for everyone who is eligible, and therefore some eligible individuals may be unable to obtain all desired services through publicly funded programs. Eligibility for certain services will require membership in a “target population.” Target populations are those determined to be at greatest need and of highest priority for services by the mental health, developmental disability and substance abuse system (MH/DD/SAS). While no one may be denied services due to an inability to pay, fees are charged on a sliding scale. Each LME has its own policies regarding charges for various services.

Where are applications taken?

The point of entry for mental health, developmental disability, and substance abuse services is at one of the LMEs (formerly called area mental health, developmental disabilities, and substance abuse programs, or area programs).

INTRODUCTION

Currently, North Carolina’s system for providing services to those with mental health, developmental disability, and substance abuse needs is carried out through a

network of 38 area programs, which are responsible for providing or contracting for services within a specified geographic area. The 38 area programs cover all 100 counties. The state is in the process of reforming the state mental health, developmental disability and substance abuse system. The North Carolina General Assembly directed the NC Department of Health and Human Services to develop a plan (hereinafter referred to as “the plan”), which would:

- ◆ Create a standardized process for accessing MH/DD/SA services (“uniform portal”).
- ◆ Ensure that core services were available throughout the state. The core services include: screening, assessment, and referral; emergency services; service coordination; consultation, prevention, and education.
- ◆ Identify target and priority populations. (Target and priority populations are discussed in greater detail within the following sections.)
- ◆ Provide an array of services appropriate to the target and priority population in each community. The services should encompass each of several life areas, including: living, day services, family support, personal support, crisis and emergency care, and a variety of specialized services.

The plan creates Local Management Entities (LMEs) to replace the current area programs. The number of LMEs will be reduced from 38 (current number of area programs) to 20 or fewer by 2007. The local programs, each covering one or several counties, are operated by local governing boards but receive funding, support, and technical assistance from the state MH/DD/SAS division. In addition, the local LMEs receive additional funding from local and federal sources. LMEs must develop a 3-year local business plan with detailed information about how the LME will ensure the delivery of core services to the targeted populations. The state plan will be phased in over the next several years, through 2006.

Mental health, developmental disability, and substance abuse services are organized around the specific populations they are intended to serve. The major populations served by the system are:

- ◆ Persons with developmental disability
- ◆ Children and adolescents with or at risk for serious emotional disturbance
- ◆ Adults with serious or severe and persistent mental illness
- ◆ Adolescents with substance abuse problems
- ◆ Adults with substance abuse problems

Each LME will be required to provide the core services listed above. Other services offered at the local level vary from one LME to another. Therefore, all the programs described in this chapter may not be available in all locations. LMEs may also offer services not mentioned here. You will need to contact your LME to find out about the services that are available in your community. All of the current offices are listed

in Appendix B.

Additionally, all LMEs are required to make provisions to ensure that those with serious emotional disturbance, mental illness, developmental disabilities, or substance abuse disorders have access to inpatient hospital services.

At the time this chapter was being written, the state Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS) operated four psychiatric hospitals, one certified nursing facility, five mental retardation centers, three substance abuse facilities and three schools for children with serious emotional disturbance. However, the state has plans to close one of the three schools for children with serious emotional disturbance, and to merge two of the four psychiatric hospitals. In addition, the state plan calls for reducing the numbers of beds in the hospitals and mental retardation centers each year beginning in 2002 and continuing until at least 2004.

Each of the populations and the services designed to address their problems are described more fully below.

PERSONS WITH DEVELOPMENTAL DISABILITIES

Populations served

The target population of developmental disability services include those meeting the state definition below. Within this group, the priority populations are those with the most immediate need or who have already waited the longest for services.

A developmental disability is a severe, chronic disability that is attributable to a mental or physical impairment, or both, and is generally manifested before the age of 22. Developmental disabilities are likely to persist throughout a person's life. Without appropriate support and treatment, people with developmental disabilities may be significantly limited in their ability to function well in daily living. Developmental disabilities are often referred to as developmental delays in children under age four. Examples of developmental disabilities are mental retardation, epilepsy, and autism.

Services

Three categories of services may be available to persons with developmental disabilities. They are day/night services, periodic services, and residential services. Some services, such as preschool services are unique to children. Children who need to be evaluated to determine whether they have a developmental disability may be diagnosed by an interdisciplinary team at one of the state's 18 Developmental Evaluation Centers, discussed more fully in the section on state health programs in Chapter 15.

Day/Night Services

Day services include supported employment, mainstreamed preschool and school-based services.

Supported employment provides intensive job training, job placement, and ongoing supervision in regular work settings. Individuals who have completed training may continue to receive long-term assistance in the form of job monitoring, additional vocational training, and consultation with employers, as requested by the client and/or the employer.

The Individuals with Disabilities Education Act is a federal law and provides assistance for children and adolescents. Young children (birth through age two) are served by the NC Department of Health and Human Services. Older children (three through 21) are served through the North Carolina Department of Public Instruction. Preschoolers are served through the preschool program, and school-age children are served through the school age program. More information about both programs can be found in the section on state health programs in Chapter 15.

Mainstreamed preschool services are focused on placing children with developmental disabilities into preschool programs, day care homes and centers, and Head Start programs that are designed for children without disabilities. The service also provides training and support to staff at these sites to help them work with children with developmental disabilities.

The school age program provides services to children with developmental disabilities within the school system. The goal is to provide an appropriate education to children, providing the assistance to place them in mainstream classrooms whenever possible.

Periodic Services

Periodic services include early childhood intervention, case management, and in-home support services.

The Early Intervention Program is designed to provide assistance to children with developmental delays or at risk of developmental disabilities. Also known as the Infant/Toddler program, it is specifically designed for children under age three. It includes assessment, consultation to families, training and education for children and their parents. The services are designed to improve the development of children who are developmentally delayed or are at high risk of atypical development. Children age three or older can receive services through the preschool program, discussed above. More information about this program can be found in the section on state health programs (Chapter 15).

Case management services provide a client and his or her family with a professional who can assist in coordinating and monitoring services available in a variety of agencies.

In-home support services can be given to people wherever they live, either in a private home, a rest home, or in some other setting. These services may include assessment, consultation, treatment, and respite care (providing temporary care for the person with developmental disabilities to give parents or primary caregivers a brief respite from caregiving responsibilities).

Residential Services

A wide array of residential services is available, including but not limited to, supported living, group living, alternative family living and therapeutic foster homes.

Alternative family living allows children and adults to live with and receive care from trained professionals in a family-style atmosphere in a residential community.

Supported living allows an individual to reside in the home setting of their choice with the level of support appropriate to facilitate a desirable lifestyle.

Group homes provide a community setting for children and adults with developmental disabilities.

Five regional **mental retardation centers** around the state provide a residential service for those who are unable to or do not wish to live in a community setting. The centers also provide outreach training and technical assistance to community programs. The state operates the following centers:

- ◆ Black Mountain Center in Black Mountain
- ◆ Western Carolina Center in Morganton
- ◆ O'Berry Center in Goldsboro
- ◆ Murdoch Center in Butner
- ◆ Caswell Center in Kinston

The Division plans to continue efforts to move residents wishing a community placement into the community. This serves the dual goals of providing services in the least restrictive setting and reducing the number of institutional beds.

Community Alternatives Program

Some individuals with mental retardation or other developmental disabilities who would normally require care in an institution may be able to live in the community by receiving support through the Community Alternatives Program for people with Mental Retardation or Developmental Disabilities (CAP-MR/DD). The program is offered in all 100 counties and is coordinated through the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, in cooperation with the Division of Medical Assistance. The participants must be eligible for Medicaid. Through CAP-MR/DD, certain services not otherwise covered by Medicaid are paid

for while the participant lives in a community setting. At the time this book was written, there was a waiting list for this program. More information about this program can be found in the chapter on Medicaid (Chapter 12).

CHILDREN AND ADOLESCENTS WITH OR AT RISK FOR SERIOUS EMOTIONAL DISTURBANCE

Populations served

Children and adolescents who have a serious emotional disturbance (SED) are eligible to receive these services. They will be given priority if they are identified as sexually aggressive, deaf or have multiple diagnoses *and* a functional impairment that seriously interferes with or limits the child's ability to function in the family, school or community activity. In addition, children with SED will be given priority if they are in need of services from more than one child serving agency (such as the Department of Social Services and a LME) and have either been placed out of the home or is at risk of being paced out of home. Children who have a SED and who are identified as deaf or homeless are also given priority for services.

Services

Services for children with serious emotional disturbance include both residential and non-residential services.

Residential Services

Residential services include crisis stabilization, respite, therapeutic family homes, individual and group residential treatment, and inpatient treatment.

Crisis stabilization provides a temporary, supervised residential environment for children in crisis.

Therapeutic family homes are homes with a specially trained teaching family or specialized foster care parents who have expertise in working with children with complex needs. Additional treatment and supports are provided off-site to the children and the families working with them.

Supervised independent living is available to older adolescents who are able to live in a home or apartment with some supervision. Special activities are also provided to promote positive emotional development and readiness for adulthood.

Group living provides residential treatment for children with moderate to serious emotional disturbances who must be removed from their family homes. A range of other services and supports are made available for these children, including counseling; social, emotional, and cognitive training; adult role models; and in some cases job placement. Children usually attend public school.

Inpatient evaluation and treatment is provided in a hospital to children with severe disturbances who cannot be served elsewhere. Services may include crisis stabilization, psychiatric evaluation, psychological and medical procedures, and therapy. Inpatient treatment always includes continuous planning for placement in a less restrictive environment and transition services and supports necessary for effective community-based services.

Non-residential Services

Non-residential services include prevention, consultation and education, in-home family services, community-based respite, in-school services, case management, day treatment, and outpatient treatment.

Prevention services are designed to avert mental health problems in early stages of development. Prevention includes education and other services aimed at promoting mental health, elevating functioning, reducing the prevalence or severity of emotional disturbance and its consequences, and reducing functional impairment.

In-home family services are community-based and offered to reduce the need for out-of-home placement for children. Services include intensive family preservation for families in crisis. In addition, family support services such as respite, parent training, counseling, and support groups help parents better understand and cope with their child's disability while building on their strengths.

Case management services are provided to a child and family to assist in coordinating and monitoring services available through multiple agencies. In addition, case consultation may be available, allowing several agencies to collaborate on the best overall course of treatment for a child.

Day treatment is targeted to children with moderate to severe problems who have difficulty participating in public school programs or who, without intensive intervention, may need hospitalization. It is often provided in conjunction with residential treatment services.

Outpatient treatment is offered to children with less severe difficulties who are functioning in the community and to those with complex treatment needs as part of a constellation of community-based services. It may include screening, evaluation, diagnosis, treatment, consultation with other professionals, and case management.

ADULTS WITH SERIOUS OR SEVERE AND PERSISTENT MENTAL ILLNESS

Populations Served

Adults with serious or severe and persistent mental illness have some type of mental disorder that interferes substantially with their capacity to take care of themselves, maintain households or interpersonal relationships, or hold jobs and support themselves.

Adults with **severe and persistent mental illness (SPMI)** have a mental disability that limits their ability to function in activities of daily living in such areas as interpersonal relations, homemaking, self-care, employment and recreation. People with schizophrenia, schizoaffective and schizophreniform disorders, bipolar disorder, major depressive disorder, and other psychotic disorders are generally classified as having SPMI.

Adults with **serious mental illness (SMI)** have a mental, behavioral or emotional disorder that substantially interferes with one or more major life activities. People who are diagnosed with delusional disorders, shared psychotic disorders, dissociative disorders, factitious disorders, obsessive-compulsive disorders, phobias, dysthymic disorder, borderline personality disorder, pedophilia, exhibitionism, anorexia, bulimia, post traumatic stress disorder, depressive disorder not otherwise specified, impulse control disorder and intermittent explosive disorders are generally considered to have SMI.

While all individuals with SPMI or SMI who have certain functional limitations are part of the target populations, certain individuals are given priority for services. Priority is given to those with multiple diagnoses, people who are homeless and mentally ill, adults in the criminal justice system, elderly, deaf or minorities.

Services

Services for adults with serious or severe and persistent mental illness range from outreach to hospitalization. Some services are limited to individuals with SPMI or SMI. Services may include:

Outreach efforts are designed to reach mentally ill people who may need assistance but have “fallen through the cracks.” Among outreach services are advocacy, drop-in programs, and case consultation.

Acute psychiatric crisis stabilization and intervention services are designed to treat and stabilize people who are experiencing acute episodes of mental illness. Services may be provided in a crisis stabilization unit, local psychiatric inpatient unit, or by mobile teams.

Evaluation and ongoing mental health treatment involves counseling and psychiatric and medical evaluation and treatment.

Atypical Antipsychotic Medication Program assists individuals who are mentally ill with the purchase of antipsychotic medication. Individuals with incomes below 150% of the federal poverty guidelines are eligible. If they become employed while enrolled in the program, they may be eligible to continue receiving help paying for medications until their income reaches 300% of the federal poverty guidelines.

Individuals with incomes above 150% of the federal poverty guidelines are required to pay for part of the medication costs as follows:

<u>Income</u> <u>(Percent of Federal</u> <u>Poverty Guidelines)</u>	<u>Required Client Cost</u> <u>Sharing</u>
0-150%	0%
151-200%	25%
201-250%	50%
251-300%	75%
300% and over	100%

Rehabilitation, supervision, and access to community resources allow mentally ill individuals to participate in the community. Psychosocial rehabilitation programs, vocational employment opportunities, self-help groups, and supported housing are some of the available resources. One of the most widely used services is community based services which provides one-to-one assistance in teaching clients the skills necessary for successful community living. Skills training are provided in areas such as personal hygiene, interpersonal relations, housekeeping, and use of community resources.

Case management services assist individuals and their families gain access to the range of services that may be available in the community. Case management services for adults with SPMI include the Assertive Community Treatment (ACT) and Home-based wrap-around (HB) services. ACT services are provided in the community by a comprehensive service team. Services are provided directly to people with SPMI. HB services involve a case manager that works with an individual in their home or in the community, but helps to link the person with SPMI to community-based therapeutic services.

Housing assistance is available in some areas, often as part of a public/private partnership. The availability of this assistance, however, is extremely limited.

Inpatient hospitalization is available at the four state psychiatric hospitals and at a number of general hospitals throughout the state. The four state psychiatric hospitals are:

- ◆ Broughton Hospital in Morganton
- ◆ Cherry Hospital in Goldsboro
- ◆ Dorothea Dix Hospital in Raleigh
- ◆ John Umstead Hospital in Butner

The hospitals provide a wide array of services to patients of various ages. Note: at the time this chapter was being written, the state had plans to close Dorothea Dix Hospital and merge it with John Umstead Hospital in Butner.

SUBSTANCE ABUSE SERVICES

Many services are available to adults and adolescents with alcohol or other substance abuse or dependence problems. Services may also be available to those "at-risk" of substance abuse or dependence.

CHILDREN AND ADOLESCENTS WITH OR AT RISK FOR SUBSTANCE ABUSE PROBLEMS

Populations Served

Children and adolescents are targeted if they have a primary substance-related disorder, using alcohol or drugs (but are not yet classified as "abusers"), or at-risk for substance abuse. Children may be at-risk for substance abuse if they are currently experiencing school related problems, have had problems with law enforcement or the courts, have one or both parents or caretakers with documented substance abuse problems, abuse or neglect. Within these targeted populations, certain children will be given priorities, including: children who are injecting drug users, pregnant, involved in the juvenile justice or social services systems, deaf, homeless or those with co-occurring physical disabilities.

Services

The services available to children with substance abuse problems or who are at-risk of abusing are categorized as either community-based services or 24-hour services.

Community-based Services

The community-based services include primary prevention services, outreach, screening and evaluation, high-risk intervention, outpatient treatment, day treatment, and case management.

Primary prevention services are provided to children who are at risk for substance abuse. The services are designed to prevent the first use of drugs or alcohol. These services are generally targeted to the entire community or to specific high-risk groups.

Outreach services are provided in a variety of community locations. Their primary purpose is to inform children and adolescents about the dangers of substance abuse and about the availability of treatment if substance abuse is occurring.

Screening and evaluation services assess substance abuse problems to determine the child's need and eligibility for services. An evaluation assesses a child's social, emotional, physical, behavioral, and intellectual strengths and weaknesses, and is used in developing a treatment plan.

High-risk intervention attempts to delay the onset or reduce the severity of substance abuse problems among youth who are at high risk of developing problems. Early treatment, psychological counseling, educational activities, and recreational activities may be offered.

Outpatient treatment includes individual, group, and family counseling for substance abuse problems. It can be provided in a variety of settings. Outpatient treatment for adolescents is similar to that for adults and may include detoxification, rehabilitation, or narcotic addiction treatment.

Day treatment is intensive group treatment for adolescents who need more structured treatment than can be provided in an outpatient setting. Among the services offered may be individual, group, and family counseling; recreational therapy; substance abuse education; life skills education; and continuing care planning.

Case management services help children and their families gain access to other services and resources. A case manager will try to coordinate services to meet social, health, educational, vocational, residential, and financial needs. Case management begins when a client starts a treatment program and continues until program completion.

24-hour Services

These services include regional halfway houses, residential treatment facilities, training schools, and detention centers.

Regional halfway houses combine day treatment, on-site educational services, and group living. There are four programs across the state.

Residential treatment is a comprehensive substance abuse treatment service in a group living facility. Facilities may provide detoxification and rehabilitation services. This service integrates intensive day services and structured residential programming. The services are individualized to meet the need of each child.

Five **youth development centers** are located throughout the state. Adolescents with substance abuse problems who are sent to training school may be able to receive screening and evaluation, high-risk intervention, outpatient treatment, case management, and continuing care services to address substance abuse problems. The Department of Juvenile Justice and Delinquency Prevention operate these centers.

Eleven **detention centers** are located throughout the state. Services including screening and evaluation and high-risk intervention, and referral may be made available to children with substance abuse problems at these centers. The Department of Juvenile Justice and Delinquency Prevention operates these centers.

ADULTS WITH SUBSTANCE ABUSE PROBLEMS

Populations Served

Both drug and alcohol abusers are eligible for services. Individuals who are eligible for substance abuse services include intravenous drug users, substance-abusing women with children, parents who are involved in the DSS or criminal justice systems, DWI offenders, deaf or hard of hearing, or high-management adult substance abusers. Because of limited resources, not every individual with substance abuse problems may be able to receive services. The state has given priority to certain individuals, including: injecting drug users, pregnant women, those involved in the social services system, deaf and hard of hearing, homeless and those with co-occurring physical disabilities.

Services

Services to adults with substance abuse problems range from outpatient treatment to more structured residential treatment.

Outpatient treatment services for alcohol and other drugs are provided in each of the LMEs. Outpatient programs include detoxification and support services following detoxification. Outpatient detoxification programs provide periodic care supervised by a physician, which allows for monitoring and management of withdrawal symptoms. Upon discharge from a detoxification program, patients are referred to appropriate rehabilitation support services.

Outpatient facilities that treat patients after detoxification provide education along with group, individual, and family counseling.

Methodone treatment programs may be available to individuals with narcotic addiction in an outpatient setting. These programs supply methadone or other approved treatments for narcotic withdrawal symptoms. In addition, these programs offer counseling, educational or vocational counseling, job development and placement, financial management, nutrition education, and appropriate referrals to other support services.

Day treatment programs can be an alternative to residential treatment for individuals needing more structure than that provided in an outpatient setting. These programs include counseling, substance abuse education, continuous care planning, and other support services. Upon discharge, the client will be referred to other community support services.

Residential programs provide 24-hour treatment to substance abusers in non-hospital settings. Room, board, and supervision are important parts of the care, treatment, and rehabilitation provided in residential programs. Treatment services are offered on-site or in other locations.

Residential programs include non-hospital detoxification of withdrawal symptoms and necessary medical care for individuals during the initial detoxification period.

After discharge, clients are referred to appropriate follow-up rehabilitation care. Residential care for treatment and rehabilitation are available after detoxification. These facilities provide individual, group, and family counseling, education counseling, job placement, nutrition education, and referral to other support services.

Social setting facilities provide 24-hour care to individuals not in need of the medical care provided in a hospital setting.

Therapeutic communities are highly structured 24-hour facilities that treat emotional and behavioral issues along with substance abuse. These programs aim to promote self-help, abstinence from drugs and alcohol, personal growth, and self-sufficiency. By creating an environment of an extended family, the programs use peer support to assist individuals in successfully reentering the community. Therapeutic communities may serve as an alternative to incarceration.

Halfway houses provide structured living environments for substance abusers. Halfway house residents must be engaged in outpatient treatment. The goal is to return individuals to independent living within a specified time.

Treatment Alternative to Street Crime (T.A.S.C.) links the criminal justice system and substance abuse services. T.A.S.C. offers supervised community-based alternatives to incarceration or potential incarceration, primarily to individuals who are substance abusers and who are involved in non-violent crimes. Individuals with developmental disabilities or mental illness are also eligible for the program. The service includes screening, identification, evaluation, referral, treatment, and treatment monitoring.

Alcohol and Drug Education Traffic Schools (ADETS) are provided in each of the LMEs. These programs are designed to address substance abuse needs for individuals convicted of a first offense of driving under the influence. ADETS provide education about substance abuse and evaluation of a client's needs.

Drug Education Schools (DES) are provided in all LMEs, and primarily serve individuals who, although not considered drug-dependent, are engaged in drug use but not drug dealing. The schools have a prevention, intervention, and education goal aimed at drug offenders. The programs provide classroom education and needs assessment, with referral to treatment programs as required.

SOURCES OF LAW

State statutes:	N.C.G.S. § 122C-2 <i>et. seq.</i>
State regulations:	10 N.C.A.C. § 14V.0101 <i>et. seq.</i>
State Plan:	http://www.dhhs.state.nc.us/mhddsas/

FOR MORE INFORMATION

Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

325 N. Salisbury Street
3001 Mail Service Center
Raleigh, NC 27699-3001
(919) 733-7011

Department of Juvenile Justice and Delinquency Prevention

410 South Salisbury Street
1801 Mail Service Center
Raleigh, North Carolina 27699-1801
(919) 733-3388

Carolina Legal Assistance, Inc.

224 S. Dawson Street
P.O. Box 2446
Raleigh, NC 27611
919-856-2121

Carolina Legal Assistance provides free legal services to persons with mental disabilities.

Governor's Advocacy Council for Persons with Disabilities

2113 Cameron Street, Suite 218
1314 Mail Service Center
Raleigh, NC 27699
877-235-4210
<http://www.doa.state.nc.us/doa/gacpd/gacpd.htm>

Family Support Network of North Carolina

CB# 7340
University of North Carolina at Chapel Hill
Chapel Hill, NC 27599-7340
800-852-0042
<http://fsnnc.med.unc.edu/>

HILL-BURTON

What is it?

The Hill-Burton program started in 1947. Federal funds were made available to hospitals, nursing homes, clinics, and other facilities to help build, enlarge, or modernize their facilities. Instead of paying back the money, the facilities agreed to provide certain health care benefits to patients. Facilities that received Hill-Burton funds were required to provide a certain amount of free and reduced-fee care to patients, and to follow other practices that increased access to the facility.

Almost all the non-profit hospitals and a number of other health care facilities in North Carolina participated in the program.

Who is it for?

In the past, free and reduced-fee services were available to persons whose incomes were below the federal poverty guidelines (FPG). However, most facilities no longer have an obligation to provide free or reduced-fee services. Other provisions are still in force that ensure a certain level of access to health services for people who live or work in the service area of a participating health care facility.

BENEFITS

Health care facilities that participated in Hill-Burton have two obligations. One is known as the “community services” obligation; the other is the “uncompensated care” obligation.

- ◆ *Community services:* Under the community services obligation, a Hill-Burton facility must make its services available to anyone who lives within the facility’s service area and has some means of payment. It must make emergency services available to anyone who lives or works within its service area, regardless of that person’s ability to pay. There is no time limit on the community services obligation, as long as the facility continues to be operated by a non-profit or public entity.
- ◆ *Uncompensated care:* Health care facilities were required to provide a certain amount of free or reduced-fee care each year for 20 years after completion of the construction project using Hill-Burton funds. Facilities that still have an uncompensated care requirement must provide a certain amount of free or reduced-fee care. They must provide free care to people with incomes below the FPG, and may provide free or reduced-fee services to people with incomes up to twice the FPG. The facilities also have some discretion to determine what type of services will be offered free or for reduced fees. Each Hill-Burton facility must

post notice of the availability of uncompensated services in appropriate areas, such as the admissions areas, the business office, and the emergency room.

Most health care facilities in North Carolina have already completed the obligation to provide uncompensated services. The Atlanta Regional Office of the U.S. Department of Health and Human Services (HHS) determines whether an individual health care facility has completed its obligation.

ELIGIBILITY

Eligibility for uncompensated care is based on an individual's income. Within the community services obligation, a Hill-Burton facility may not discriminate on any grounds unrelated to an individual's need for the service or the availability of the needed service at the facility. The facility may not exclude Medicare or Medicaid recipients or establish practices that make it difficult for recipients of those programs to be admitted to the facility. It may not exclude anyone on the grounds of race, color, national origin, religion, or creed.

A Hill-Burton facility may determine, however, that the prospective patient does not need the medical service requested, needs a service not offered at the facility, or has no ability to pay for the services or to make any arrangements to pay for the services. In these cases, the facility may refuse to admit a patient (except for needed emergency services).

APPLICATIONS

Applications for uncompensated care are taken at participating health care facilities. The community service portion has no specific application process. Anyone with a complaint about a facility failing to comply with its Hill-Burton obligations may file an appeal with the U.S. Department of Health and Human Services (HHS). If HHS finds a violation, it may order appropriate corrective action.

SOURCES OF LAW

Federal regulations: 42 C.F.R. § 53.113 (community service); 42 C.F.R. § 53.111 (free care obligation)

FOR MORE INFORMATION

U.S. Department of Health and Human Services
Atlanta Regional Office
61 Forsyth Street SW
Suite 3M60
Atlanta, GA 30303
(404) 562-7972

PART V

HEALTH CARE PROVIDED FREE, AT REDUCED RATES, OR UNDER OBLIGATION OF LAW

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COMMUNITY, MIGRANT, AND RURAL HEALTH CENTERS

What are they?

North Carolina has 63 community and migrant health centers in 34 counties. There are also 31 state-funded rural health centers in 20 counties. These centers provide primary health care services to more than 250,000 patients every year. The centers are located in rural or “medically underserved areas.” (The federal government defines medically underserved areas based on a variety of factors, one being a shortage of primary care providers.) Community and migrant health centers are governed by a community-based Board of Directors on which consumers are in the majority. The Board's structure helps keep these centers closely connected to the needs of their clients.

Community and migrant health centers are funded primarily by the U.S. Public Health Service. Many of the rural health centers are self-supporting, receiving income from patients, public and private insurance, and state and private grants. The rural health clinics discussed in this book also receive operating grants from the state through the North Carolina Office of Research, Demonstrations and Rural Health Development.

Who are the programs for?

Community, migrant, and state-funded rural health centers are for residents in medically underserved areas of North Carolina. The centers provide services to all in need, regardless of ability to pay, based on a sliding fee schedule.

SERVICES

Community, migrant, and rural health centers offer comprehensive health care services. Services include primary and preventive health care. Services vary from center to center. Please call individual centers for detailed information about the special services they provide. For example, some centers offer dental care, laboratory work, family planning, translation, and transportation.

Most of the community and migrant health centers are open daily and have extended hours in the evenings and on weekends. Appointments are not always necessary at these health centers, but it is recommended that you call first to check the center's hours of operation, and for the special information you might need.

CLINIC LOCATIONS

Contact information for each of the clinics is listed in the directory in Appendix B at the end of the book. The clinics are found under the county in which they are located.

FREE OR LOW-COST CLINICS

What are they?

North Carolina has a number of free and low-cost clinics that provide health care services to low-income people. Some are based at local hospitals, while others are freestanding. Many of the clinics provide general medical care, but some are specialized, offering only dental care or substance abuse counseling, for instance. Many have limited hours or other restrictions, such as serving mainly homeless people or the residents of a specific county. At most of these clinics, health care services are free or provided on a sliding-scale fee basis.

Free clinics rely on volunteer nurses, physicians, pharmacists, and dentists in order to provide care to their communities. The clinics are funded primarily through private sector donations.

Appointments are not always necessary at these clinics, but it is recommended that you call first to check the hours of operation and to receive any other special information you might need.

Many of North Carolina's clinics belong to the North Carolina Association of Free Clinics. Additional information about some of the clinics and updated listings may be available at the association's Web site: <http://www.ncfreeclinics.org>.

Who are the programs for?

The clinics primarily target patients who are unable to pay for private medical care. Most clinics provide care to people living at or near federal poverty guidelines, but specific eligibility requirements vary from clinic to clinic. Proof of income is required in some cases. Please see Appendix A for more information on federal poverty guidelines (FPG).

SERVICES

Services usually include general medical care, screening and testing (blood pressure checks, cholesterol and blood sugar tests, Pap smears, mammograms), and limited pharmacy. Some clinics offer special services such as gynecological or dental care, or mental health or substance abuse counseling. Services provided vary from clinic to clinic. Please call individual sites for specific information.

ELIGIBILITY

Most clinics serve uninsured persons with incomes up to 200% of the FPG. Specific requirements, however, are determined at the local level for each clinic. You should call the clinic in your area to determine your eligibility, and to find out what information you may need to bring with you.

CLINIC LOCATIONS

The clinics are listed by county in the directory in Appendix B. Information is subject to change without notice. Please call the clinic number listed for information. If there is not a clinic listed for your county, call your county's Department of Social Services for other possible sources of low-cost health care.

FOR MORE INFORMATION

North Carolina Association of Free Clinics

2135 New Walkertown Road
Winston-Salem, NC 27101
(336) 251-1111
<http://www.ncfreeclinics.org/>

National Association of Free Clinics

155 Livingston Street
Asheville, NC 28801
(828) 259-5339

AREA HEALTH EDUCATION CENTERS PROGRAM (AHEC)

What are they?

Area Health Education Centers Program (AHECs) provide a variety of educational opportunities for health practitioners and health science students of all types. There are nine regional centers, each of which has partnerships with area medical schools and other health organizations. All of the centers are non-profit and community based, and are either affiliated with a non-profit hospital or governed by a non-profit board of directors.

Some AHECs operate clinics that are open to all patients regardless of ability to pay. These clinics are offered as part of the AHEC training and education programs.

Who are they for?

Although many AHEC educational programs are targeted to health professionals, the clinics are available to anyone living in the community.

SERVICES

The AHEC program operates several clinics as part of the primary care residency programs. The residency programs, and the services provided, include family medicine, internal medicine, pediatrics, obstetrics and gynecology, and general surgery. Some of the centers also offer specialty care.

CLINIC LOCATIONS

The AHEC locations are listed in Appendix B. Contact the AHEC to find out if they operate primary care residency programs or specialty care in your area.

SOURCES OF LAW

State Law:	AHEC is included in the annual appropriations bill. See, e.g., Chapter 126 of the 2002 Session Laws.
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HOSPITALS

ACCESS TO EMERGENCY SERVICES

What is it?

Hospitals will screen and stabilize anyone who comes to a hospital-based outpatient clinic or the emergency room seeking care.

Who is it for?

Access to emergency services is provided to everyone, regardless of income, health insurance, or immigration status.

SERVICES

Hospitals traditionally screen anyone who requests treatment at the emergency room, regardless of their ability to pay. In addition, the federal Emergency Medical Treatment and Active Labor Act (EMTALA) places certain requirements on hospitals to provide emergency care. EMTALA applies to hospitals that participate in Medicare, which includes almost all of the North Carolina hospitals. If the person is determined to have a medical emergency, the hospital must either treat the person, or stabilize them for transfer to another hospital.

The federal statute defines emergency as any of the following:

- ◆ A medical condition with acute, severe symptoms, that without immediate medical attention could reasonably:
 - Place the health of the individual (or the unborn child, in the case of a pregnant woman) in serious jeopardy;
 - Risk serious impairment of bodily functions; or
 - Risk serious dysfunction of any body organ or part
- ◆ A pregnant woman having contractions:
 - If there is not enough time to safely transfer her to another hospital before delivery, or
 - If transfer to another hospital poses a danger to the woman or the unborn child

EMTALA does not provide payment for any services. It simply requires that emergency treatment be provided. Patients can still be billed for services.

In addition to the providing emergency services, some hospitals offer outpatient services on a sliding-fee scale, based on the family's income. Contact your local hospital to determine if these services are available.

SOURCES OF LAW

Federal law: 42 U.S.C. § 1320a-7b (EMTALA)

PLANNED PARENTHOOD

What is it?

Planned Parenthood provides a wide range of confidential, affordable reproductive and sexual health care as well as general health care. Planned Parenthood also provides information and education on family planning, preventing sexually transmitted infections (STIs), and promoting healthy sexuality.

Who is it for?

Most clients are female, but Planned Parenthood also provides health care and/or educational opportunities for males. Planned Parenthood fees are generally reasonable and special arrangements can be made for teens, uninsured, and low-income clients. Planned Parenthood accepts clients on Medicaid and accepts private insurance as well.

SERVICES

All Planned Parenthood sites provide important preventive gynecological care: regular Pap smears and pelvic exams, breast exams, screening and treatment for sexually transmitted infections, pregnancy testing and counseling, and birth control services. In addition, Planned Parenthood offers other routine preventive care like blood pressure checks and physical exams.

Some of the eight Planned Parenthood sites in North Carolina also have distinctive programs and services (for instance, some locations offer a support group for people with herpes, and two sites offer abortion services). Please consult the list below for information on what services are offered at what locations. Services are constantly being updated. Call the location nearest you for specific information, or call (800)-230-PLAN. This “smart-800 number” will route your call automatically to the Planned Parenthood center nearest you.

Also see <http://www.plannedparenthood.org/> for general information about Planned Parenthood.

Planned Parenthood Health System

Raleigh Health Center
100 South Boylan Avenue
Raleigh 27603
919-833-7526

Wilmington Health Center
3965-A Market Street
Wilmington 28403
910-762-5566

Asheville Health Center
603 Biltmore Avenue
Asheville 28801
828-252-7928

Greensboro Health Center
1704 Battleground Avenue
Greensboro 27408
336-373-0678

**Planned Parenthood
Forsyth Women's Clinic**
3000 Maplewood Avenue
Winston-Salem 27103
336-768-2980

Charlotte Health Center
4822 Albemarle Road, Suite 103
Charlotte 28205
704-536-7233

Services offered:

- ◆ Reproductive health services (pelvic exam, Pap smear, breast exam) and general health check-ups
- ◆ Family planning services including birth control pills, birth control patch, Lunelle, Norplant, Depo-Provera, IUDs, diaphragms, condoms and other barrier methods
- ◆ Confidential pregnancy testing and counseling
- ◆ Statewide emergency contraception hotline (morning-after pill). Call 1-866-942-7762
- ◆ Referral for abortion, adoption, and prenatal services
- ◆ Confidential HIV testing and counseling
- ◆ Screening and treatment of STIs
- ◆ Diagnosis and treatment of vaginal and urinary tract infections
- ◆ Mid-life services including hormone replacement therapy (HRT)
- ◆ Herpes support group
- ◆ Bilingual medical staff
- ◆ Abortion services at the clinic in Winston-Salem

Health center hours vary including 'early bird' hours (7-9am), evening and Saturday hours. Clients pay according to their income, and no one is turned away because of an inability to pay.

More information available at: <http://www.plannedparenthood.org/ppcc>

PLANNED PARENTHOOD OF CENTRAL NORTH CAROLINA

Chapel Hill Health Center

1765 Dobbins Drive
Chapel Hill 27514
919-942-7762

Durham

Health Center

820 Broad Street
Durham 27705
919-286-2872

Services offered:

- ◆ Reproductive health services (pelvic exam, Pap smear, breast exam) and general health check-ups
- ◆ Abortion services, including medical abortion (abortion by pill) in Chapel Hill
- ◆ School, employment or premarital exams
- ◆ Family planning services including all methods of birth control
- ◆ Confidential pregnancy testing and counseling
- ◆ Emergency contraception (morning-after pill)
- ◆ Referrals for adoption, and prenatal care
- ◆ Screening and treatment of STIs
- ◆ Diagnosis and treatment of vaginal and urinary tract infections

The centers offer some evening and weekend hours. Both health centers are Blue Cross Blue Shield and Partners in-network providers. The centers also accept Medicaid and will file most types of insurance for clients. Special payment arrangements can be made for teens and people with financial difficulties.

More information is available at: <http://www.plannedparenthood.org/ppcnc/>

PHARMACEUTICAL ASSISTANCE PROGRAMS

Many pharmaceutical companies provide prescription medicines free of charge to consumers and to physicians whose patients might not otherwise have access to necessary medicines. Each of the special programs offered by the pharmaceutical companies has its own set of eligibility criteria and specific instructions about making a request for assistance. In many cases, your physician is required to refer you to the pharmaceutical assistance program or to make an application on your behalf.

Most of these programs have strict eligibility requirements. Many require that a patient have no health coverage (including Medicaid or “Medigap” insurance). Some companies use income limits to ascertain eligibility.

This guide lists some of the drugs available from the different companies. Other drugs may also be available. Talk with your pharmacist or physician to find out which company makes the drug you need.

These programs may change at any time. Other programs may also be available. If you need assistance, talk to your doctor. He or she may be able to ask local sales representatives about other programs. In addition, the Pharmaceutical Research and Manufacturers of America (PhRMA) maintains a list of companies with patient assistance programs. Visit the organization’s Web site at <http://www.phrma.org> for additional information.

The following section provides information about the pharmaceutical assistance programs offered by various drug manufacturers. They are listed in alphabetical order by manufacturer.

Abbott Laboratories Patient Assistance Program

(800) 222-6885

Product: Most Abbott Laboratories products.

Physicians should call for application information.

**Agouron
Pharmaceuticals**

Agouron Patient Assistance Program

(888) 777-6637

Products: Viracept and Rescriptor

The applicant or physician may contact the program. Applications are mailed to the physician. Eligibility is determined on a case-by-case basis.

Alcon Labs

Glaucoma Assistance Program

(800) 451-3937

Products: Glaucoma medications only

Ophthalmologists must call on behalf of the patient.

Medical Needs Program

(800) 222-8103, Ext #3

Products: All non-glaucoma products

The physician must write a letter on the patient's behalf.

Allergan, Inc.

Allergan Patient Assistance Program

(800) 347-4500

Products: Alphagan, Betagen, Celluvisc, Propine, Pilagan, Epifrin, Laci-Lube, Refresh, Refresh Plus, Refresh PM, Tears Plus

The physician must send a special request letter on behalf of the patient.

**Alza
Pharmaceuticals**

Indigent Patient Assistance Program

(800) 577-3788

Products: BiCitra, Concerta, Ditropan, Elmiron, Mycelex, Neutro-Phos, PolyCitra, Testoderm, Ocusert, Progestasert

The physician must request an Indigent Patient Application Kit.

**Amarin
Pharmaceuticals**

Indigent Patient Program

(908) 580-5535

Products: Bontril, Capital and Codein oral suspension, Exgest, Hydrocet, Motofen, Nolahist, Nolahist, Phrenilin, Phrenilin Forte, Salflex

The physician must call and complete the application. The patient's income must be below the federal poverty guidelines and the patient may not have any other assistance.

Amgen, Inc.

Safety Net Programs for Epogen
(800) 272-9376
Products: Epogen

For dialysis patients only. Providers apply on behalf of their patients.

Safety Net Program for Infergen
(888) 508-8088
Products: Infergen

For Chronic Hepatitis C patients only. Providers apply on their patients' behalf.

Safety Net Program for Neupogen
(800) 272-9376
Products: Neupogen

Providers should call for an application.

AstraZeneca

AstraZeneca LP Patient Assistance Program
(800)-355-6044

Products: Atacand, Emla, Lexxel, Plendil, Prilosec, Tonocard, Toprol

The physician must apply on behalf of the patient.

Foscavir Assistance and Information on Reimbursement
State and Federal Associates
(800) 488-FAIR (3247)
Product: Foscavir

The physician must make referral.

AstraZeneca Foundation Patient Assistance Program
(800) 424-3727
Products: Many AstraZeneca products

The patient may call for application information. Eligibility is determined on a case-by-case basis.

Aventis Pasteur

Indigent Patient Program
(800) VACCINE, (800) 822-2463
Products: Imovax and Imogam rabies vaccine

Eligibility is determined on a case-by-case basis.

**Aventis
Pharmaceuticals**

Aventis Pharmaceuticals Patient Assistance Program

(800) 221-4025

Product: Many Aventis products

Patients must have income below the federal poverty guidelines and not have any other coverage. The patient or physician may contact the company.

**Bayer Corporation
Pharmaceutical
Division**

Bayer Indigent Patient Program

(800) 468-0894, Ext. 2765; (800) 998-9180

Products: Most Bayer prescription products

The physician or patient can call to determine eligibility. Patients who are eligible for government programs or covered by insurance are not eligible for this program.

Berlex Laboratories Berlex Laboratories

(800) 423-7539

Products: Betapace, Quinaglute Dura-Tabs

The enrollment form must be completed by the physician.

Oncology CamCare

(800) 473-5832

Product: Campath Fludara

A short qualification form must be completed by the physician.

Biogen, Inc.

Avonex Access Program

(800) 456-2255

Product: Avonex

Eligibility is determined based on insurance status and income. The physician should call for information.

**Boehringer
Ingleheim
Pharmaceuticals**

Patient Assistance Program

(800) 556-8317

Products: Aggrenox, Atrovent, Cafcit, Catapres, Combivent, Flomax, Micardis, Mobic, and Viramune

Eligibility is determined on a case-by-case basis. Patients who qualify for Medicaid or have other drug coverage are not eligible.

**Bristol-Myers Squibb
Company**

Patient Assistance Program
(800) 332-2056

Products: Many Bristol-Myers Squibb pharmaceutical products

Physicians or other providers should call the toll-free number above to request an application form.

Centocor, Inc.

Remicade Patient Assistance Program
(800) 964-8345

Product: Remicade

The patient or physician may submit an application. The patient must meet financial qualifications.

Centocor Solutions Program for Retavase
(800) 331-5773

Product: Retavase

The patient must meet financial criteria. The provider should contact the company and complete an application.

**Ciba
Pharmaceuticals**

See Novartis Pharmaceuticals

**DuPont
Pharmaceuticals
Company**

Patient Assistance Program
(800) 474-2762

Products: Most non-controlled prescription products

The physician should contact the company for application information. Eligibility is based on income and insurance status.

Eisai Inc.

Aricept Patient Assistance Program
(800) 226-2072

Product: Aricept

The patient may not have insurance coverage for medications and must also meet income criteria.

Aciphex Patient Assistance Program
(800) 523-5870

Product: Aciphex

The patient must meet certain financial criteria. Physicians should call for information.

Elan**Pharmaceuticals**Elan Pharmaceuticals Prescription Assistance Program

(800) 528-4362 (Patients)

(800) 621-4835 (Physicians and staff only)

Products: Permax, Zanaflex, Diastat, Mysoline, Zonegran

Patients must meet income criteria and have no third-party coverage.

Fujisawa Healthcare Prograf Patient Assistance Program

(800) 4-PROGRAF, (800) 477-6472

Product: Prograf

Patients must have no insurance coverage for medications and must meet financial eligibility criteria. Physicians should call for information.

Genentech, Inc.Genentech Assistance Program

(800) 879-4747

Products: Activase, Herceptin, Protropin, Nutropin, Rituxin, and TNKase

The physician should contact the program. A completed application form including medical, financial, and insurance information must be submitted for consideration. The patient cannot be eligible for other assistance.

Genentech Endowment for Cystic Fibrosis

(704) 357-0036

Product: Pulmozyme

Three programs can help patients who are uninsured, or can help with the out-of-pocket costs for patients who do have insurance. Assistance is based on a sliding scale. Physicians should contact the company for more information.

Genetics InstituteThe Benefix Reimbursement and Information Program

(888) 999-2349

Product: Benefix Coagulation Factor IX

The patient must meet certain financial criteria. An application must be completed by the physician and patient.

Neumega Access Program

(888) NEUMEGA (888-638-6342)

Product: Neumega

This program is for patients who meet financial eligibility criteria and are uninsured or underinsured. The physician or patient may call for information.

Genzyme Corporation

Ceredase/Cerezyme Access Program

(800) 745-4447, Ext. 17808

Products: Ceredase, Cerezyme

Eligibility is based on financial need. The patient cannot have other coverage.

Gilead Sciences, Inc. Gilead Sciences Reimbursement Support and Assistance Program

(800) 226-2056

Products: Daunoxome, Vistide

The program can assist both uninsured and insured patients with reimbursement.

GlaxoSmithKline

Glaxo Wellcome Patient Assistance Program

(800) 722-9294

Products: All current Glaxo Wellcome products for outpatient use.

Eligibility is based on information provided by a physician or advocate regarding the patient's prescription drug coverage and financial resources.

SmithKline Beecham Foundation Access to Care

(800) 546-0420, (800) 729-4544

Products: Amoxil, Augmentin, Avandia, Bactroban, Compazine, Coreg, Dyazide, Famvir, Paxil, Relafen, Requip, and Tagamet

The patient must meet financial criteria. Assistance may also be available for co-payments for insured patients. The patient and physician must complete the application.

Oncology Access to Care Program

(800) 699-3806

Product: Hycamtin

The patient or physician should call for more information about this program.

Hoechst Marion Roussel

See Aventis Pharmaceuticals

Immunex Corporation

Patient Assistance Program

(800) 321-4669

Products: Leukine, Novantrone, Amicar, Thioplex

The physician should apply on the patient's behalf. Eligibility is based on the patient's income and insurance status. The patient cannot be eligible for other assistance.

**Janssen
Pharmaceutica**

Patient Assistance Program
(800) 652-6227
(800) 523-5870 for Aciphex
Products: All Janssen prescription products

Patients must meet certain medical and financial criteria.

Aciphex Patient Assistance Program
See Eisai, Inc.

The Risperdal Patient Assistance Program and the Risperdal Reimbursement Support Program
(800) 652-6227

Eligibility is determined by financial criteria. The program also provides support obtaining insurance reimbursement.

**Knoll Pharmaceutical
Company**

Indigent Patient Program
(800) 240-3820
Products: Mavik, Rythmol, Synthroid, Tarka

Physicians should call the toll-free number above and request an evaluation form. Decisions are made on a case-by-case basis.

**Lederle
Laboratories**

See Wyeth-Ayerst Laboratories

**Eli Lilly and
Company**

Lilly Cares
(800) 545-6962
Products: Almost all prescription products; no controlled substances

Patient eligibility is determined on a case-by-case basis in consultation with the prescribing physician. Applications are given to physicians.

Gemzar Patient Assistance Program
(888) 4-GEMZAR (888-443-6927)
Product: Gemzar

Patients must meet financial criteria and have exhausted all other sources of assistance.

**The Liposome
Company**

Financial Assistance Program for Abelcet
(800) 335-5476
Product: Abelcet

The physician should call to enroll the patient. The patient must meet financial eligibility criteria and have no other source of reimbursement.

Merck and Co., Inc. Patient Assistance Program

(800) 994-2111
Products: Most Merck products

The physician should call the toll-free number above for an enrollment form. The application must be completed by the physician and patient. Eligibility is determined on a case-by-case basis.

Patient Assistance Program for Aggrastat
877-810-0595
Product: Aggrastat

Patients must meet financial eligibility criteria and have no other source of reimbursement. The program can also assist in gaining reimbursement from insurance. The physician or patient may call for information.

The Support Program for Crixivan
(800) 850-3430
Product: Crixivan

The program can assist patients in finding a payment source and may provide medication for those who meet financial criteria. The physician or patient may call for more information.

**Novartis
Pharmaceuticals**

Patient Assistance Program
(800) 257-3273
Product: Certain single-source or life-sustaining products; no controlled substances

The physician and patient must complete an application. Eligibility is determined on a case-by-case basis.

Organon, Inc. Remeron Indigent Patient Program
Product: Remeron

The physician should direct a request for assistance to a local sales representative.

Gold Star Fertility Assistance Program
Product: Follistim

Eligibility is determined on a case-by-case basis. The physician should direct a request to a local sales representative.

Ortho Biotech Inc. Procritline
(800) 553-3851
Products: Procrit (for non-dialysis use), Leustatin Injection

Call the toll-free number above; this call can help determine if a patient meets medical and financial criteria.

Ortho Dermatological Patient Assistance Program
Products: Prescription products

Patients can have no insurance coverage for medications and must have incomes below the federal poverty guidelines. The physician should request an application form.

**Ortho-McNeil
Pharmaceutical, Inc.** Patient Assistance program
(800) 797-7737
Product: Most prescription products

The physician should request an application. The patient can have no other source of reimbursement and must have income below the federal poverty guidelines.

**Otsuka America
Pharmaceutical, Inc.** RxMAP Prescription Medication Assistance Program
(800) 242-7014
Product: Pletal

Eligibility is based on the federal poverty guidelines and lack of other coverage. The physician should call for more information.

Parke-Davis See Pfizer

Pfizer Inc.Pfizer Prescription Assistance

(800) 646-4455

Products: Most outpatient products

While special application forms are not required, the physician must write a letter on the patient's behalf.

Parke-Davis Patient Assistance Program

(908) 725-1247

Products: Accupril, Accuretic, Dilantin, Estrostep, FemHRT, Lipitor, Loestrin, Neurontin, Zarontin

The physician should request an application from a local sales representative. The patient must have no other source of reimbursement.

Sharing the Care

(800) 984-1500

Products: Certain single-source products

The program operates through community, migrant, and homeless health centers. Only patients at these clinics are eligible.

Diflucan and Zithromax Patient Assistance Program

(800) 869-9979

Products: Diflucan and Zithromax

The physician should call for enrollment information. The patient must meet income eligibility criteria and may not have insurance or other assistance.

Pharmacia CorporationPatient Assistance Program

(800) 242-7014

Products: Many products

The patient or physician may initiate a request for assistance by calling the toll-free number above. An application form must be completed by the physician and patient.

Patients in Need

(800) 542-2526

Products: Aldactazide, Aldactone, Calan SR, Kerlone, Calan, Covera-HS, Norpace, Norpace CR, Arthrotec, Celebrex, Cytotec

The physician determines patient eligibility based on medical and financial guidelines. The physician should contact a local Searle representative or call on the patient's behalf.

**Proctor & Gamble
Pharmaceuticals,
Inc.**

Customer Services

(800) 830-9049

Products: Actonel, Asacol, Dantrium capsules, Didronel, Macrochantin, Macrobid

The physician and patient must complete an application form. Eligibility is determined on a case-by-case basis.

**Rhone-Poulenc
Rorer, Inc.**

See Aventis Pharmaceuticals

Roche Laboratories Medical Needs Program

(800) 285-4484

Products: Most products

The physician must request an application form. The patient may not have insurance coverage or other assistance.

Medical Needs Program for CellCept, Cytovene, and Cytovene-IV

(800) 772-5790

Products: CellCept, Cytovene, Cytovene-IV

The physician should call for information.

Medical Needs Program for Fortovase, Invirase, Cytovene, Cytovene-IV, and Hivid

(800) 282-7780

Products: Fortovase, Invirase, Cytovene, Cytovene-IV, Hivid

For HIV patients. The physician should call for more information.

Medical Needs Program for Kytril, Roferon-A, Vesanoïd, Xeloda, and Fluorouracil Injection

(800) 443-6676 (press 2 or 3)

Products: Kytril, Roferon-A, Vesanoïd, Xeloda, Fluorouracil Injection

The physician should call for information.

**Roxane Laboratories,
Inc.**

Patient Assistance Program

(800) 556-8317

Products: Oramorph SR, Roxanol, Roxanol 100, Roxicodone

Physicians must call the program to discuss their patients' eligibility. If the patient appears to meet insurance and financial eligibility, an application form will be mailed to the physician.

**Sandoz
Pharmaceutical
Corporation**

See Novartis Pharmaceuticals

Sankyo Pharma

Open Care Program
(866) 268-7327
Product: WelChol

The physician must apply on a patient's behalf. Patients must have no source of reimbursement. The program can help obtain insurance reimbursement for insured patients.

**Sanofi-Synthelabo,
Inc.**

Needy Patient Program
(800) 446-6267

Products: Several products, including Aralen, Danocrine, Primaquine

The physician should call the toll-free number or the local Sanofi Winthrop representative. Eligibility is determined on a case-by-case basis.

**Schering
Laboratories/**

Key Pharmaceuticals Commitment to Care

For Intron A/Eulexin: (800) 521-7157

For other products: (800) 656-9485

Products: Most prescription products

Patient eligibility is determined on a case-by-case basis. An application form must be completed by the physician and patient.

Searle

See Pharmacia

Serono, Inc.

Connections for Growth
(800) 582-7989
Product: Saizen

A referral must be made by the physician.

SeroCare
(800) 714-2437
Product: Serostim

The physician should call for more information.

**Sigma-Tau
Pharmaceuticals,
Inc.**

NORD/Sigma-Tau Carnitor Drug Assistance Program
(800) 999-NORD
Product: Carnitor

The patient must demonstrate financial need beyond any available reimbursement. The patient may call and submit an application.

NORD/Sigma-Tau Matulane Patient Assistance Program
(800) 999-NORD
Product: Carnitor

The patient must show financial need and the physician must feel a treatment response is possible. The patient may call for information.

**SmithKline Beecham
Pharmaceuticals** See GlaxoSmithKline

**Solvay Pharmaceuticals/
Unimed**

Pharmaceuticals Patient Assistance Program
(800) 256-8918

Products: Aceon, Creon Minimicrospheres, Estratab, Estratest, Estratest HS, Lithobid, Rowasa, Anadrol, Marinol, Teveten

The patient must meet financial eligibility criteria. The physician must call for an application form.

3M Pharmaceuticals Indigent Patient Pharmaceutical Program
(800) 328-0255
Products: Most products

Patients are considered on a case-by-case basis, based on financial need and insurance status. The physician should call for more information.

**Takeda
Pharmaceuticals
America**

Patient Assistance Program
(877) TAKEDA or 877-825-3327
Product: Actos

The patient must meet financial eligibility criteria and have no other source of reimbursement. An application is sent to the physician.

**Unimed
Pharmaceuticals** See Solvay Pharmaceuticals

**Wyeth-Ayerst
Laboratories**

Norplant Foundation

(703) 706-5933

Product: Norplant five-year contraceptive system

Eligibility is determined on a case-by-case basis. The physician should call for more information.

Rheumatoid Arthritis Assistance Foundation

(800) 282-7704

Product: Enbrel

The patient or physician should call to determine eligibility.

Patient Assistance Program

Write to:

John E. James

Professional Services IPP

555 E. Lancaster Avenue

St. Davids, PA 19087

Products: Various products

The physician must identify a patient as indigent, defined as having low or no income and not covered by any third party. A limited supply of the requested medication is provided to the physician for dispensing to the patient.

**Zeneca
Pharmaceuticals**

See AstraZeneca

PART VI

CONSUMER PROTECTIONS AND GLOSSARY

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CONSUMER PROTECTIONS

North Carolina law requires that health insurance and health maintenance organization (HMO) products sold in the state provide certain consumer protections. These consumer protections are generally applicable to:

- ◆ Non-group policies
- ◆ Most small group policies
- ◆ Large groups that purchase health insurance through an HMO, a commercial carrier, or Blue Cross and Blue Shield of North Carolina

There are special consumer protections built into the laws governing small-group and large-group insurance. Those protections are listed in Part III.

Most of the consumer protections listed in this chapter are not applicable to groups that self-fund or are otherwise exempt from state law (unless otherwise stated). For information on self-funded (ERISA) plans, please see Chapter 11.

Throughout this chapter, insurance companies and HMOs are referred to collectively as “insurers” or “health plans.” Sometimes, the chapter refers to managed care organizations—which typically includes HMOs, Preferred Provider Organizations (PPOs), or Point-of-Service (POS) plans. When a law or provision refers specifically to an HMO, this term is used. Individuals who are insured by or covered under a health plan are referred to as “enrollees.” Other documents may refer to enrollees as insureds, members, patients, or beneficiaries.

This chapter concerns general consumer protections in the following areas:

Access to Providers

Continuing Care Retirement Communities

Maintaining Relationships with Existing Providers (Continuity of Care)

Network Adequacy

No Penalty for Going Outside a Network if Insufficient Providers

Obstetricians and Gynecologists

Optometrists, Podiatrists, Certified Clinical Social Workers, Certified Substance Abuse Professionals, Licensed Professional Counselors, Dentists, Chiropractors, Psychologists, Pharmacists, Certified Fee-Based Practicing Pastoral Counselors, Advanced Practice Nurses, Nurse Practitioners

Pediatricians

Provider Hold-Harmless Provisions

Specialists

Using Specialists and Primary Care Providers

Standing Referrals to Specialists

Appeals and Grievances, External Review, and Right to Sue

- Internal Appeal and Grievance Procedures
- Appeals of Noncertification Decisions
- First-Level Grievance Reviews
- Second-Level Grievance Hearings
- Independent External Review
- Right to Sue Insurers

Confidentiality

- Confidentiality of Medical Records

Consumer Information

- Evidence of Coverage
- False and Misleading Advertisements
- Information About Treatment of Certain Health Conditions
- Information to Compare Insurers
- Materials Must Be Understandable
- Provider Directories

Managed Care Patient Assistance Program

- Patient Advocacy Office

Mandated Benefits¹

- Bone Mass Measurement
- Chemical Dependency Treatment
- Clinical Trials
- Colorectal Screenings
- Contraceptives
- Dental Procedures for Young Children and Persons with Serious
Mental or Physical Conditions
- Diabetes Self-Care
- Emergency Services
- Mammograms and Pap Smears
- Maternity Care
- Newborn Hearing Screening
- Prescription Drugs
- Prescription Drugs for Cancer Treatment
- Prostate-Specific Antigen Test
- Public Health Measures
- Reconstructive Breast Surgery
- Tax-Supported Institutions
- Temporomandibular Joint Treatment

¹ Note: Insurers and HMOs are not always required to provide all the mandated benefits listed in this section. Some of the mandated benefits are limited to group plans. Other laws require insurers to cover certain services if the insurer or HMO already is providing a similar benefit. The extent of the mandate is described in more detail in the section below on Mandated Benefits.

Nondiscrimination

Acquired Immune Deficiency Syndrome (AIDS)/Human Immunodeficiency Virus (HIV)

Children

Children Born Out of Wedlock

Newborns, Adoptive Children, and Foster Care Children

Children with Developmental Disabilities or Other Disabilities

Medical Support Orders

Gender or Marital Status

Genetic Information

Health Status

Medicaid Coverage

People with Mental Illness or Chemical Dependency

People with Sickle Cell Trait or Hemoglobin C Trait

People with Visual or Hearing Impairments

Race, Color, or National Origin

Point-of-Service (POS) and Preferred Provider Organization (PPO)**Protections**

Cost Sharing

Covered Services

Disclosure of Cost Sharing to Enrollees

Procedural Protections

Free Look Period

Grace Period to Pay a Premium

Inadvertent Misstatements by Consumers

Notice of Nonrenewal or Discontinuance

Unfair Claims Settlement Practices

Provider Protections

Gag Clauses Prohibited

Nondiscrimination Against Certain Health Professionals

Prohibition on Certain Managed Care Provider Incentives

Prompt Payment

Providers Protected From Retaliation When Filing Appeals on Behalf of Enrollees

Quality Assurance

Internal Quality Assurance Systems

Provider Credentialing Procedures

Provider Discipline Systems

Regulatory Oversight by the NC Department of Insurance

Accountability and Enforcement Mechanisms

Consumer Services Division

Financial Solvency

Adequate Financial Resources

Insolvency Protections
Obtaining Other Coverage Upon Insolvency
Premium Rate Oversight
Premium Rates Established
Premium Rates Periodic Adjustments

Utilization Review

Assessing Utilization of Health Services
Conducting Utilization Reviews
Medical Necessity Standards
Notice to Enrollees About Utilization Review Procedures
Time Limits for Review

Each section below provides a reference to the laws codified in the North Carolina Statutes [N.C.G.S.], or to the North Carolina Administrative Code—the regulations that govern insurance companies and HMOs [N.C.A.C.]. There is also a glossary at the end of this book.

ACCESS TO PROVIDERS

Continuing-Care Retirement Communities

Insurers must allow residents of continuing-care retirement communities who need nursing home care to obtain the care from a facility within the continuing-care retirement community. However, the facility must be a Medicare-certified skilled nursing home and must agree to be reimbursed at the same rate negotiated with similar providers. The nursing home must meet the health plan's billing, quality assurance, utilization review, confidentiality, nondiscrimination, grievance, and appeal procedures [N.C.G.S. § 58-3-200(f)].

Maintaining Relationships with Existing Providers (Continuity of Care)

HMOs must allow certain enrollees with special health conditions to continue to see their providers, even if the provider is not part of the HMO's network. The intent of this law is to give people with special health conditions a reasonable amount of time to transition to a network provider. During the transition period, the enrollee can continue the relationship with the existing provider, if the provider agrees to accept the HMO's prevailing rates, and meet other usual HMO requirements. The law applies to individuals who have just joined an HMO (if a physician is not part of the HMO network) as well as to existing HMO enrollees if the provider leaves the network. To qualify for this protection, you must have a special health condition such as a terminal condition, a chronic illness or condition that is life threatening, degenerative, or disabling. An enrollee with an acute illness or condition that is serious enough to require treatment to avoid death or permanent harm can also receive this transitional coverage. Pregnant women are also entitled to this protection beginning with the second trimester of pregnancy. As a general rule, enrollees are given 90 days to transfer to a new provider, but this period may be

extended for some people. For example, enrollees with a terminal illness can continue to see their existing providers for the remainder of their lives, and pregnant women can continue their relationships with their providers until the child is born (and for 60 days post partum) [N.C.G.S. §§ 58-67-88, 135-39.4A(g)].

Network Adequacy

Insurers that operate network-based plans (like HMOs or PPOs) must have systems to ensure the adequacy of the network. Insurers must set their own access standards and monitor how well the network meets these internal standards. The health plan's access standards should include information about how long enrollees must travel to obtain primary care, specialty care, hospital-based services and other facilities. Insurers must also monitor waiting times to find out how long it takes to get an appointment with network providers [N.C.G.S. §§ 58-3-191(a)(4)(c); 135-39.4A(g)].

Insurers may not charge enrollees more money or otherwise penalize enrollees for using out-of-network providers, if the health plan lacks sufficient network providers to meet the health care needs of the patients without unreasonable delay [N.C.G.S. § 58-3-200(d)].

Insurers may not restrict enrollees from selecting a pharmacy if the pharmacy has agreed to participate in the health benefit plan according to the terms offered by the insurer. Insurers may *not* charge higher cost sharing that would affect the enrollees' choice of a pharmacy [N.C.G.S. § 58-51-37].

Obstetricians and Gynecologists (OB/GYNs)

Insurers that use network providers must allow female enrollees 13 years or older to obtain the services of a contracting obstetrician-gynecologist without prior referral for obstetrical or gynecological related services [N.C.G.S. § 58-51-38].

Optometrists, Podiatrists, Certified Clinical Social Workers, Certified Substance Abuse Professionals, Licensed Professional Counselors, Dentists, Chiropractors, Psychologists, Pharmacists, Certified Fee-Based Practicing Pastoral Counselors, Advanced Practice Nurses, and Physician Assistants

Insurance plans may not deny payment or reimbursement for any service which is within the scope of practice of a licensed optometrist, podiatrist, certified clinical social worker, certified substance abuse professional, licensed professional counselor, dentist, chiropractor, psychologist, pharmacist, certified fee-based practicing pastoral counselor, advanced practice nurse (such as a nurse practitioner or nurse midwife) or physician assistant. This section does not require insurers to cover services that would not otherwise be covered. But if the service is normally covered, the insurer may not deny payment to any of these licensed or certified practitioners, if they are providing the covered services within their scope of practice. The goal is to give the enrollee a choice of providers [N.C.G.S. §§ 58-50-26, 58-50-30, 58-65-1; 58-65-36, 135-39.4A(g), 135-40.6(11), 135-40.7B (c)(10)].

Insurers who operate network-based plans may not exclude these providers from their provider network solely on the basis of their license or certification. In other words, the insurer cannot exclude whole categories of providers if the providers can provide covered services within the scope of their license or certification. However, providers that are included in the network must agree to the insurer's regular rules of participation (such as quality assurance and utilization review requirements). Persons who are enrolled in an HMO will need to choose a network provider in order to obtain coverage. Those who are enrolled in either a Point-of-Service (POS) or Preferred Provider Organization (PPO) will need to choose a network provider in order to obtain the higher level of coverage [N.C.G.S. §§ 58-50-30(g), 135-39.4A(g)].

Pediatricians

Insurers that use a provider network must allow children under the age of 18 to choose a contracting pediatrician in the network as their primary care provider [N.C.G.S. §§ 58-3-240, 135-39.4A(g)].

Provider Hold-Harmless Provisions

Providers are prohibited from charging HMO enrollees for covered services other than the allowable coinsurance, co-payments or deductibles. The providers may not charge patients for these services, even if the HMO fails to pay the provider [11 N.C.A.C. § 20.0202]. The patient can, however, agree to pay for *non-covered* services out-of-pocket. This protection applies only to enrollees in HMOs.

Specialists

North Carolina laws have provisions that allow certain enrollees to use specialists as their primary care providers, and other laws that enable certain enrollees to obtain standing or extended referrals to specialists.

Using a Specialist as a Primary Care Provider

Insurers must have procedures to allow enrollees with a serious or chronic degenerative, disabling, or life-threatening disease or condition to select a specialist with expertise in treating this condition as their primary care provider. To serve as a primary care provider, the specialist must coordinate the enrollee's ongoing care and must follow all of the insurer's other rules for primary care providers [N.C.G.S. §§ 58-3-235, 135-39.4A(g)].

Standing Referrals to Specialists

All insurers that require patients to obtain referrals before they can see a specialist must have new procedures to allow certain patients to obtain standing or extended referrals. Insurers must have a process to allow patients with chronic, degenerative, disabling, or life-threatening diseases or conditions to obtain extended or standing referrals to in-network specialists. The standing referrals will not exceed 12 months,

and shall be part of a treatment plan coordinated with the primary care physician, specialist, and the health plan [N.C.G.S. §§ 58-3-223, 135-39.4A(g)].

APPEALS AND GRIEVANCES, EXTERNAL REVIEW, AND RIGHT TO SUE

Persons who are covered by most insurance plans have multiple ways to appeal denials of care or treatment, or to otherwise complain about the care or coverage under the plan. In general, they must first exhaust internal insurance appeal and grievance mechanisms (called “internal review”), then must appeal to an independent external review organization (called the “external review”). If the enrollee goes through the internal and external appeals route and is still not satisfied with an insurer’s decision to deny or limit health care services, then that person can sue the insurer in court.

Internal Appeals and Grievance Procedures

Enrollees have two separate internal appeal routes. One takes place when the enrollee contests a decision to deny or limit health care services (noncertification decision). This is called an “appeal.”² The other appeal route occurs when a member is unhappy with other aspects of the plan’s operations. A complaint about other operations of the plan is called a “grievance.”

Enrollees have the right to two levels of review, for both appeals and grievances. The first level of review has a different name and a slightly different process depending on whether it is a first-level appeal or first-level grievance review. However, the second-level review is the same regardless of whether the dispute is a denial of services or another problem with the plan’s operation. This is referred to as a second-level grievance hearing.

Enrollees who contest noncertification decisions (denials of services or procedures) have the right to ask for expedited review if the normal time limits could hurt the enrollee’s health. Otherwise the normal time limits apply. There is not an expedited process for first-level grievance decisions, because first-level grievance hearings do not deal with noncertification decisions (these are handled at the first level appeals).

Under state law, state employees are also entitled to have internal appeals that are substantially similar to those set out below [N.C.G.S. § 135-39.7].

Appeals of Noncertification Decisions

Denial Notices: When insurers deny care, they must send the enrollee a noncertification letter explaining why the requested service or procedure was denied. The notice must include the clinical reasons for the noncertification as well as instructions on how to appeal the plan’s decision [N.C.G.S. § 58-50-61(h)]. Enrollees

² The appeals procedures do not apply to any noncertification given solely on the basis that a health benefit plan does not provide coverage for the health care services being requested if the exclusion of the specific service requested is clearly stated in the certificate of coverage [N.C.G.S. § 58-50-61(a)(13)].

should always ask for a copy of the clinical review criteria used in making the decision. This provides a more complete explanation for why the requested treatment, procedure, or admission was denied.

First-Level Appeals: Enrollees can file appeals on their own behalves. In addition, a physician or other person acting on the enrollee's behalf can file an appeal [N.C.G.S. § 58-50-61(j)]. All plans must offer at least two levels of appeals. A physician who was not involved in the original decision must hear the first appeal. Normally the physician has 30 days to decide the appeal [N.C.G.S. § 58-50-61(k)].

Expedited Review: Enrollees can request expedited appeals if their health would be harmed by the 30-day delay. In an expedited appeal, the physician has up to four days to make a decision. However, enrollees can request the decision be made immediately if there is a more immediate health care need [N.C.G.S. § 58-50-61(k), (l)]. Enrollees will have their health services covered until notified of the expedited review decision, if the appeal involves concurrent review such as continued stay in a hospital. Enrollees are not entitled to expedited review if the health care services have already been provided and the issue is whether the care was appropriate (retrospective review).

Notice of Decision: Each health plan or utilization review organization must provide a written decision to the enrollee and the enrollee's provider. The decision should contain the qualifications of the person reviewing the appeal, the reviewer's decision including the medical rationale and evidence used as the basis for the decision, instructions on how to file a second-level grievance hearing, and information about the right to seek an independent, external review [N.C.G.S. §§ 58-50-61(k), 58-50-77].

First-Level Grievance Reviews

Reasons to File a Grievance: Enrollees have the right to file a grievance any time they are dissatisfied with any of a plan's policies, decisions, or actions. For example, enrollees can file grievances if they are unhappy with the quality of care or the availability of health care services. Similarly, they can file grievances if the health plan fails to reimburse them for certain out-of-pocket payments that should have been covered by the plan [N.C.G.S. §§ 58-50-62(b), 58-50-61(a)(6)].

First-Level Grievance Reviews: The enrollee, his representative, or the provider may submit a first-level grievance. Within three business days after receiving notice of the grievance, the health plan must provide the enrollee with information on how to submit written materials. The person reviewing the grievance cannot be the same person who initially handled the grievance. If the issue is a clinical one, at least one of the reviewers must be a medical physician with appropriate expertise. The health plan must make a grievance decision within 30 days after receiving the complaint. The notice of the decision must include the same information as provided in first-level appeal decisions [N.C.G.S. §§ 58-50-62(e), 58-50-77].

Second-Level Grievance Hearings

Hearing Procedures: Health plans must also have second-level grievance reviews for enrollees who are dissatisfied with the decision of the noncertification appeal or first-level grievance review. The health plan must notify the enrollee of the name and telephone number of the grievance coordinator, and must provide information about the second-level grievance process within 10 days of receiving a request for a second-level grievance. Enrollees have more extensive due-process rights at the second-level grievance review. Specifically, an enrollee can attend the second-level grievance hearing and request and receive all information relevant to the case in order to prepare for the hearing. Enrollees may present their cases to the review panel, submit supporting materials before and at the review meeting, ask questions of any member of the review panel and bring other persons to help in the review hearing. These could include a family member, employer representative, or attorney. If the enrollee chooses to bring an attorney, then an attorney may also represent the health plan [N.C.G.S. § 58-60-62(f)(1)b].

The health plan will convene a hearing panel to hear second-level grievances. The panel will usually consist of people who are not employees of the health plan or utilization review organization, who were not previously involved in the decision, and who do not have a financial interest in the outcome of the review. All people reviewing a second-level grievance involving a noncertification or clinical decision should be providers who have appropriate expertise³ in the health issue in dispute. The review panel has up to 45 days to hold the hearing, and up to 15 days thereafter to make a decision. This decision is a recommended decision to the health plan.

Expedited Hearings: Enrollees can request an expedited second-level review if their health could be harmed because of any time delays [N.C.G.S. § 58-60-62(i)]. Enrollees may request an expedited second-level review even if the first-level appeal or grievance review was not expedited. If necessary, the health plan may conduct the hearing over the phone or through submission of written information.

Second-level Hearing Decisions: Each health plan must provide a written decision to the enrollee and the enrollee's provider (if appropriate). The decision should contain the qualifications of the people reviewing the grievance, the reviewer's decision, the medical rationale for the decision, and the evidence used as the basis for the decision. The decision must also notify the enrollee of the right to seek an independent, external review [N.C.G.S. §§ 58-60-62(h), 58-50-77].

Independent External Review

Enrollees who are not satisfied with the outcomes of the internal appeals and grievances can appeal further to an independent, external review organization. There are no fees to appeal to an independent, external review organization. The right to

³ If the HMO used a clinical peer in the noncertification appeal or a first-level grievance review panel, then the HMO may use one of its employees on the second-level grievance review panel (if the second-level panel consists of three or more people). [N.C.G.S. §§ 58-50-62(f)(2)].

seek an outside, independent review applies only to cases involving noncertification decisions (i.e., the decision by the insurer to deny covered medical care). State employees also have a right to external review after exhausting the internal review process [N.C.G.S. § 135-39.7].

Requesting an external review. Ordinarily, the enrollee must exhaust the internal appeals and grievance process. The enrollee will be considered to have exhausted the internal process if the enrollee obtained a decision in a second-level grievance hearing, or if he or she filed a second-level grievance and has not received a written decision within 60 days of filing the grievance. In certain instances, the enrollee can file a request for an independent, external review without having first exhausted the internal appeals and grievance procedures. First, the enrollee can seek an expedited external review if he or she has a medical condition where the time for completing an expedited internal appeals or second-level grievance would reasonably be expected to jeopardize his or her life or health, or jeopardize the ability to regain maximum function. In addition, the enrollee need not exhaust the internal appeal and grievance process if the insurer agrees to waive the exhaustion requirement [N.C.G.S. § 58-50-79].

Standard external review. The enrollee has 60 days from the date of the appeals or second-level grievance decision to request an external review. The request must be made to the Commissioner of the Department of Insurance. The Commissioner will then obtain information from the insurer to determine whether the case is appropriate for external review. To be considered appropriate, the individual requesting the review must have been covered under the plan at the time the health care services were requested, the requested services must be covered under the plan, and the enrollee must have exhausted the internal appeals and grievance procedures (or satisfied one of the exceptions to the exhaustion requirement). The Commissioner can request additional information from either the insurer or the enrollee in making his decision about whether the case is appropriate for external review. Both the enrollee who requested the review and the insurer will be notified of the Commissioner's decision.

If the case is accepted for external review, it will be assigned to an independent external review organization (assignment is made on a rotating basis to review organizations). The insurer has seven days to provide to the external review organization any information considered in making the noncertification appeals or second-level grievance decision. The Commissioner will forward any new information provided by the enrollee to the insurer. The insurer can reconsider its internal review decision at any time prior to the completion of the external review. If the insurer reverses its original noncertification decision, then the external review process will end [N.C.G.S. § 58-50-80(a)-(h)].

Expedited external review. An enrollee may request an expedited external review at various times in the review process. The enrollee may request an expedited external review after the initial noncertification decision, the notice of the first-level appeals, or the second-level grievance. To qualify for an expedited external review, the enrollee must show that the completion of the normal expedited internal appeals and

grievance procedures would reasonably be expected to seriously jeopardize the life or health of the enrollee, or jeopardize the ability to regain maximum function. Enrollees can also request an expedited external review if they received emergency services but have not yet been discharged from the facility, and if the disputed issue is a noncertification of an admission, continued stay in a facility, or health care service needed in the facility. The Commissioner must decide within three days after the request if the case is appropriate for expedited external review. In making this determination, the Commissioner shall consult with a medical professional who has not been involved in the internal appeals and grievance procedures, and who will not be involved in the external review [N.C.G.S. § 58-50-82].

Review organization. The external review organization must be independent—that is, it cannot have any ties to the insurer, enrollee, or any health care provider involved in the underlying dispute. The organization must ensure timely decisions and confidentiality of the medical records. In addition, the external review organization must have qualified and impartial health professionals who can review the underlying dispute. These health professionals must be experts in the treatment of the injury, illness, or medical condition that is being contested. In addition, the health professionals must have current clinical experience treating patients with the same or similar condition, injury, or illness, and be knowledgeable about the recommended care or treatment. If the enrollee’s treating provider is a doctor, then the health care professional who reviews the underlying dispute must also be a doctor holding a similar specialty certification. If the enrollee’s treating provider is not a medical doctor, then the provider who reviews the dispute should hold a license, registration, or certification similar to that of the treating provider [N.C.G.S. § 58-50-87].

Standards of review. The external review organization must base its decision on the enrollee’s medical condition at the time of the initial noncertification decision. In addition, it must consider the following factors in making its decision:

- ◆ The enrollee’s medical records
- ◆ The attending health care provider’s recommendation
- ◆ Consulting reports from appropriate health care providers and other documents submitted by the insurer, the enrollee, or the enrollee’s treating physician
- ◆ The most appropriate practice guidelines based on sound clinical evidence and periodically updated
- ◆ Any applicable clinical review criteria developed and used by the insurer
- ◆ Medical necessity, as defined under the North Carolina statutes [N.C.G.S. §58-3-200(b)]
- ◆ Any documentation supporting the medical necessity and appropriateness of the provider’s recommendation

The external review organization’s decision may not be contrary to the terms of coverage under the enrollee’s health benefit plan. Thus, for example, the external review organization may not require the insurer to cover a particular treatment or

procedure if it is specifically excluded under the applicable health plan [N.C.G.S. § 58-50-80(i)].

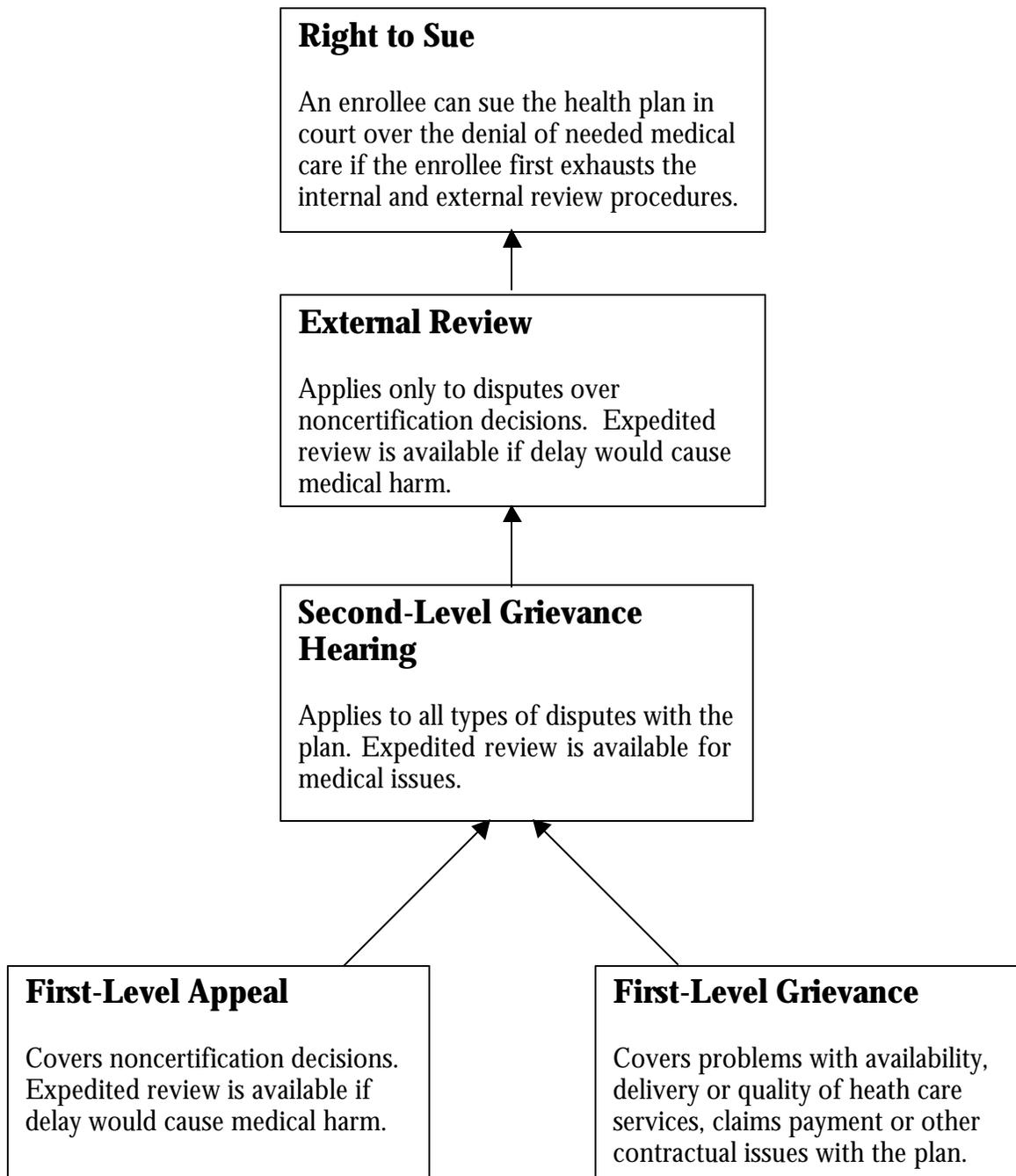
Notice of decision: The external review organization must generally make its decision within 45 days of when the enrollee initially requested an external review. However, in the case of an expedited external review, the organization must make its decision as expeditiously as the medical condition requires, but in no event more than four days after the initial request for a review. The notice of decision must include information about the underlying reason for the request, the date the organization received information from the enrollee and insurer, the date the review was conducted and the date of the decision, the principal reason(s) for the decision (including the clinical rationale), reference to any evidence or guidelines considered in making the decision, and the professional qualifications of the clinical peer reviewers. An insurer has three business days to reverse its original noncertification decision if the external review organization decides in favor of the enrollee for regular reviews, and one day in the case of an expedited review. [N.C.G.S. §§ 58-50-80(j)-(l); 58-50-82].

Right to Sue Insurers

In the past, it has been difficult for enrollees to sue their insurance company for damages caused by a wrongful denial of care. However, in 2001, the NC General Assembly enacted legislation making it somewhat easier to sue insurers if an enrollee was harmed by an insurer's decision to deny coverage for health services (noncertification decision). In order to be able to sue the insurer, the enrollee must first exhaust both the internal and external appeals process [N.C.G.S. § 90-21.54]. State employees also have a similar right to bring suit for wrongful denials of care [N.C.G.S. § 143-291]. Either side can introduce the decision of the independent review organization as evidence during the trial.

Enrollees who win their lawsuits may be able to recover actual damages (for example, for the cost of care, lost wages, or reimbursement for pain and suffering). In addition, the enrollee may be able to recover punitive damages, if the action by the insurer was particularly egregious. However, as a practical matter it will be very difficult to prevail in a lawsuit against an insurer. Insurers are required to exercise only "ordinary care." Ordinary care has been defined in the statutes as "that degree of care that, under the same or similar circumstances, a[n insurer] of ordinary prudence would have used at the time the [insurer] made the health care decision." [N.C.G.S. §§ 90-21.50(8); 90-21.51]. If the insurer prevails in the independent, external review, it may be difficult to show that the insurer was not exercising ordinary care.

Procedures for Appeals, Grievances, and Reviews



CONFIDENTIALITY

Confidentiality of Medical Records

In general, insurers may not disclose any medical information of an enrollee or applicant without his or her prior written consent. Sometimes a person may be asked to authorize the release of medical information in order to obtain health insurance coverage. In addition, there are some limited circumstances when the consent of the patient is not needed. Insurers can release medical information by court order. Insurers can also release medical information in the event of litigation between the insurer and enrollee if the information is relevant to the case. Medical information can be shared within the insurer so that the insurer can assess the appropriateness of the care provided or monitor quality. Any organization that the insurer contracts with to help in these activities is subject to these confidentiality provisions [N.C.G.S. §§ 58-39-75, 58-67-180, 11 N.C.A.C. §§ 20.0408, 20.0509].

All insurers (including HMOs) are also subject to the Insurance Information and Privacy Act [N.C.G.S. §58-39-1 et. seq.]. This statute sets rules for the collection, use, and disclosure of medical information involving insurance transactions. For example, insurers may seek information about your medical history before offering you certain types of non-group health insurance. Applicants and enrollees have the right to examine this information for accuracy. Also, you can find out the reason why a health plan decides not to offer you insurance coverage [N.C.G.S. § 58-39-5].

The US Department of Health and Human Services recently issued regulations to further protect patient privacy. The regulations were implemented as part of the Health Insurance Portability and Accountability Act (often referred to as the HIPAA requirements). These privacy regulations spell out in detail when and how health plans and providers can use and disclose patient health information. The regulations also establish several new important patient protections. For example:

- ◆ You have a right to know how your medical information will be used and when it will be shared with others.
- ◆ You have a right to inspect and obtain a copy of your health information (with certain limited exceptions, such as when providing access may cause harm). In addition, you have a right to correct the medical information if you think it is inaccurate, or to submit a “statement of disagreement” if the health care provider disagrees with your proposed correction.
- ◆ You have a right to find out when your information has been disclosed to other organizations over the past six years. (Note: this does not include when your information is disclosed in order to obtain insurance reimbursement or to other providers for treatment purposes).
- ◆ You have a right to request that your providers make special arrangements for communicating with you—for example, if you don’t want medical information sent to your home, you can arrange to have it sent to another location.

- ◆ You also have a right to request that your provider not release your medical information for specific purposes—such as for research purposes.

These new privacy protections are scheduled to become effective on April 14, 2003. [45 C.F.R. §§ 160.101 *et. seq.*, 160.102 *et. seq.*, 160.500 *et. seq.*]

CONSUMER INFORMATION

Evidence of Coverage

Insurers must provide enrollees with an explanation of the services or benefits covered under the insurance plan. Many plans refer to this document as the Evidence of Coverage (EOC), while other insurance companies refer to similar documents as member handbooks, subscriber contracts, or insurance policies. [N.C.G.S. §§ 58-65-60, 58-67-50(a)].

Insurers have specific requirements for what information must be included in the evidence of coverage or insurance policy. These documents must include a description of:

- ◆ The health services or other benefits covered under the plan
- ◆ Any limitations on the services or benefits covered
- ◆ Any required cost sharing
- ◆ The total amount that the enrollee must pay for health services
- ◆ A description of the insurer's method to resolve enrollee complaints
- ◆ A detailed explanation of appeal and grievance procedures
- ◆ Explanation of information that is available to enrollees and prospective enrollees upon request and instructions on how to obtain this information
- ◆ Definition of medical necessity
- ◆ Coverage that is available for out-of-network services
- ◆ Information about the utilization review process
- ◆ A description of the reasons, if any, that a health plan can terminate a member's enrollment

[N.C.G.S. §§ 58-3-191(b), 58-50-61, 58-50-62, 58-65-60, 58-67-50(a)(3)(b), 135-39.4A(g)]. Insurers must give enrollees or prospective enrollees a copy of these documents, upon their request [N.C.G.S. § 58-3-191(b)]. Similar requirements also apply to self-funded or ERISA plans (see Chapter 11).

False and Misleading Advertisements

Consumers have certain protections to ensure that they receive accurate information. For example, insurers are prohibited from using false and misleading advertisements, or misleading incentives to encourage people to purchase a health insurance policy. False and misleading advertisements and inducements are prohibited as unfair competition. Insurers are required to include information about major coverage limitations prominently in all of their advertisements. Consumers who think they have been harmed by false and misleading advertisements should contact the Consumer Services Division of the NC Department of Insurance for more information about their rights at: (800) 662-7777 or (800) 546-5664 [N.C.G.S. §§ 58-63-1 *et. seq.*, 58-67-65, 11 N.C.A.C. § 12.0518-0536].

Information About Treatment of Certain Health Conditions

Insurers that offer managed care plans (HMOs, PPOs or POS plans) must provide enrollees and prospective enrollees certain information upon their request. A current or prospective enrollee has the right to request information about:

- ◆ How his or her health condition would be treated under the plan (called the insurers' review criteria or treatment protocol)
- ◆ A list of the health plan's drug formulary, and how to request drugs outside the formulary
- ◆ The procedures the health plan uses in determining whether a specific procedure, test, or treatment is considered experimental or investigational

This information is especially important for people with pre-existing health problems or special health needs [N.C.G.S. § 58-3-191(b), 135-39.4A(g)].

Information To Compare Insurers

Insurers that offer managed care plans (HMOs, PPOs or POS plans) are required to report certain information to the NC Department of Insurance. Some of this information may be useful in comparing insurers. These data include:

- ◆ *Grievances:* Managed care plans must report information about member grievances. Grievances can result from problems with accessibility or quality of services, claims payments, questions about covered benefits, or other complaints. Insurers must provide information on the number of and reasons for the grievances, and the number of grievances resolved in the members' favor.
- ◆ *Participants and groups that withdraw from the health plan:* Managed care plans are required to report the number of groups (generally employer-based plans) and individual enrollees that left the health plan. In addition, the insurers must report data on the numbers of providers who left a plan voluntarily and involuntarily. [N.C.G.S. §§ 58-3-191(a)(2)(3), 135-39.4A(g)].

- ◆ *Provider Network Adequacy Information:* The managed care plans are required to report information on the number of specific types of providers who are in their network, by county. This includes primary care providers, specialists, facilities, and mental health and chemical dependency providers. [N.C.G.S. §§ 58-3-191(a)(4), 135-39.4A(g)]. In addition, plans are required to develop internal standards to ensure network adequacy (for example, that each enrollee has access to in-network providers within reasonable distances and time frames). Each managed care plan establishes its own standards, and then must measure its actual performance against its internal standard.
- ◆ *Utilization review and appeal data:* Managed care plans are required to report information on the types and number of utilization reviews performed and how many of these reviews resulted in a denial of services (noncertifications). In addition, managed care plans must also provide information on the number of appeals, and the outcome of these appeals. [N.C.G.S. § 58-3-191(a)(4)(f), 135-39.4A(g)].
- ◆ *Provider compensation data:* HMOs are required to submit information on the percentage of providers paid according to different payment arrangements, including capitation, discounted fee-for-service, or salary. In addition, the HMOs must also report about the range of compensation paid under a withhold or incentive system [N.C.G.S. § 58-3-191(a)(5), 135-39.4A(g)]. (Note: this section does not apply to PPOs.)
- ◆ *Health Plan Employer Data and Information Set (HEDIS®):* HMOs are required to report HEDIS® data to the state. HEDIS® is a standardized set of performance measures that consumers and other purchasers can use to compare insurers. [N.C.G.S. § 58-67-50(e)]. PPOs are not required to collect or report HEDIS® data.

Some but not all of the information noted above is available in a publication called *The 2001 Managed Care Consumer Guide: A Comparison of HMOs and PPO plans in North Carolina*. The Consumer Guide includes selected HEDIS® data, as well as information on grievances, appeals, member and physician turnover, and plan contact information. It is updated annually. You can access the Guide on the Internet at: <http://www.ncdoi.com/Consumer/Publications.asp>. (Note: Once you get to this page, click on the Health Insurance and Managed Care publications under type of publications. You should then see this publication listed.) Alternatively, if you want a copy of the publication or need additional information, you can call the NC Department of Insurance Consumer Services Section at: (800) 546-5664.

Materials Must Be Understandable

State law requires that all materials given to consumers be understandable at a ninth grade reading level. This means that the member handbooks (Evidence of Coverage or insurance policies) should be understandable to those with a high school reading level [N.C.G.S. §§ 58-38-1 *et. seq.*, 58-66-1 *et. seq.*]. However, the state allows each health plan to assess the readability of its consumer materials. Insurers can exclude

medical terminology in their assessment of the readability level. In effect, insurance materials are often difficult for the average person to understand.

Provider Directories

Every insurer that has a network of providers must maintain a provider directory. The directory shall include information about the provider's name, address, phone number, and, if applicable, the provider's specialty. The directory must also state whether the provider can be selected as a primary care provider. In addition, the directory should note whether or not the provider is accepting new patients (if that is known by the insurance company). The directory must list all the different types of participating providers. If the provider requests, the directory must also include the names of any allied health professionals who provide primary care services under the supervision of the participating provider. The directory shall be updated no less frequently than once a year. The insurer must also maintain a telephone system or on-line system so that enrollees can obtain up-to-date network information [N.C.G.S. §§ 58-3-245, 135-39.4A(g)].

MANAGED CARE PATIENT ASSISTANCE PROGRAM

An Office of Managed Care Patient Assistance has been created in the Consumer Protection Division of the NC Department of Justice. The Managed Care Patient Assistance Program was created to help managed-care enrollees. The Office will help answer consumer questions, advise managed-care enrollees about the utilization review process, and help enrollees with their grievance, appeal, and external review procedures. The Office will also develop and distribute consumer education materials, and make recommendations to the General Assembly about efforts that could be implemented to help managed care enrollees [N.C.G.S. § 143-730].

The Managed Care Patient Assistance Program can be reached at:
Managed Care Patient Assistance Program
Consumer Protection Division
N.C. Department of Justice
P.O. Box 629
Raleigh, NC 27602-0629
(866) 867-6272 (toll-free outside of Raleigh)
(919) 733-6272 (in Raleigh)
mcpap@mail.jus.state.nc.us

MANDATED BENEFITS

Bone Mass Measurements

Insurers must provide coverage of bone mass measurements for enrollees who are at risk of developing osteoporosis or low bone mass. Coverage must include bone mass measurements at least every 23 months and more frequently if follow-up measurements are medically necessary. Coverage for the bone mass measurements

shall be the same as for other similar services. Persons who qualify for coverage of bone mass measurements include those with:

- ◆ Estrogen deficiency and risk of osteoporosis or low bone mass
- ◆ Radiographic osteopenia anywhere in the skeleton
- ◆ Long-term steroid therapy
- ◆ Primary hyperparathyroidism
- ◆ Monitoring to assess their response to osteoporosis drug therapies
- ◆ Histories of low-trauma fractures
- ◆ Other known conditions or medical therapies known to cause osteoporosis or low-bone mass. [N.C.G.S. §§ 58-3-174, 58-50-155]

Chemical Dependency Treatment

Insurers must offer groups coverage for the treatment of chemical dependency. If the health plan provides the group total annual benefits for all services in excess of \$8,000, then that plan must provide a minimum of \$8,000 for the necessary care and treatment of chemical dependency. The plan must provide a lifetime maximum of no less than \$16,000. While insurers are required to offer this coverage, groups may reject it [N.C.G.S. §§ 58-51-50; 58-65-75, 58-67-70].

Clinical Trials

Insurers must cover the health care costs for certain enrollees who are enrolled in phase II, phase III, or phase IV clinical trials. Only trials that are funded by the National Institutes for Health, Centers for Disease Control, Veterans Administration, Department of Defense, Food and Drug Administration, or Agency for Health Care Research and Quality, and that are designed to evaluate new treatments for life-threatening medical conditions, have to be covered. To be eligible for coverage, the enrollee must show that the treatment offered by the trial is medically preferable to other non-investigational treatments. The insurer is only responsible for the costs of medically necessary health care services associated with participation in the clinical trial—not the costs of the health care services or treatment provided and paid for as part of the clinical trial. For example, if a clinical trial is evaluating a new drug, the cost of the medication will be covered by the trial. However, the insurer must cover the doctor's costs in monitoring the enrollee's condition and any diagnosis or treatment of complications [N.C.G.S. §§ 58-3-255].

Colorectal Cancer Screening

Insurers must cover colorectal cancer examinations and laboratory tests for cancer. Screenings must be covered for persons who are at least 50 years old, or who are younger than 50 but at high risk for colorectal cancer. The screenings must be covered in accordance with the most recently published American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on

Cancer Coordination and Control. Insurers may not impose higher deductibles, co-payments, or coinsurance on colorectal cancer screenings than they do on other similar screening tests. [N.C.G.S. §§ 58-3-179, 58-50-155].

Contraceptives

Insurers that cover prescription drugs and devices must also cover prescription contraceptives or devices. Coverage must include the insertion and removal of contraceptive devices as well as contraceptive examinations. With one exception, insurers may not impose higher deductibles, co-payments, or coinsurance on contraceptive drugs and devices than they do on other prescription drugs or devices. Special payment rules apply to drugs or devices that are inserted and do not need to be refilled on a periodic basis (such as IUDs). For these drugs or devices, the insurer may require advance payment of the total coinsurance amount, based on the useful life of the drug or device. Religious employers (such as churches) can request that insurers not provide contraceptive coverage if it is contrary to the employer's religious tenets. [N.C.G.S. §§ 58-3-178, 58-50-155].

Dental Procedures for Young Children and Persons with Serious Mental or Physical Conditions

Insurers must pay for the costs of anesthesia and hospital or facility charges associated with dental procedures provided to children under age nine, to persons with serious mental or physical conditions, or persons with significant behavioral problems, if the provider certifies that hospitalization or general anesthesia is needed in order to safely perform the procedures. The same deductibles, coinsurance, network requirements, and medical necessity provisions as apply generally to coverage of physical illness will apply to coverage of these services [N.C.G.S. § 58-3-122].

Diabetes Self-Care

Insurers must cover diabetes outpatient self-management training, equipment, supplies, medications, and laboratory procedures used to treat diabetes. The insurer may decide who shall provide and be reimbursed for the outpatient self-management training and educational services [N.C.G.S. §§ 58-51-61, 58-65-91, 58-67-74].

Emergency Services

Insurers must provide coverage for emergency medical services needed to screen and to stabilize an enrollee. Prior authorization cannot be required if an ordinary person (prudent layperson) acting reasonably would have believed that an emergency medical condition existed. The enrollee may obtain emergency-related services from a non-network provider if the person reasonably believes that the delay in seeking care from a network provider would worsen the emergency. The health plan may charge its regular coinsurance, co-payments, or deductibles but may not charge

additional cost-sharing amounts for using a non-network provider [N.C.G.S. § 58-3-190].

Mammograms and Pap Smears

Insurers must provide coverage for periodic pap smears and mammograms. Coverage of pap smears will be provided once a year or more often if recommended by a physician. Mammograms must be covered according to the following schedule:

- ◆ One or more mammograms a year, as recommended by a physician, for any woman who is at risk of breast cancer
- ◆ One baseline mammogram for any woman 35-39 years of age
- ◆ A mammogram every other year for any woman 40-49 years of age or more frequently upon a physician's recommendation
- ◆ A mammogram every year for any woman 50 years of age or older

Insurers may not impose higher co-payments on pap smears or mammograms than they do on other similar screening tests [N.C.G.S. §§ 58-50-155, 58-51-57, 58-65-92, 58-67-76].

Maternity Care

Insurers are not required to provide maternity coverage. When the company does provide coverage, benefits must be the same as for other services [N.C.G.S. § 58-3-170]. In other words, an insurer may not impose higher co-payments on maternity care than it does on other similar care. Regardless of whether the policy provides maternity coverage, a complication of pregnancy must be treated similarly to other illnesses or sicknesses covered under the health plan's contract. A nonelective cesarean section is considered a complication of pregnancy [11 N.C.A.C. § 12.0323]. Insurers may not deny maternity coverage to an unmarried woman if the coverage is available to married women.

Also, any health benefit plan that provides maternity coverage must pay for inpatient care for a mother and her newborn child for at least 48 hours after vaginal delivery or 96 hours after a cesarean section [N.C.G.S. §§ 58-3-169, 58-3-170].

Newborn Hearing Screening

Insurers must cover the costs of newborn hearing screening, and may not charge higher deductibles, coinsurance, or other cost sharing than required for other similar services [N.C.G.S. §§ 58-3-260, 130A-125].

Prescription Drugs

Insurers that use a closed or restricted formulary for prescription drugs must have a process to allow exceptions to the formulary. To obtain coverage of a restricted or nonformulary drug, a participating provider must notify the health plan that:

- ◆ The drugs on the formulary have been ineffective in treating the patient's condition
- ◆ The drugs on the formulary are reasonably expected to cause a harmful reaction in the patient

In addition, the drug must be prescribed in accordance with the health plan's clinical protocol. Insurers may not charge patients any additional deductible, cost-sharing, or a higher co-payment for using nonformulary medications as an exception to the formulary [N.C.G.S. § 58-3-221, 135-39.4A(g)].

Prescription Drugs for Cancer Treatment

Insurers that cover the medication cost for the treatment of one type of cancer must, under certain circumstances, also cover the costs of that medication for the treatment of another type of cancer. For this protection to apply, the following standards must be met:

- ◆ The drug must be approved by the US Food and Drug Administration (FDA)
- ◆ It must have been proven effective
- ◆ It must be accepted for the additional use by the American Medical Association Drug Evaluations, the American Hospital Formulary Service Drug Information, or the United States Pharmacopoeia Drug Information

Coverage may be denied if the medication is experimental or investigational (unless it meets the requirements for coverage of clinical trials) or if the FDA finds that the drug should not be used to treat the other type of cancer [N.C.G.S. §§ 58-50-156, 58-51-59, 58-65-94, 58-67-78].

Prostate-Specific Antigen Test (PSA)

Insurers must cover prostate-specific antigen (PSA) tests or other tests for the presence of prostate cancer. A physician must order a PSA test in order for it to be covered. PSAs must be covered at the same level as other similar services [N.C.G.S. §§ 58-50-155, 58-51-58, 58-65-93, 58-67-77]. In other words, plans may not impose higher co-payments or cost sharing on PSA tests than they do on other similar screening tests.

Public Health Measures

HMOs and local health departments are required to collaborate and cooperate to protect the public health. For example, HMOs and local health departments could jointly sponsor a local health promotion or disease prevention activity [N.C.G.S. § 58-67-66].

Reconstructive Breast Surgery

Insurers that cover mastectomies must also cover reconstructive breast surgery following a mastectomy [N.C.G.S. §§ 58-50-155, 58-51-62, 58-67-79]. The decision to discharge a patient following a mastectomy must be made in consultation by the attending physician and the patient [N.C.G.S. § 58-3-168].

Tax-Supported Institutions

Insurance companies must provide the same coverage for services provided in a tax-supported institution, such as a state psychiatric institution, as the company provides for services in other public or private health care facilities. This provision *only* applies to *group* coverage, and does *not* apply to HMOs [N.C.G.S. §§ 58-51-40, 58-65-65].

Temporomandibular Joint (TMJ) Treatment

Insurers must provide coverage for diagnostic, therapeutic, or surgical procedures involving bones or joints of the jaw, face, or head, including the temporomandibular joint, if the procedure is medically necessary. These insurers must provide coverage if the condition is caused by congenital deformity, disease, or traumatic injury [N.C.G.S. § 58-3-121].

NONDISCRIMINATION

Acquired Immune Deficiency Syndrome (AIDS) / Human Immunodeficiency Virus (HIV)

HIV infection and AIDS must be covered as any other illness or sickness in health insurance policies. Insurers may *not* write plans excluding coverage of AIDS or HIV [11 N.C.A.C. § 2.0324].

Children

There are a number of antidiscrimination provisions that apply to children. Some laws are intended to protect children born out of wedlock; others are for newborn, adoptive, or foster children; and other laws protect children born with disabilities. In addition to the nondiscrimination provisions, non-custodial parents may be required to provide insurance coverage for their children in certain instances.

Children Born Out of Wedlock

No child may be denied coverage because the child was born out of wedlock, was not claimed as a dependent on the parent's federal income tax return, or does not reside with the parent or in the health plan's service area. In addition, the plan must allow a parent to enroll a child when required to do so by court or administrative order. This is true even if it is outside the normal enrollment period [N.C.G.S. § 58-51-120].

Newborns, Adoptive Children, and Foster Care Children

Insurers must provide coverage for newborn infants and foster children from the moment of the child's birth or on the day that the foster child is placed in a foster home. The plan shall provide the same coverage for congenital defects or anomalies that is provided for most sicknesses or illnesses [N.C.G.S. § 58-51-30]. The plan must also cover adopted children upon placement with a person who has insurance coverage, and may not impose pre-existing-condition exclusions [N.C.G.S. § 58-51-125].

Children with Developmental Disabilities or Other Disabilities

Insurers cannot refuse to enroll a child in an insurance plan that covers physical illness or injury because of that child's physical disability or mental retardation [N.C.G.S. §58-51-35]. Insurance companies must continue coverage for dependent children who are mentally retarded or have physical disabilities after the child reaches the age at which coverage would normally terminate. This applies if the child is incapable of self-supporting employment and is chiefly dependent upon the policyholder for support and maintenance [N.C.G.S. §§ 58-51-25, 58-65-2, 58-67-171].

Medical Support Orders

Noncustodial parents may be ordered to cover their children under their health insurance coverage as part of a child support order. If ordered by the court, employers and health insurers are required to provide health insurance for the child, if dependent coverage is normally available. Employers are not required to pay for dependent coverage if they do not otherwise contribute to the costs of dependent or family coverage [N.C.G.S. §§ 50-13.11, 110-136.11 *et. seq.*].

Gender or Marital Status

No health plan can limit, refuse to issue, or refuse to continue coverage because of a person's sex or marital status. However, the plan may charge different premiums and may take marital status into account when determining a person's eligibility for dependent coverage. For example, a plan could not deny health insurance coverage to a woman working part-time if men working similar part-time jobs could obtain coverage. A plan also may not deny dependent coverage to husbands of female

employees when dependent coverage is available to the wives of male employees. Similarly, plans may not restrict, reduce, or modify benefits payable for disorders of the genital organs of only one sex [N.C.G.S. §§ 58-63-1, 58-2-40, 58-3-120, 58-63-1, 58-63-60].

Genetic Information

Insurers may not discriminate against enrollees on the basis of genetic information [N.C.G.S. §58-3-215(c)]. Specifically, insurers may not raise either the group premium rates or the premium rates for any specific individual in the group, and may not refuse to issue a policy because of genetic information obtained about one of the prospective enrollees.

Health Status

Insurers have certain rules that prevent them from discriminating against people because of their health status. There are different rules for people enrolled in group plans (typically employer-sponsored plans), and those who are seeking coverage in the individual market (non-group plans).

Group plans: Insurers may not exclude individuals from coverage or refuse to renew coverage because of their health status, medical condition, claims experience, genetic information, disability, use of health care services, or being a victim of domestic violence. In addition, the health plan may not charge any individual covered under a group plan a higher premium on the basis of that person's health (or any of the other factors listed above). However, insurers may exclude coverage for certain pre-existing conditions (see below). Insurers may charge the group as a whole higher premiums based on that group's use of health services [N.C.G.S. § 58-68-35]. Generally, insurers must renew coverage to groups at the option of the employer. In other words, the insurer cannot refuse to renew coverage to a group based on the group's use of health services, although the insurer can refuse to renew for certain limited reasons. For example, an insurer need not renew the policy if the employer failed to pay premiums or committed fraud, or if the insurer stops writing health insurance in the area [N.C.G.S. § 58-68-45].

Non-group plans: Insurers cannot refuse to enroll *eligible* individuals in the non-group market because of their health status. Eligible individuals are people who:

- ◆ Had 18 or more months of prior health insurance coverage from an employer group, governmental or church health plan
- ◆ Do not have access to another group or government-sponsored health plan
- ◆ Did not lose prior health insurance coverage because of nonpayment of premiums or fraud
- ◆ Elected continuation coverage if it was offered and, if so, continued the coverage until the guaranteed time period ran out

Insurers are not required to offer individuals coverage under all the health insurance policies they sell in the non-group market. At a minimum, plans must offer the two most popular non-group plans, such as the policies with the largest premium volume. While insurers have to offer coverage to certain individuals in the non-group market, there is no limit on the premiums that can be charged [N.C.G.S. § 58-68-60 et seq.].

Pre-Existing Conditions. Some people may have more limited coverage when they first apply for health insurance coverage. These are people who received medical advice, diagnosis, or treatment for a physical or mental condition within six months of enrolling in the health insurance plan (called a “pre-existing condition”). Some persons with pre-existing conditions may be subject to a pre-existing condition exclusion period. In these instances, the insurer will provide health insurance—but need not cover the health condition that existed prior to coverage. For example, if a person had a heart attack within the six months prior to coverage, then the insurance can exclude coverage for any heart-related health condition for a “pre-existing exclusionary period.” However, an insurer cannot impose a pre-existing exclusionary period if you were previously insured, had health insurance coverage for at least twelve months, and did not experience a gap in coverage for more than 63 days [N.C.G.S. § 58-68-30].

The length of the exclusionary period depends on two factors: 1) when you enroll in your health insurance plan; and 2) if you previously had health insurance coverage and met part of the pre-existing condition exclusionary time period.

Enrolling During an Open-Enrollment Period. The maximum pre-existing exclusionary period is 12 months if you enroll during your employer’s open-enrollment period (i.e., generally within 30-31 days of when you become eligible for enrollment). Note: an employer need not impose any pre-existing exclusionary time period. Often very large employers do not impose pre-existing condition exclusionary periods regardless of whether you sought care within the six month prior to enrolling in health insurance.

Late Enrollment. People who do not enroll during the “open-enrollment” period can generally be subject to an 18-month exclusionary time period. However, certain enrollees are not considered “late enrollees.” For example, newborns are not considered late enrollees if they enroll within 30 days after birth. Similarly, children who are adopted are not late enrollees if enrolled within 30 days after being placed for adoption. Individuals who lose other coverage (for example, because their spouse or parent who was providing health insurance coverage loses that coverage) are also not considered late enrollees.

Creditable Prior Coverage. People who were previously covered with health insurance will get credit for any coverage (as long as there was not a gap in coverage for more than 63 days). Thus, if a person had a pre-existing condition and was previously covered by a health plan for four months, he or she will be credited with four months’ coverage in meeting their new 12-month or 18-month pre-existing condition exclusionary period.

Medicaid Coverage

Insurers are prohibited from taking into account the fact that an enrollee is receiving Medicaid coverage in insuring the person or making payments under the health benefit plan [N.C.G.S. § 58-51-115]. In other words, insurers may not exclude individuals or services because they are already covered by Medicaid.

People with Mental Illness or Chemical Dependency

Persons with mental illness or chemical dependence enrolled in group contracts covering 20 or more employees are given limited protections. Insurers may not refuse to enroll someone in a health plan that covers physical illness or injury because that person has a mental illness or chemical dependence. Similarly, insurers may not charge these enrollees a higher premium or reduce the coverage for physical illness or injury [N.C.G.S. §§ 58-51-55, 58-65-90, 58-67-75].

People with Sickle Cell Trait or Hemoglobin C Trait

Insurers cannot refuse to enroll someone in an insurance plan that covers physical illness or injury because of that person's sickle cell or hemoglobin C trait [N.C.G.S. §§ 58-51-45, 58-65-70, 58-67-171]. In addition, insurers are prohibited from charging higher premiums because of these health conditions.

People with Visual or Hearing Impairments

Insurers cannot refuse to enroll a person, limit coverage, or charge higher premiums because that person is fully or partially blind or deaf [N.C.G.S. §§ 58-3-25(b), (c), 58-51-15(7), 58-67-65(b)].

Race, Color or National Origin

Insurers are prohibited under state law from limiting coverage, refusing to insure, refusing to continue coverage, and from charging different premium rates because of a person's race, color, or national or ethnic origin [N.C.G.S. §§ 58-3-25(c), 58-65-85, 58-67-65(f)].

POINT-OF SERVICE (POS) AND PREFERRED PROVIDER ORGANIZATION (PPO) PROTECTIONS

Cost Sharing (Point of Service Plans)

In POS plans enrollees have the option of seeking care outside of the network. Usually enrollees have to pay deductibles, higher co-payments, and/or more coinsurance than they would if they received care inside the network. North Carolina laws limit the amount that HMOs can charge for using out-of-network providers. For example, coinsurance for out-of-plan covered services may not be more than 30 percent more than coinsurance for in-plan coverage. The deductible may not be

more than five times the amount of the annual deductible for in-plan coverage. The deductible may not be more than \$2,000/\$6,000 for individual/family coverage if the in-plan does not have a deductible. The co-payments may not exceed the co-payments for in-plan covered services by more than \$50 or 100%, whichever is greater. The annual and lifetime maximum, if any, may not be less than one-half of the amounts of any annual or lifetime maximums for in-plan covered services [11 N.C.A.C. § 12.1403].

Cost-Sharing (Preferred Provider Organizations)

Enrollees in PPOs also have the option of seeking care outside the network. Often, enrollees will have to pay higher deductibles or coinsurance than if they received care inside the network. North Carolina limits the amounts that insurers can charge for using out-of-network providers. Coinsurance for out-of-plan covered services may not be more than 30 percent more than coinsurance for in-plan coverage. The deductible may not be more than two times the amount of the annual deductible for in-plan coverage. If the insurer does not have a deductible for in-plan coverage, then the deductible for out-of-plan coverage cannot exceed \$250 per person or \$750 per family. The co-payments may not exceed the co-payments for in-plan covered services by more than \$20 or 100%, whichever is greater. The annual and lifetime maximum, if any, may not be less than one-half of the amounts of any annual or lifetime maximums for in-plan covered services. [N.C.G.S. § 58-50-56, 11 N.C.A.C. § 12.1800, 1803].

Covered Services

POS plans must make all benefits available for in-plan covered services. But they need not cover preventive services on an out-of-plan basis. Any out-of-plan covered service must also be available on an in-plan basis. POS products must give enrollees the option to choose in-plan or out-of-plan covered services each time the enrollee seeks services. POS products must provide incentives for enrollees to use in-plan services [11 N.C.A.C. § 12.1403].

Disclosure of Cost-Sharing to Enrollees

All marketing materials, evidence of coverage, member handbooks and other materials must explain the method of reimbursement, applicable cost-sharing amounts, and any uncovered costs or charges. Materials should also explain covered benefits that an enrollee may receive on an out-of-plan basis and instructions to submit claims for out-of-plan covered services [11 N.C.A.C. § 12.1404].

PROCEDURAL PROTECTIONS

Free-Look Period

State law gives insurance consumers a “free-look” period in which to review and revoke a new policy if they are not fully satisfied. In order for you to receive a full

refund on a policy, you must return the policy to the company within ten days from the date the policy is received [N.C.G.S. § 58-51-10]. Medicare supplement (“Medigap”) policies and long-term care policies have a 30-day “free look” period [N.C.G.S. §§ 58-54-30, 58-55-30(f),(g)].

Grace Period to Pay Premiums

All policies must contain a grace period for late payment of premiums. Neither insurance companies nor HMOs may cancel a policy for nonpayment of the premium if it is paid during the grace period. Grace periods are not less than seven days for policies with weekly premium payments, 10 days for monthly premiums, and 31 days for all other policies [N.C.G.S. § 58-51-15(a)(3)].

Inadvertent Misstatements by Consumers

Health insurance contracts may not be valid, and the insurance company may not be responsible for the payment of claims, if there was a misstatement in the application or if the information about the medical history of the insured person was omitted. Thus, it is very important for consumers to provide accurate and complete information in the application process.

In the past, some insurance companies have used inadvertent mistakes in the original application as a way to avoid paying medical bills. State laws were enacted to give consumers some protection from their own inadvertent mistakes. During the first two years after the date of issuance of a major medical or catastrophic hospitalization policy, the insurance company may use inadvertent misstatements as grounds for voiding a policy or denying a claim. After two years, however, inadvertent misstatements may not be so used. Fraudulent misstatements (that is, statements submitted with the intent to deceive) are grounds for voiding a policy whenever the misstatement is discovered [N.C.G.S. § 58-51-15].

Notice of Nonrenewal or Discontinuance

Individuals who are covered by group policies must be given at least 45 days’ written notice before termination of an insurance policy. [N.C.G.S. § 58-51-80(g)].

Individuals covered by individual or blanket hospitalization and accident health policies must be given between 30 days’ and two years’ notice before the premium renewal date if the insurer refuses to renew the policy. In general, the notice must be equal to one-fourth the number of months of continuous coverage. So, for instance, if a policy has been in effect for two years, the insurer must give you six months’ notice that the policy is not going to be renewed. There is a minimum of 30 days’ notice for a policy that has been in effect for one year or less, up to a maximum of two years’ notice for four or more years of continuous coverage. [N.C.G.S. § 58-51-20].

Unfair Claims Settlement Practices

Insurance companies that routinely fail to acknowledge a claim or to act reasonably promptly on the payment of claims, or that fail to settle claims promptly where liability has become reasonably clear, may be committing “unfair claims settlement practices.” In these instances, the Commissioner of Insurance has the right to suspend, revoke, or refuse to renew the insurer’s license. Insurers do have the right to ask for additional claims information if the information submitted is insufficient to process the claim. Delays in settling a claim while waiting for sufficient information are not considered an unfair claims settlement practice. [N.C.G.S. §§ 58-3-100(c), 58-63-15(11)].

PROVIDER PROTECTIONS

“Gag Clauses” Prohibited

Insurers may *not* limit providers’ ability to discuss clinical treatment options with their patients, whether or not these options are covered under the benefit package. Insurers may not limit providers’ professional responsibilities to patients [N.C.G.S. § 58-3-176(a)]. Physicians and other providers have an ethical duty to explain all treatment options to their patients, regardless of whether the health plan will pay for the treatment.

Nondiscrimination Against Certain Health Professionals

Insurers cannot discriminate against providers who are located in geographic areas that contain high-risk populations. Nor can they discriminate against providers who treat patients that present a risk of higher-than-average claims or use of health care services [N.C.G.S. § 58-3-200(e)]. This section is intended to ensure that insurers do not intentionally exclude certain providers from their networks because they are more likely to treat high-risk populations.

Prohibition on Certain Managed Care Provider Incentives

Managed care plans may not offer or pay any type of material financial incentive (such as an incentive payment or bonus) to a network provider to deny, delay, or withhold medically necessary services to any specific enrollee. However, insurers are not prohibited from paying providers a financial incentive based on the provider’s aggregate services or the insurer’s financial performance [N.C.G.S. §§ 58-3-265, 135-39.4A(g)].

Prompt Payment

Normally, insurers must either pay providers or, if appropriate, deny the claim within 30 calendar days of receiving a health care bill. However, the insurer need not pay the bill immediately if the provider failed to submit information needed to process the claim or submitted the claim on the wrong form. In addition, the insurer need

not immediately pay the claim if the insurer is waiting for the enrollee to pay premiums. In these cases, the insurer must notify the provider of the missing information or other reason for the delay within the 30-day time period. Once the needed information is received, the insurer has 30 days to make the payment. If the health plan payments are not made in the proper time period, then the insurer is responsible for paying interest on the outstanding payment (at an 18% interest rate) [N.C.G.S. § 58-3-225].

Providers Protected From Retaliation When Filing Appeals on Behalf of Enrollees

Insurers are prohibited from discriminating against providers who appeal a plan's decision affecting the availability, delivery, or quality of health care services. For example, an insurer cannot retaliate against a physician who appeals the insurer's decision to deny or limit care [N.C.G.S. § 58-50-62(j)].

QUALITY ASSURANCE

Internal Quality Assurance Systems

HMOs must have an internal quality assurance system to ensure the overall performance of the HMO and the quality of health care services provided to its enrollees [11 N.C.A.C. § 20.0501 *et seq.*]. The HMO must employ a variety of tools to assess the quality of health care services provided in different types of treatment settings. The HMO must also ensure the quality of its internal administrative and utilization review operations. In addition, the system must include procedures to investigate and take corrective action in response to patient complaints about the providers' or HMO's decisions. Any HMO that delegates the quality management activities to another organization must ensure that the other organization follows state laws.

Provider Credentialing Procedures

HMOs must have systems to ensure the minimum competency of the health care providers in their networks. These are called credentialing procedures. The HMO must check physicians' credentials before listing them in its provider directory or other materials given to enrollees [11 N.C.A.C. § 20.0401 *et seq.*]. For example, the HMO must check the following information on physicians:

- ◆ Personal information
- ◆ Practice information, including the non-work hours that the provider can be contacted (call coverage)
- ◆ Education and training history
- ◆ Current provider license, registration, or certification. States where the provider has previously been licensed, certified, or registered should be listed.
- ◆ Drug Enforcement Agency registration and any prescribing restrictions

- ◆ Specialty board certification, professional and hospital affiliation
- ◆ The amount of professional liability coverage and the provider's malpractice history
- ◆ Any disciplinary actions by medical organizations and/or regulatory agencies
- ◆ Any felony or misdemeanor convictions
- ◆ The type of affiliation requested
- ◆ A statement signed and dated by the applicant attesting to the truthfulness and completeness of the information submitted

HMOs must also obtain information on health care facilities, including accreditation status from the Joint Commission on Accreditation of Health Care Organizations, state licensure information, Medicaid and Medicare certification, and evidence of current malpractice insurance.

HMOs must verify all information included in the provider's application for credentials and must reverify the provider's credentials not less than once every three years. The HMO is responsible for ensuring that these rules are followed, even if it subcontracts the credentialing process to another organization.

Provider Discipline Systems

HMOs must have a mechanism to reduce, suspend, or terminate providers from participating in the network if the HMO believes the physician is providing poor quality of care or the physician drops malpractice coverage [11 N.C.A.C. § 20.0411]. In addition, HMOs, like other health care institutions, must report to the Board of Medical Examiners any time they revoke, suspend, or limit a physician's practice privileges or when a physician decides to stop participating in the plan [N.C.G.S. § 90-14.13]. This law was established to ensure that the Board of Medical Examiners is alerted to any potential provider competence issues.

REGULATORY OVERSIGHT BY THE NC DEPARTMENT OF INSURANCE

Accountability and Enforcement Mechanisms

The NC Department of Insurance inspects domestic insurers at least every five years [N.C.G.S. § 58-2-131, 11 N.C.A.C. § 19.0106]. Insurers that are not incorporated in North Carolina can be examined more frequently.

In addition, the Department can investigate complaints outside of the normal three-year cycle. If the Department finds problems, it can seek corrective action. If the problems are significant, the Department can seek to suspend or revoke the license, issue civil penalties, or seek injunctive relief. [N.C.G.S. §§ 58-2-60, 58-2-65, 58-2-70, 58-67-140, 58-67-165].

Consumer Services Division

The NC Department of Insurance has a Consumer Services Division which can help address consumer complaints. The Department can investigate the complaint and will intervene on behalf of the consumer if it thinks the health plan is acting improperly. The Consumer Services Division is open from 8:00 A.M to 4:50 P.M. Monday through Friday. The Division can be reached at: (800) 546-5664.

Financial Solvency

North Carolina state law offers several protections to insure the financial solvency of insurance companies and HMOs and to protect enrollees in the event of possible insolvency, including adequate financial reserves, insolvency protections and procedures to help enrollees obtain alternative coverage upon insolvency. Generally, the laws governing HMOs are different than the laws governing other health insurers.

Adequate Financial Resources

North Carolina laws mandate that insurers and HMOs have minimum financial resources to protect against insolvency. The statute sets out minimum requirements for working capital, deposits, net worth, surplus and reserves. For example, HMOs must have a minimum deposit of at least \$500,000 for full-service HMOs, and must maintain a minimum net worth of at least \$1 million. Insurers must also meet minimum capital and surplus requirements. [N.C.G.S. §§ 58-67-20(a), 25, 40, 110; 58-65-95, 58-3-71, 58-13-1 *et. seq.*, 58-49-40, 58-7-75].

Insolvency Protections

HMOs have different insolvency protections than other health insurers. HMOs must ensure that providers do not collect sums from enrollees that are owed by the HMO. If the HMO does not have this protection in its provider contracts then it must set up an additional special deposit to cover unpaid claims [N.C.G.S. § 58-67-115]. Each HMO must ensure that enrollees can obtain benefits for the duration of the contract period for which premiums have been paid, even if the HMO lacks sufficient funds to continue operating (insolvency). In case of hospitalization, this applies until a member's discharge. HMOs must also have other protections against insolvency that are approved by the Commissioner of Insurance, such as a reinsurance agreement that covers the HMO against excess losses, or any other arrangement that the Commissioner may require [N.C.G.S. § 58-67-120].

Other insurers are included in the North Carolina Life and Health Insurance Guarantee Association. This Guarantee Association was created to help enrollees in the event that an insurer becomes insolvent. The Association will help pay for services up to \$300,000 for an individual, and up to \$5,000,000 for a group contract. In addition, the Association will also help locate substitute coverage [N.C.G.S. § 58-62-2 *et. seq.*].

Obtaining Other Coverage Upon Insolvency

If an HMO does become insolvent, the Insurance Commissioner has the authority to order other carriers to offer a 30-day enrollment period for enrollees of the insolvent plan. HMOs that previously offered coverage to groups enrolled in the insolvent health care plan will be the first required to offer coverage. The Commissioner may allocate the insolvent HMO's group or non-group contracts to other HMOs [N.C.G.S. § 58-67-125]. Enrollees in other health insurance plans will be assisted in obtaining substitute coverage by the Life and Health Insurance Guarantee Association [N.C.G.S. § 58-62-2 *et. seq.*].

Premium Rate Oversight

Premium Rates Established

The Department of Insurance's authority to review and approve premium rates varies, depending on the type of insurer (HMO, commercial insurer, or nonprofit) and type of product line (group or non-group). In general, the Department of Insurance must review and approve health insurance premiums in the individual, non-group market. The Department also reviews premiums for group Medicare supplements, HMOs, and for any nonprofit health insurer (such as Blue Cross Blue Shield of North Carolina) [N.C.G.S. §§ 58-51-95; 58-65-40; 58-65-45].

In the small-group market, the Commissioner has the authority to review the rating methodology [N.C.G.S. § 58-50-130(b)]. In contrast, the Commissioner does not have the authority to review the premiums charged to large-group policyholders of commercial insurers (group is defined as having more than 50 employees). In most instances involving large-group health plans, insurers must provide evidence only that the rates are established using sound actuarial principles that are certified by a recognized actuary [N.C.G.S. §58-51-85]. The Commissioner does not have the authority to review the premiums or the rating methodology.

Premium Rates Periodic Adjustments

The premiums for non-group coverage cannot be adjusted more frequently than once every 12 months and may not become effective unless the insurer has given the enrollees at least 45 days advance notice [N.C.G.S. § 58-67-50(b)(3), 58-51-95(f)]. HMOs may not adjust group rates more frequently than once every six months, and this adjustment also requires at least 45 days' advance notice. The Department of Insurance is unlikely to approve a rate adjustment in the first 12 months of enrollment.

UTILIZATION REVIEW PROVISIONS

Assessing Utilization of Health Services

Each managed care organization (MCO) that uses utilization review must have a system that collects data and assesses the use of health care services. Specifically, the system must have mechanisms to evaluate medical necessity, as well as the appropriateness, effectiveness, and efficiency of health services. The utilization review criteria must be based on sound, up-to-date clinical criteria and must be applied consistently in all appropriate reviews. Managed care organizations must monitor health care to see if providers are providing unnecessary care (overutilization) or withholding necessary care (underutilization). Any problems identified in the utilization review process should be used to improve the system [N.C.G.S. § 58-50-61(c)].

Conducting Utilization Reviews

Qualified health professionals such as nurses must make all initial utilization review determinations. These reviewers act under the direction of one of the managed care organization's physicians. An MCO physician must also review all decisions to deny requested services. The person making the utilization review decisions may not be paid on the basis of the numbers of services or treatments denied or the money saved [N.C.G.S. § 58-50-61(d)].

The MCO can conduct utilization review procedures in-house, or it can contract these functions to another body called a utilization review organization. Whether it does its own review or contracts with another organization, the MCO has overall responsibility to ensure that the review process meets state law [N.C.G.S. § 58-50-61(b)].

Medical Necessity Standards

Any plan that limits coverage to medically necessary services and supplies must use the state statutory definition of medical necessity. The state law defines medical necessity as services or supplies that are:

- ◆ Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease
- ◆ Not for experimental, investigational, or cosmetic purposes, unless allowed under N.C.G.S. § 58-3-255
- ◆ Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms
- ◆ Within generally accepted standards of medical care in the community
- ◆ Not solely for the convenience of the insured, the insured's family, or the provider

A health plan may examine cost-effectiveness when choosing between two or more services or supplies that are medically appropriate for the condition. However, a health plan may not consider cost-effectiveness in determining whether a service or supply is medically necessary [N.C.G.S. § 58-3-200(b)].

Notice to Enrollees about Utilization Review Procedures

MCOs and other utilization review organizations must notify enrollees and prospective enrollees about the review procedures, including the procedures to appeal denials of care. MCOs must have a toll-free telephone number for enrollees to use in seeking prior authorization, and must include this number on their enrollee membership cards [N.C.G.S. § 58-50-61(e)(3), (m)]. In addition, insurers must make sure the utilization review staff is accessible by telephone by monitoring the average speed of answer and call abandonment rates on at least a monthly basis.

Time Limits for Review

The MCO also has certain time limits to make utilization review determinations. MCOs must make all prospective and concurrent review determinations within three business days after the insurer obtains all necessary information about the admission, requested procedure, or health care service [N.C.G.S. § 58-50-61(f)]. Reviews of services and supplies that are conducted after the services have been provided (retrospective review) must be conducted within 30 days of the time the MCO receives the necessary information to make the determination [N.C.G.S. § 58-50-61(g)].

ACRONYMS AND GLOSSARY

ADLs	Activities of Daily Living
AHEC	Area Health Education Center
BCBSNC	Blue Cross Blue Shield of North Carolina
CAP/AIDS	Community Alternatives Program for People with AIDS or Children who are HIV-positive
CAP/C	Community Alternatives Program for Children
CAP/DA	Community Alternatives Program for Disabled Adults
CAP-MR/DD	Community Alternative Placement Program for Children and Adults with Mental Retardation or Developmental Disabilities
CSC	Child Service Coordination
C/MHC	Community or Migrant Health Center
CMS	Centers for Medicare and Medicaid Services
DEC	Developmental Evaluation Centers
DOI	Department of Insurance
DME	Durable Medical Equipment
DRG	Diagnostic Related Grouping
EMTALA	Emergency Medical Treatment and Labor Act
EOC	Evidence of Coverage
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
ERISA	Employee Retirement Income Security Act
EOB	Explanation of Benefits
FDA	Food and Drug Administration
FFS	Fee-for-Service
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health Maintenance Organization
HEDIS	Health Plan Employer Data and Information Set
IDEA	Individuals with Disabilities Education Act
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
LOS	Length of Stay
LTC	Long-term Care
MCO	Managed Care Organization
MEWA	Multiple Employer Welfare Arrangement
NAIC	National Association of Insurance Commissioners
NC DHHS	North Carolina Department of Health and Human Services
NCQA	National Committee for Quality Assurance
NP	Nurse Practitioner
OB-GYN	Obstetrician-Gynecologist
OTC	Over the Counter medications
PA	Physician Assistant
PCP	Primary Care Provider
POS	Point-of-Service plan
PPO	Preferred Provider Organization
PCCM	Primary Care Case Management
PSA	Prostrate Specific Antigen
UCR	Usual, Customary and Reasonable Charges
UR	Utilization Review
URO	Utilization Review Organization
US DHHS	US Department of Health and Human Services

ACRONYMS AND GLOSSARY

- Access:** The ease and ability of a patient to obtain needed care in a timely manner. In managed care, access to certain providers may be limited because the provider does not contract with the health plan or is not in the plan's approved network. Access may also be limited by a health plan's requirement that services be approved in advance by a PCP or the plan.
- Access Standards:** The process by which a plan determines if there are sufficient numbers and types of providers available to care for members. Access standards often compare the number of providers contracting with a plan with the number of members enrolled in a plan in a particular geographic area (provider:patient ratios), the distance or travel time needed to obtain care from certain providers, and how long members have to wait from the day they make an appointment until the day of the appointment.
- Accreditation:** A quality review process by an outside agency that looks at how well an organization provides services and the system it uses to continuously improve those services. The National Committee for Quality Assurance (NCQA) conducts most of the HMO reviews. Hospitals and other health care facilities must go through a separate review process to become accredited. These reviews are often conducted by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Accreditation should be distinguished from state licensure, as accreditation is a voluntary process. Further, the accrediting bodies (NCQA and JCAHO) do not have enforcement mechanisms to ensure plans provide the required quality of, and access to, care.
- Activities of Daily Living (ADLs):** Refers to basic functions individuals living independently can perform. These are part of the criteria used to evaluate if an individual needs home health services or needs to be in an assisted-living, residential or nursing home facility. The following seven activities comprise the main ADLs: eating, bathing, dressing, getting to the toilet, moving from place to place, getting outside and walking.
- Adjusted Community Rating:** A system which sets health insurance premiums based on the average cost of providing health care for everyone in the plan (or "community"), with some adjustments based on demographic and claims experience factors. In North Carolina, insurers and plans that sell policies to small employer groups may charge higher rates based on age, gender, family size and geographic area. In addition, small group carriers can vary the premiums charged to small employers with similar age, gender, family size and location by no more than 20%. This additional charge is permitted to adjust for the use of health services by small-employer groups. [N.C.G.S. § 58-50-130(b)].

Administrative Costs:	The amount of money spent on administering a health plan. Administrative costs typically include those costs the health plan incurs in paying claims, enrollment, marketing, or the utilization review process.
Ambulatory Review:	Review of the appropriateness, necessity, efficacy or efficiency of health care services performed or provided in an outpatient setting. [N.C.G.S. § 58-50-61(a)(17)(a)].
Annual Limits:	The maximum amount of money that the insurer or plan will pay for a member's health care services in a given year. The insurer can have an annual limit for all health care services, or may have separate annual limits for specific services (for example, prescription drugs or durable medical equipment). Some insurers also have a lifetime limit, which is the maximum amount of money the insurer or plan will pay during the lifetime of a particular member.
Any Willing Provider Laws:	Any willing provider laws require plans to include in their provider network any provider who agrees to accept the plan's compensation and abide by the plan's internal quality assurance, utilization review and other administrative rules.
Appeal:	A request by a member to their health plan to review a noncertification decision—that is, a decision to deny or limit care recommended by the member's physician or provider.
Authorization:	Approval for the provision of health services and referrals to specialists to obtain care outside of the network, or for coverage of a hospitalization. A primary care provider (PCP) can often authorize the provision of health services and referrals to specialists. However, sometimes the health plan requires member to obtain prior authorization from the health plan for non-emergency hospital admissions or certain high-cost or high-technology procedures.
Balance Billing:	Billing the patient directly for the provider's charges that remain after the health plan pays the portion it is willing or obligated to pay. For example, Dr. Jones charges \$115 for a certain procedure. The insurance company will only pay 80% of the usual, customary and reasonable charges (UCR). In this instance, the insurer sets \$100 as the UCR rate, so pays \$80 (80% of \$100). Under balance billing, Dr. Jones would then charge the patient \$35 (the \$20 coinsurance and the remaining \$15 of her bill).
BCBSNC:	Blue Cross Blue Shield of North Carolina.
Board Certified:	Physicians or other health care professionals who have passed a medical specialty board and have been certified to practice in that specialty. Board certification should be distinguished from state licensure, as board certification is a voluntary process.

Bonuses:	A reimbursement system used by some plans to give providers an incentive to be cost-efficient and reduce unnecessary services. Some plans may also pay bonuses based on the results of member satisfaction surveys or other quality of care measures.
Brand Name Drugs:	Medications that are made by the pharmaceutical company that first developed them and have a patent protection on the name and exact formulary of the drug. After the patent ends, other companies can replicate the active ingredients and offer a generic alternative, which is usually significantly cheaper than the brand name drug.
Capitation:	A fixed periodic payment the plan pays to a physician, group practice, hospital or network of providers. The capitation payment is calculated to cover the expected costs of providing certain services to patients over a period of time. The provider gets the same payment each month (or other fixed time period), regardless of the amount or type of services actually rendered. Capitation payment systems can cover just the cost of providing primary care (“primary care capitation”), may cover the costs of primary care and some specialty care (“partial capitation”) or may also include the costs of hospitalization (“full or global capitation”).
Carolina Access:	See PCCM.
Care Coordinator:	A person who acts as a coordinator to ensure that patients receive all needed health care services. Within governmental programs, care coordinators also help patients remove barriers to access, and help link patients to other needed services in the community (such as financial assistance, housing, social services, etc.). Sometimes plans or insurance companies use the term care coordinator for a case manager who is also concerned with controlling health care costs.
Case Management:	A coordinated set of activities to manage the health care services provided to patients with serious, complicated or prolonged health conditions. [N.C.G.S. § 58-50-61(a)(17)(b)]. Case management services may also be offered in governmental programs. See Care Coordinator.
Case Manager:	A person (often a nurse or social worker) who coordinates all of a person’s care. Case managers are often employed by insurance companies or health plans to help coordinate and manage care provided to members with complex or costly medical conditions. In these instances, case managers also help ensure patients receive appropriate care in the least costly setting. Case managers may also be employed by governmental agencies. See Care Coordinator.

Centers for Medicare and Medicaid Services (CMS):	The federal agency responsible for administering the Medicaid and Medicare programs. CMS is part of the U.S. Department of Health and Human Services. (CMS was formerly known as the Health Care Financing Administration, or HCFA.)
Certification:	A determination by an insurer or its designated Utilization Review Organization that an admission, continued stay in a hospital, or other health care services has been reviewed and satisfies the insurer or plan's requirements for coverage. [N.C.G.S. § 58-50-61(a)(17)(c)].
Chemical Dependency:	Physical addiction to a drug or substance, such as alcohol or heroine, that results in biological changes (including withdrawal) if discontinued suddenly.
Child Service Coordination (CSC):	A publicly-funded program that works with families who have children under the age of five with certain medical, developmental, or social/emotional needs. Each family is assigned a care coordinator who works with them to identify their strengths and outstanding needs. Special emphasis is placed on helping families obtain preventive, specialty and support services.
Children Special Health Services:	A publicly-funded program designed to provide health care for children with special health needs. The two main components of this program are: (1) A network of specialty clinics that provides diagnostic evaluations and treatment; and (2) Reimbursement for certain medical services not covered by Medicaid.
Clinical Guidelines:	The criteria used that outlines the process and standard of care to be given for a specific health condition, disease or illness. Clinical guidelines are usually developed by practicing health care providers, and are an attempt to identify the best way to prevent, detect or treat a particular medical condition. Managed care organizations and other health care institutions use clinical guidelines as a way to ensure that practitioners are providing appropriate care, and to standardize care across providers. Clinical guidelines may also be called clinical protocols, practice guidelines, or medical protocols.
Clinical Peer:	“A health care professional who holds an unrestricted license in a state of the United States, in the same or similar specialty, and routinely provides the health care services subject to utilization review.” [N.C.G.S. § 58-50-61(a)(1)]. Plans must use clinical peers in the second-level grievance hearings to determine if requested services should be approved.
Clinical Review Criteria:	The criteria used that outlines the process and standard of care to be given for a specific health condition, disease or illness. May include clinical protocols or practice guidelines used by an insurer to determine the services or treatments that are appropriate and medically necessary for a person with a specific health condition, disease or illness. [N.C.G.S. § 58-50-61(a)(2)].

- Clinical Trials:** Clinical trials are research studies to determine whether new drugs or treatments are safe and effective. Phase I clinical trials are the first evaluation to determine the safety, safe dosage range or side effects of new drugs or treatments. Phase I trials are usually conducted among a small group of people (20-80). Phase II clinical trials test the drugs or treatments among a larger group of people (100-300). Phase III clinical trials examine the drug or treatment among an even larger group of people (1,000-3,000). These trials are used to confirm effectiveness, monitor side effects, and compare the drug or treatment to commonly used treatments. Phase IV studies are conducted after the drug or treatment has been marketed. These studies determine the effect of the drugs or treatments in various populations, and monitor any side effects from long-term use. For more information on clinical trials, check the National Institute of Health: <http://www.clinicaltrials.gov/>.
- Coinsurance:** The percentage of a provider's fee that the patient is expected to pay. For example, some traditional insurance companies pay 80 percent of a doctor's usual, customary and reasonable (UCR) fees. The patient is expected to pay the 20% difference between the doctor's UCR fees and what the insurance company pays. The 20% which the patient pays is called the coinsurance.
- Community Alternatives Program for People with AIDS (CAP/AIDS):** The Medicaid community alternatives program for persons with AIDS as well as children who are HIV-positive. The program helps individuals who would otherwise need nursing facility care, but who can reside safely in a private residence with additional services and supports.
- Community Alternatives Program for Children (CAP/C):** The Medicaid community alternatives program for children was established to provide medically fragile children with a cost-effective home care alternative to institutional care. It provides a package of home care and other support services to enable the children to remain with their families in a private residential setting.
- Community Alternatives Program for Disabled Adults (CAP/DA):** The Medicaid community alternatives program for older adults or people with disabilities who would otherwise need nursing facility care. The program provides services and supports to enable older adults and people with disabilities to be served in the community rather than an institutional setting.

Community Alternative Placement Program for Children and Adults with Mental Retardation or Developmental Disabilities (CAP-MR/DD):	The Medicaid-financed community alternative placement program for children and adults with mental retardation or developmental disabilities provides support services to enable individuals with developmental disabilities or mental retardation to remain in the community instead of residing in an institutional setting.
Community and Migrant Health Center (C/MHC):	Health care facilities located in medically underserved areas that provide comprehensive primary and preventive care to patients on a sliding fee scale. CHCs receive grant money from the federal government to cover the cost of providing care to uninsured low-income patients as well as for providing other services to help patients access services, such as transportation or translation.
Concurrent Review:	Utilization review conducted during the course of a patient's hospital stay or course of treatment, to determine whether the hospital stay or treatment is still necessary. [N.C.G.S. § 58-50-61(a)(17)(d)].
Congenital Abnormality:	Physical or mental health problem that develops during pregnancy or the birth of a child.
Continuing Care Retirement Community:	A facility which contracts with individuals to provide lodging, nursing services, medical services and other health related services for at least one year. Continuing care retirement communities typically provide a continuum of lodging facilities, from independent living to assisted living facilities and nursing home care.
Copayment (Copay):	A fixed payment that must be paid out-of-pocket by a patient upon receiving health care services. In some HMOs, for instance, you pay a \$20 copayment for a doctor visit, or a \$10 copayment for a prescription.
Cost Sharing:	A generic term used to describe any payment the member must make for covered services. Different cost-sharing methods include deductibles, coinsurance and copayments.
Covered Services:	Services the HMO or insurance company will cover. Not all services listed in the insurance company's or HMO's list of covered services will automatically be covered. Often, the insurance company or HMO will further limit covered services, for example, by limiting services to those deemed "medically necessary." Other services may be limited based on other criteria, such as number of visits or dollar limits.

Credentialing:	The process that health plans use to ensure that health care providers and institutions meet certain minimum competency and malpractice coverage requirements. Typically, plans verify a professional's medical license, board certification (if any), malpractice history, and educational background.
Custodial Care:	Services that relate to daily activity that do not require skilled medical personnel to provide, such as cleaning, dressing, eating and paying bills.
Day Treatment:	Health services provided on an outpatient basis during normal business hours.
Deductible:	The amount an insured person must pay out-of-pocket each year before the insurance plan begins to cover health care costs. A policy with an individual deductible of \$300 and a family deductible of \$900 means that each individual person in the family must pay \$300 of medical expenses before the policy begins paying benefits for that individual. Once the out-of-pocket expenses of the family members reaches \$900, then the insurance company will pay for the covered services provided to all of the insured family members.
Department of Insurance (DOI):	The NC agency charged with regulating and overseeing insurance companies and HMOs.
Developmental Evaluation Centers (DEC):	A publicly funded program with 18 centers located throughout North Carolina whose interdisciplinary staffs provide clinical evaluations, treatment, and case management services for children who have known or suspected developmental disabilities.
Diagnostic Related Groups (DRG):	This classification system was developed in the Medicare program (but used by some private insurers) to pay hospitals based on a patient's primary and secondary diagnosis, surgical procedures, age, sex, and presence of complications.
Discharge Planning:	The process used to determine how a patient's ongoing health care needs will be coordinated and managed after being discharged from a hospital or other health care facility. [N.C.G.S. § 58-50-61(a)(17)(e)].
Disenrollment:	When either an individual or group leaves a particular health plan.
Drug Utilization Review:	A review process used to determine the appropriateness of a physician's medication prescribing patterns. Drug utilization reviews are typically conducted by other providers, and used to provide feedback to practitioners.
Dual Eligible:	A person who is eligible for both Medicare and Medicaid.

Durable Medical Equipment (DME):	Equipment to assist individuals with injury or disease-related problems that can be used repeatedly. Examples of DME include wheelchairs, walkers, and home hospital beds.
Early and Periodic Screening, Diagnosis and Treatment (EPSDT):	A program that provides well-baby and well-child screenings to children receiving Medicaid. Children are entitled to receive all the needed health care services or treatment identified as part of the screening, as long as the federal Medicaid laws permit states to cover that service. In North Carolina, the EPSDT program is known as Health Check.
Efficacy:	Under <i>ideal conditions</i> , how well a treatment, therapy or procedure produces a desired health outcome (cure, alleviation of pain, return of functional abilities).
Effectiveness:	Under <i>real life</i> conditions, how well a treatment, therapy or procedure produces a desired health outcome (cure, alleviation of pain, return of functional abilities).
Employee Retirement Income Security Act (ERISA):	A Federal law that prevents states from enacting laws or regulations that have an impact on employer welfare plans, including employer sponsored health benefits. States can regulate insurance carriers or HMOs. If an employer purchases a regulated insurance or HMO plan, then the enrollees are covered by the state consumer protection laws. However, employers that pay directly for all of health services (self-funded or self-insured plans) are not subject to the same state laws.
Emergency Medical Condition:	North Carolina state law uses a “prudent layperson” definition of emergency medical condition. That is, state law considers certain acute symptoms to be emergency medical conditions if a prudent layperson, possessing an average knowledge of health and medicine, thinks that in the absence of immediate medical attention, the medical condition is likely to place him or her (or in the case of a pregnant woman, her unborn child) in serious jeopardy, or cause serious impairment to bodily functions or bodily organs. [N.C.G.S. § 58-50-61(a)(4)].
Emergency Medical Treatment and Active Labor Act (EMTALA)	Originally part of the Comprehensive Omnibus Reconciliation Act of 1986 (COBRA). It requires all Medicare participating hospitals to screen any individual who comes to the emergency department requesting treatment for a medical condition. If the screening determines that the person does have an emergency, then the hospital must either treat or stabilize the person to transfer the individual to another hospital.
Emergency Services:	“Health care items and services needed to screen for or treat an emergency medical condition until the condition is stabilized, including pre-hospital care and ancillary services routinely available in the emergency department.” [N.C.G.S. § 58-50-61(a)(5)].

Enrollee, Insured or Member:	The person covered under the health insurance or HMO plan. The member may include the employee (if covered by an employer group health plan) and his or her dependents.
Evidence of Coverage (EOC):	The document given to HMO enrollees that describes the covered benefits and exclusions, utilization review requirements, cost-sharing, and other coverage provisions. The evidence of coverage is similar to a policy contract that other insurers issue.
Explanation of Benefits (EOB):	A statement sent to insured which explains what services were or were not covered, and the amount the insurer or HMO paid for the services.
Experimental Services:	A new treatment developed from research that is different from the commonly provided standard of care for a given disease, illness or condition. Experimental or investigational drugs, treatments or procedures are typically not approved for use by the FDA, and may be the subject of clinical trials to test its toxicity level, efficacy or effectiveness.
Food and Drug Administration (FDA):	Federal agency that regulates food, drugs, devices, and biological products.
Fee-for-Service (FFS):	Payments to providers based on the specific services rendered. Fee-for-service systems are typically distinguished from capitation payments, which involve a fixed periodic payment per individual regardless of what services are provided. Under a fee-for-service system, the provider is paid each time he or she provides a different service.
Fee Schedule:	A provider reimbursement system that pays providers according to a fixed fee-schedule established by an insurer, HMO or government.
Formulary:	List of pharmaceuticals that the managed care organization will cover. A formulary may limit the type and number of medications available for a physician to select from when treating any given disease, illness or condition.
Gatekeeper:	In managed care systems, a primary care provider who is responsible for authorizing treatment by specialists or non-emergency hospitalizations. If you are in a managed care system that uses “gatekeepers,” you must see your “gatekeeper” before visiting a specialist (for example, a cardiologist).
Generic:	Drug produced after the patent on a brand name drug ends. Generics contain the same active ingredients as the brand name drug.

- Grievances:** A written complaint submitted by a member, which challenges the insurer's decisions, policies or actions related to availability, delivery or quality of health care services; claims payment or handling; reimbursement for services; the contractual relationship between the member and the insurer; or the outcome of an appeal of a noncertification decision. [N.C.G.S. § 58-50-61(a)(6)].
- Group Insurance Plan:** Health benefits purchased to cover individuals who are grouped together for purposes other than purchasing health insurance coverage. Employers often sponsor group insurance plans for their employees. Group plans tend to be less expensive than individual non-group plans because the insurer or HMO can spread the administrative costs and health risks over more individuals. Unions and churches may also sponsor group insurance plans.
- Guaranteed Issue:** Law requiring insurers that participate in the small group market to offer health benefit plans to any small group that applies for coverage. In certain limited situations, state law also requires insurers and HMOs to guarantee issue a health benefit plan to individuals seeking non-group coverage. The goal is to increase access to health insurance for small groups/individuals who, without this type of law, may be turned down by health insurers due to health problems or risks.
- Guaranteed Renewability:** Law requiring insurers to renew the current health plan as long as the insurer continues to offer coverage in that market and the purchaser has not failed to pay premiums, engaged in fraudulent activities or moved from the coverage area. These laws prohibit insurers from terminating health benefits due to enrollees' health status or past use of services.
- Health Benefit Plan:** Health insurance coverage provided by an HMO, Blue Cross Blue Shield, a commercial insurance company, or a plan provided by a multiple welfare arrangement (MEWA). The definition of a health benefit plan (or health plan as used in these documents) does not include long term care, accident, credit, disability, dental, vision or specific disease insurance policies. Under state laws, health benefit plans do not include Medicare supplements, workers' compensation, medical payments under auto or homeowners insurance or hospital income policies. These plans are governed by different laws. [N.C.G.S. § 58-3-200(a)(1)].
- Health Check:** A publicly funded Medicaid initiative to improve Medicaid-eligible children's access to preventive health services. Medicaid-eligible children are eligible to receive comprehensive health care check-ups, immunizations, vision, hearing and dental screening services on a regular basis throughout childhood. Any medically necessary diagnostic or treatment services needed to treat the conditions identified during the screenings will also be covered. Health Check is the name for North Carolina's EPSDT program.

Health Insurance Portability and Accountability Act (HIPAA):	Passed by Congress in 1996, it established minimum standards for access, portability and renewability of coverage for all health plans, including self-funded or ERISA plans. Most of the protections apply to large and small group purchasers and certain individuals leaving or changing group coverage. Provisions of the bill include guaranteed issue, guaranteed renewability, limits on pre-existing condition waiting periods, nondiscrimination based on health status, portability and special enrollment periods. HIPAA also contains provisions to protect the confidentiality of medical records.
Health Maintenance Organization (HMO):	A type of health care organization that manages and finances its members' care. Historically, HMOs emphasized preventive care in order to keep their members healthy. HMOs have exclusive provider networks and often use primary care providers as "gatekeepers." Gatekeepers are responsible for arranging the patient's referral to a specialist or admission to a hospital. While most HMOs use gatekeepers, some HMOs have "open access" plans. These plans allow the patient to choose any primary care provider or specialist in the network without a referral. HMOs also may use reimbursement systems such as fixed payments for each member (called "capitation") or performance incentives to encourage providers to be more cost conscious.
Health Plan Employer Data and Information Set (HEDIS)®:	A standardized set of performance measures that consumers and other purchasers can use to compare health plans. HEDIS® collects information to measure effectiveness of care, access/availability of care, satisfaction with care, health plan stability, informed health care choices, and health plan descriptive information.
In-Area:	The geographic area covered by the managed care organization. Typically, this includes areas where the HMO has provider contracts and enrollees. Generally, managed care organizations will not pay for care sought by members outside of this area, unless it is urgent care or an emergency.
Incentive Payments:	Financial payments managed care organizations give to physicians or facilities to encourage certain behavior. Examples of the types of behaviors for which an MCO may provide incentive payments include cost containment and improving the quality of care provided.
Indemnity Insurance:	Traditional major medical insurance that pays a percentage of the provider's charges. Typically, indemnity plans pay providers on a fee-for-service or discounted fee-for-service basis. Many insurers, for example, will pay providers 80 percent of the usual, customary and reasonable charges for a comprehensive array of services. An indemnity plan that includes a network of providers is generally referred to as a Preferred Provider Organization (PPO).

Individuals with Disabilities Education Act (IDEA):	The publicly funded early intervention program is actually two separate programs for young children with special needs. The Infant-Toddler program covers children from birth through age two, and the Pre-school program covers children from three to five (or until the child enters kindergarten).
Insured:	The person covered under the health insurance plan. The insured person may include the employee (if covered by a employer group health plan) and his or her dependents. Insured typically refers to a person covered through an insurance company, whereas member or enrollee typically refers to a person covered by an HMO.
Insurer:	An entity that writes a health benefit plan and that is an insurance company. Sometimes also used generically to include health maintenance organizations and multiple employer welfare arrangements.
Investigational Services:	See Experimental Services.
Joint Commission on Accreditation of Healthcare Organizations (JCAHO or Joint Commission):	An organization that accredits hospitals, home care, other medical facilities, and most recently, health networks.
Late Enrollee:	Generally refers to individuals or their dependents who do not choose to be covered by employer-sponsored coverage when initially offered at the start of employment, during the annual open-enrollment period, or within 30 days of birth in the case of a newborn dependent, or within 30 days of adoption, but do enroll at a later point in time.
Length of Stay (LOS):	The term which refers to the length of stay in hospitals. Often, performance measures examine the average length of stay.
Lifetime Limits:	The maximum amount of money that the insurer or HMO will pay for care over the member's lifetime. The insurer can have a lifetime limit for all health care services, or may have separate lifetime limits for specific services. Some insurers also have annual limits, which is the maximum amount of money the insurer or HMO will pay for the member during a particular year.
Long-Term Care (LTC):	Health services provided in non-hospital facilities for chronically ill or disabled individuals. May include custodial care, maintenance or rehabilitation care for chronic, debilitating conditions. Long-term care can be provided on an inpatient basis (for example, in nursing homes or group homes), or may be provided on an outpatient basis (such as a dult day health care), or in the person's home.

Major Medical Insurance:	A medical insurance plan that provides broad coverage for hospitalizations and outpatient expenses. These policies often have deductibles, coinsurance, and other limitations, but generally provide comprehensive coverage of health care services.
Managed Behavioral Health Plan:	A separate managed care company that typically subcontracts with either an insurance company or another HMO to manage the mental health and substance abuse services provided to the enrollees. In North Carolina, Magellan Behavioral Health, Cigna and Value Behavioral Health are some of the larger managed behavioral health providers.
Managed Care Plan:	A health benefit plan that creates a financial incentive to use providers that are in the health plan's network. Some managed care plans limit coverage to care obtained from network providers. Others pay more if the member obtains care from within the network, but will pay something for covered services obtained from non-network providers (PPOs or POS). Managed care systems often use utilization review mechanisms to oversee the amount and type of health care services being used. Some HMOs also use provider reimbursement methods that discourage unnecessary care.
Managed Care Organization (MCO):	A generic term applied to managed care companies such as Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs) or Point of Service (POS) plans.
Mandated Benefits:	Certain health services that insurers and HMOs must cover because of either state or federal laws. North Carolina law, for example, mandates that insurers and HMOs cover emergency services, pap smears, mammograms and PSAs.
Medicaid:	A governmental health insurance program that provides assistance with medical costs for certain low- and moderate-income individuals and families. The federal government sets the broad guidelines for the program. A state is then given considerable latitude to establish eligibility criteria and to determine what services will be covered for the state's Medicaid population.
Medical Loss Ratio:	The percentage of the health plan's health care related revenues (i.e. premiums) that is used to pay for health care services in contrast to profit or administrative overhead.
Medical Necessity:	See Medically Necessary Services or Supplies.

Medically Necessary Services or Supplies:

State law defines medically necessary services or supplies as “Covered services or supplies that are:

- ◆ Provided for the diagnosis, treatment, cure or relief of a health condition, illness, injury or disease;
- ◆ Not for experimental, investigational, or cosmetic purposes, unless authorized under N.C.G.S. § 58-3-255;
- ◆ Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms;
- ◆ Within generally accepted standards of medical care in the community;
- ◆ Not solely for the convenience of the insured, the insured’s family or the provider.”

[N.C.G.S. § 58-3-200(b)]. HMOs and insurers can compare the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered.

Medicare:

The national health insurance program provided primarily to older adults (65 or older) and some disabled people who are eligible for Social Security, Railroad Retirement, or Disability benefits. Medicare has two parts: Part A, which is hospital insurance, and Part B, which covers the costs of physicians and other providers. In addition, Medicare offers Part C (Medicare Plus Choice), which expands the availability of managed care arrangements to Medicare recipients.

Multiple Employer Welfare Arrangement (MEWA):

Employee benefit plans created by groups of employers that band together to provide health insurance or other employee benefits to their employees. MEWAs are most often found among small employer groups belonging to a common trade association.

National Association of Insurance Commissioners (NAIC):

Professional or trade association for state Departments of Insurance.

National Committee for Quality Assurance (NCQA):

A private, independent organization that reviews and assesses the quality of services provided by health plans through an accreditation process. In addition, NCQA created a uniform data collection system to compare the quality of services provided by HMOs (see HEDIS).

Network:

A group of providers (physicians, hospitals, pharmacies, and other health care providers) that contract with managed care organizations to provide health care services to its members.

Noncertification:	A determination by an insurer or its designated utilization review organization to deny, reduce or terminate a requested service, treatment or procedure. The denial must be based on a review and a decision that the requested service, treatment or procedure does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness. [N.C.G.S. § 58-50-61(a)(13)].
Non-Group Insurance Plan:	A health insurance plan that is purchased separately, and not part of a group. Non-group plans are sometimes referred to as plans purchased in the individual market. Individuals or families who purchase health insurance directly from the insurer or HMO, and not through an employer, church or association, are usually purchasing non-group insurance plans.
Non-Participating Provider:	Physician/provider who does not contract with the managed care organization. Care by nonparticipating providers is generally not covered by HMOs without prior authorization. However, Point-of-Service and Preferred Provider Organizations allow members to obtain care from nonparticipating providers, but require the member to pay more for the services.
NC Department of Health and Human Services (NC DHHS):	The state agency responsible for administering Medicaid, NC Health Choice, public health agencies, mental health, developmental disabilities and substance abuse programs, aging programs, as well as other human services programs. In addition, NC DHHS also has responsibility to license and inspect certain health care facilities.
NC Health Choice:	A publicly funded program that offers free or reduced cost health insurance for uninsured children birth through age 18. Uninsured children must have a family income that is equal to or less than 200 percent of the federal poverty guidelines, and must not qualify for Medicaid.
Nursing Facility/Nursing Home:	Residential care for individuals requiring access to medical nursing assistance or staff 24 hours a day.
Off-Label Drugs:	Drugs used for health purposes other than their FDA-approved use(s).
Office Visit:	Outpatient health services provided in a physician's office, group practice, hospital outpatient clinic, rural or community health center.
Open-Access Plan:	An HMO that allows enrollees to see any provider within the network without a referral from a primary care provider. Open-access plans are distinguished from "gatekeeper" plans, which usually require a primary care provider to authorize all visits to specialists within the network.

Open Enrollment Period:	Designated time of year during which individuals have the opportunity to join or switch health plans. Usually applies to individuals in group plans who did not enroll when initially offered the opportunity (i.e., at time of hire or birth/adoption of child), or who want to switch benefit plans. Individuals who do not enroll during this period may have to wait until the next open enrollment period to participate in the health plan. Or they may be subject to certain pre-existing waiting periods for “late enrollees.”
Out-of-Area:	Refers to geographic area where a managed care organization does not have contracts with providers or facilities to care for its members. Often if individuals move out of the MCO’s contract area, they can no longer participate in the plan’s benefits. If members are traveling out of the area, usually only emergency and urgent care services are covered, and the coverage for the care may not be as comprehensive as for care sought within the plan’s service area. Some plans do have affiliates or national networks that their members may be able to participate in with prior approval.
Out-of-Area Emergency:	Care sought for an emergency health condition (see emergency care definition) outside of a managed care organization’s geographic service area.
Out-of-Network:	Care provided by health care providers that are not a part of the managed care organization’s network. Some plans allow members to seek care out of the network, but at a higher out-of-pocket cost and/or deductible to the member (POS and PPO plans). HMOs generally do not cover any of the costs for care obtained out of network, unless contracting health care providers are unavailable to meet the health needs of the insured without unreasonable delay.
Out-of-Network Referral:	Referrals to providers or facilities that are not a part of the HMO’s provider network. Out-of-network care usually requires prior authorization by the HMO and may be limited to cases where contracting health care providers are unavailable to meet the health needs of the insured without unreasonable delay.
Out-of-Pocket:	Money spent by members for health/medical care that the health plan either requires them to pay (such as a deductible or co-pay) or does not cover. Does not include health insurance premium payments.

Out-of-Pocket Limit:	Maximum amount established by a health plan that an individual member or his or her family will have to pay toward their medical care in a given year in deductibles, coinsurance and co-payments. Once this limit is met, the plan will pay 100 percent of the costs of future covered health services until the new policy year begins. However, a health plan may specifically exclude certain costs from the out-of-pocket maximum. For example, an individual member may not be able to count the costs of non-covered services that he or she incurs, or any costs incurred by failing to follow the health plan's prior approval process.
Outcome:	Usually refers to the resulting health or well-being of an individual following some treatment, screening, prevention program or other health promotion intervention. Outcomes typically refers to long-term effects, and may include changes in health status, control of chronic illness, decrease in hospitalizations, ability to engage in the activities of daily living, or mortality. Used to help determine effectiveness of a treatment or intervention.
Outpatient:	Health services that are provided during an office visit or other ambulatory facility. Patients who receive outpatient services do not need to stay overnight.
Outpatient Drugs:	Prescribed medications obtained by the patient at a pharmacy to be taken at home. Medications that are provided as a part of inpatient care or administered in a physician's office, during ambulatory surgery or in clinic setting are not usually considered outpatient medications.
Over-the-Counter (OTC):	Drugs or medications that are available without a prescription. Usually these drugs are not covered by health plans and must be paid in full by the patient. The plan may deny payment even if a prescription is written for the medication and it is available over the counter.
Participating Hospital/Facility:	A hospital or health care facility such as a nursing home or long-term care facility that contractually agrees to provide health care services to members in return for a payment from the managed care organization.
Participating Provider:	A provider who contractually agrees to provide health care services to members in return for payments from the managed care organization. [N.C.G.S. § 58-50-61(a)(14)].
Patient Advocate:	Individual who works with the patient to ensure that he or she receives needed and appropriate care in a timely manner. Patient advocates generally are external to the managed care organization or insurer, and can act more independently to advocate on the patient's behalf.

Peer Review:	Mechanism of ensuring quality of care within the medical community. The quality assurance review is conducted by health care professionals (peers) to ensure that care provided and services used are appropriate. It is also used to identify fraud and other abuses of health care payment systems.
Performance Measure:	A way to compare health plans on different measurements (such as quality of care, health outcomes, consumer satisfaction, etc). HEDIS [®] is one of the most commonly employed set of performance measures used to compare different HMOs.
Point-of-Service (POS) Plan:	A type of HMO plan that gives patients the opportunity to see providers outside of the network. Patients who use the HMO network of providers pay less than patients who see providers outside the network. The HMO may still require the use of a gatekeeper to authorize in-network or out-of-network services.
Policy Contract:	The document given to insured individuals that describes the covered benefits and exclusions, utilization review requirements, cost-sharing, and other coverage provisions. The policy contract is similar to the evidence of coverage that HMOs provide to their members.
Portability:	Allows individuals to change from one group plan to another without being subject to a pre-existing condition exclusionary period. In order to gain the benefit of this protection, insured individuals must change health plans without a gap of more than 63 days, and must have met prior pre-existing condition waiting periods, if any.
Preauthorization:	The health plan's approval that a requested hospital admission, treatment or procedure is a covered service and is medically necessary and appropriate. Managed care organizations often require that a member or insured individual obtain prior authorization from the health plan before a hospital admission or selected health care services, treatment or procedure will be covered. See also prior authorization or prior approval.
Precertification or Pre-Admission Screening:	Authorization that must be obtained from the health plan before inpatient care is provided in order for the plan to pay for the hospitalization. Pre-admission screening reviews the appropriateness of the requested care, while precertification may specify the allowable length of stay in addition to what services/procedures will be covered.
Pre-Existing Condition:	Mental or physical conditions for which an individual sought medical advice, care or treatment within six months prior to the enrollment in the health plan.
Preferred Provider:	A provider who has agreed to accept the health plan's reimbursement and agreed to other contractual requirements that an insurer imposes (such as quality assurance or utilization review protocols).

Preferred Provider Organization (PPO): PPOs manage medical costs by creating a network of providers who are willing to accept lower reimbursement rates. The providers are often required to meet other requirements, including the insurance company's utilization review procedures. Patients may choose any health care provider, but they will have to pay additional money if they use a provider who is not part of the PPO network. PPOs are usually associated with traditional insurance companies, not HMOs.

Prescription Drug: Medication that can only be obtained with a physician's order. Drugs that are available over the counter, even if the physician writes an order for them, may not be covered by a health plan.

Preventive Care: Medical care provided to protect against, minimize the risk of, or help in the early detection of health problems or diseases. Examples of preventive care include immunizations, pap smears and mammograms.

Primary Care: Comprehensive, coordinated and continuous health care provided by a provider who is trained to manage most of a person's health care needs. Primary care practitioners are most often trained in family medicine, general internal medicine, or general pediatrics.

Primary Care Case Management (PCCM): Primary care case management programs only operate within the Medicaid program. In PCCM programs the Medicaid agency pays a primary care provider a monthly management fee to manage the patient's care. However, the doctor is reimbursed for the services he or she provides on a fee-for-service basis. The primary care provider acts as the patient's "gatekeeper" and must authorize all non-emergency visits to the hospital and all referrals to specialists. In North Carolina, the PCCM program is called Carolina Access.

Primary Care Providers (PCP): Generally, most plans allow family physicians, general practitioners, pediatricians or general internists to serve as primary care providers. Often, advance practice nurses (such as nurse practitioners), or physician assistants (PAs) can be the primary care provider. Sometimes, the health plan will allow an OB-GYN to serve as a primary care provider. Primary care is distinguished from specialty care, which is often concerned with a particular health condition or body organ. Examples of specialty care would include oncologists who deal with cancer or cardiologists who specialize in hearts.

Prior Approval/Prior Authorization/Preauthorization: Verification by the health plan that the requested services are appropriate and will be covered. Must be obtained before services are rendered.

Prospective Review: Utilization review conducted before an admission or a course of treatment. Prospective review includes pre-authorization and pre-certification requirements that may be needed before a patient can be admitted to a hospital or obtain certain health care. [N.C.G.S. § 58-50-61(a)(17)(f)].

Provider:	Person or institution providing health care. Providers include doctors, nurses, physician assistants (PAs), therapists, dentists, hospitals, clinics, nursing homes, pharmacies, companies that sell medical equipment, etc.
Prostrate Specific Antigen (PSA):	A mandated benefit under North Carolina law to test men for prostate cancer.
Prudent Layperson:	Term used to describe how an average, reasonable person who is untrained in medicine would interpret and respond to a health problem. Most often used in determining whether or not emergency care services should be covered.
Quality Assurance:	Refers to a health plan's internal processes to verify that the care provided to its members meets the health plan's or government's quality standards.
Quality Improvement:	Refers to a health plan's internal process for developing better ways to improve the quality of care provided to its members.
Readmission Review:	Review by the health plan of patients who are admitted a second time soon after being discharged from inpatient care for the same health condition. Readmission reviews are typically conducted to determine if the initial hospital discharge was too early and whether the second hospitalization is necessary.
Referral:	Physician recommendation to a patient to see another physician for further evaluation or treatment. In HMOs that use gatekeepers, services provided by specialists or other practitioners require a referral by the patient's primary care provider in order for the health plan to cover the cost of the care.
Rehabilitation:	Services designed to assist an individual in adapting to a loss of physical or mental functioning, or to restore normal functioning. Usually provided following an accident or illness, rehabilitation is often a time-limited benefit that is only authorized if improvement is expected within a short period.
Rehabilitation Facility:	Organization that provides rehabilitation services on outpatient and/or inpatient basis.
Residential Facilities:	Facilities that provide custodial care to persons who are not able to live independently. Residential facilities may include nursing homes, assisted living facilities or group homes.
Respite Care:	Temporary supervision and care of individuals with chronic, debilitating conditions who require constant monitoring. Respite care is provided to give families who normally care for these individuals a rest.

Retrospective review:	Utilization review of services and supplies that have already been provided to a patient to determine whether they were medically necessary or appropriate. [N.C.G.S. § 58-50-61(a)(17)(g)].
Rider:	A health insurance or HMO policy that supplements regular coverage. For example, some insurers exclude prescription drug or mental health coverage. These services are not included in the comprehensive policy but may be purchased separately through a rider.
Risk:	A term used in managed care systems when some of the financial risk of paying for the costs of the health services provided to enrollees is transferred from a HMO or POS to a provider or group of providers. Capitation, withholds and bonuses are all types of systems that transfer some of the financial risk of caring for the patient to the health care provider. PPOs may not transfer financial risk to providers.
Second Opinion:	The term used when an insured person obtains a clinical evaluation by another provider in addition to the one who originally recommended a proposed service. Second opinions are used to assess the medical necessity and appropriateness of the proposed service. Sometimes insurers or HMOs require the insured individual to seek a second opinion before covering certain services. At other times the insurer or health plan may be willing to pay for the second opinion at the request of the insured individual. [N.C.G.S. § 58-50-61(a)(17)(h)].
Self-Insured or Self-Funded Plans:	Health plans in which the employer is actually the insurer and is responsible for paying the medical bills of those insured through the plan. Even though the employer may contract with an HMO, insurer or other third-party administrator to administer the coverage and pay the claims, the employer retains responsibility for paying all the medical claims. These plans are governed by federal ERISA laws rather than state insurance regulations, and are sometimes called ERISA plans.
Skilled Care:	Care that can only be provided by trained medical personnel. May also require specific licensure or credentials.
Skilled Nursing Facility:	Organization that provides care to patients whose conditions require around-the-clock access to licensed nursing services. Typically referred to as nursing homes.
Stabilize:	Provision of medical care that is appropriate to prevent the person's health condition from deteriorating. [N.C.G.S. § 58-50-61(a)(16)].

Standing Referral:	A referral from a primary care provider to a specialist for a specified period of time (often to cover a course of illness). Health plans must have a process to allow patients with chronic, degenerative, disabling or life-threatening illnesses or conditions to obtain extended or “standing” referrals to in-network specialists. The standing referrals can not exceed 12 months, and must be part of a treatment plan coordinated with the primary care physician, specialist and health plan.
Subscriber:	See Enrollee.
Substance Abuse:	Use of alcohol or drugs that impairs an individuals’ ability to function. The impairment can be mental, physical or financial to the individual abusing the substance or others around him or her.
Telephone Triage System:	Process by which medical staff review patient complaints over the phone to determine urgency of care needed. The medical staff follows the pre-established protocols to advise the patient, recommend when and where to seek care and/or contact the physician on call for assistance.
Termination Date:	The last day a health plan will cover services. The last effective date of the health insurance or HMO contract.
Tertiary Care:	Specialty and sub-specialty care that often uses new technologies and therapies to treat rare conditions or unusual cases. Usually available to patients with conditions that are too complicated, too advanced or too unusual to be treated by physicians or general acute care hospitals.
Third-Party Payer:	The organization responsible for paying for the medical costs incurred by enrollees of a health plan. Examples of third-party payers include commercial insurance plans, Blue Cross Blue Shield, Medicaid or Medicare.
Third-Party Administrator:	Company hired to handle only the non-clinical aspects of a health plan’s business, such as billing, collecting premiums and paying physicians.
Urgent Care:	Care for immediate (acute), but not life threatening health problems. An example of a condition that might require urgent care is an urinary tract infection that left untreated over a weekend could progress and damage the kidneys but does not require an emergency room visit.
Urgent Care Center:	Free-standing clinic, usually open during the evening, that sees patients with immediate health needs. Urgent care centers often do not provide regular, ongoing or preventive care.
US Department of Health and Human Services (US DHHS):	The federal agency responsible for administering most of the federal health programs in the country, including Medicare, Medicaid, public health agencies, maternal and child health programs, as well as other human services programs.

Usual, Customary and Reasonable Charges (UCR):	The prevailing amounts that health care providers charge for medical services. Insurance carriers sometimes set their reimbursement rates as a percentage of usual, customary and reasonable (UCR) charges.
Utilization Review (UR):	A system designed to monitor the use of, or evaluate the medical appropriateness, efficacy or efficiency of health care services, procedures, providers or facilities. Utilization review may include ambulatory review, case management, certification, concurrent review, discharge planning, prospective review, retrospective review or second opinions. [N.C.G.S. § 58-50-61(a)(17)].
Utilization Review Organizations (URO):	Independent organizations that conduct utilization review for a managed care plan. UROs do not include insurers or health plans that conduct their own internal utilization review. [N.C.G.S. § 58-50-61(a)(18)].
Waiting Period:	Length of time a health plan excludes coverage for a new enrollee's pre-existing health condition. Under the Health Insurance Portability and Accountability Act, the maximum pre-existing condition waiting period is 12 months, or 18 months for late enrollees. However, individuals who change health plans and have a gap in coverage of no more than 63 days will not be subject to a new pre-existing condition waiting period if they already met their pre-existing condition exclusionary period in their prior coverage.
Wellness Program:	Educational and clinical services designed to improve patients' health by promoting healthy behaviors, such as eating well or exercising, and assisting them in altering unhealthy behaviors such as smoking.
Withholds:	A payment system in which the HMO withholds a portion of the provider's payment. This may be refunded based on a set of performance criteria. For example, a provider or group of providers may have a withhold fund established to help offset all or part of the costs of specialty care. If funds remain in the specialty fund at the end of the quarter (or year), the funds may be redistributed back to the providers.

PART VIII

APPENDICES

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FEDERAL POVERTY GUIDELINES

Each year the U.S. Department of Health and Human Services issues Federal Poverty Guidelines (FPG). These guidelines are used to determine financial eligibility for many programs. The 2003 guidelines are shown here. We have listed some of the commonly used percentages of FPG, along with some of the programs that use that income level.

100% FPG Children ages 6-18 with incomes equal to or less than 100% FPG meet the income eligibility requirements for the Medicaid program for Infants and Children (MIC). Older adults (65 or older) or people with disabilities meet the income requirements for the Medicaid program for the Aged, Blind and Disabled (AABD), and the MQB-Q programs (See Chapter 12).

Family Size	Annual Income	Monthly Income
1	\$8,980	\$749
2	12,120	\$1,010
3	15,260	\$1,272
4	18,400	\$1,534
5	21,540	\$1,795
6	24,680	\$2,057
7	27,820	\$2,319
8	30,960	\$2,580
Each additional person, add	+ \$3,140	+ \$262

115% FPG People with incomes less than or equal to 115% FPG meet income requirements for the Cancer Control Program (See Chapter 15).

Family Size	Annual Income	Monthly Income
1	\$10,327	\$861
2	13,938	1,162
3	17,549	1,463
4	21,160	1,764
5	24,771	2,065
6	28,382	2,366
7	31,993	2,667
8	35,604	2,967
Each additional person, add	+ \$3,611	+ \$301

125% FPG Individuals with incomes at or below 125% FPG meet income requirements for the AIDS Drug Assistance Program (See Chapter 15).

Family Size	Annual Income	Monthly Income
1	\$11,225	\$936
2	15,150	1,263
3	19,075	1,590
4	23,000	1,917
5	26,925	2,244
6	30,850	2,571
7	34,775	2,898
8	38,700	3,225
Each additional person, add	+ \$3,925	+ \$328

133% FPG Children ages 1-5 in families with incomes at or below 133% FPG meet income requirements for the Medicaid for Infants and Children Program (MIC) (See Chapter 12).

Family Size	Annual Income	Monthly Income
1	\$11,944	\$996
2	16,120	1,344
3	20,296	1,692
4	24,472	2,040
5	28,649	2,388
6	32,825	2,736
7	37,001	3,084
8	41,177	3,432
Each additional person, add	+ \$4,177	+ \$349

135% FPG Older adults (65 or older) and people with disabilities with incomes at or below 135% FPG meet income eligibility requirements for the MQB-B and MQB-E programs (See Chapter 12).

Family Size	Annual Income	Monthly Income
1	\$12,123	\$1,011
2	16,362	1,364

150% FPG Children with incomes at or below 150% of poverty level, but higher than Medicaid income requirements, meet financial eligibility requirements for the NC Health Choice program with no cost sharing. Children with incomes above 150% FPG, but equal to or less than 200% FPG are eligible for NC Health Choice with an annual enrollment fee and some copayments (See Chapter 13).

Family Size	Annual Income	Monthly Income
1	\$13,470	\$1,123
2	18,180	\$1,515
3	22,890	\$1,908
4	27,600	\$2,300
5	32,310	\$2,693
6	37,020	\$3,085
7	41,730	\$3,478
8	46,440	\$3,870
Each additional person, add	+ \$4,710	\$393

185% FPG Infants under age 1 in families with incomes at or below 185% FPG meet income requirements for the Medicaid for Infants and Children program (MIC). Pregnant women at or below this income meet the financial eligibility requirements for the Medicaid for Pregnant Women program (MPW) (See Chapter 12).

Family Size	Annual Income	Monthly Income
1	\$16,613	\$1,385
2	22,422	1,869
3	28,231	2,353
4	34,040	2,837
5	39,849	3,321
6	45,658	3,805
7	51,467	4,289
8	57,276	4,773
Each additional person, add	+ \$5,809	+ \$485

200% FPG Children in families with incomes at or below 200% FPG, but higher than Medicaid eligibility requirements, meet income requirements for NC Health Choice (See Chapter 13). In addition, some working disabled people with incomes equal to or less than 200% FPG can qualify for Medicaid M-WD program (See Chapter 12).

Family Size	Annual Income	Monthly Income
1	\$17,960	\$1,497
2	24,240	2,020
3	30,520	2,544
4	36,800	3,067
5	43,080	3,590
6	49,360	4,114
7	55,640	4,637
8	61,920	5,160
Each additional person, add	+ \$6,280	+ \$524

Updated information on federal poverty guidelines is available from the Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services: <http://aspe.hhs.gov>.

COUNTY DIRECTORY

The following list provides contact information for Public Health Departments, Mental Health/Developmental Disabilities/Substance Abuse Services Area Programs, Departments of Social Services, Social Security Administration Offices, Legal Services Offices, Community and Migrant Health Centers, Rural Health Centers, School-Based Health Centers, and Private Free Clinics and Pharmacy Services. All are listed alphabetically by county. Some offices and clinics are not located in all counties. Where appropriate, the nearest office is listed, even if it is not located in your county. For the clinics, you may want to look at nearby counties to see what else may be available in your area.

Many local health departments do not offer comprehensive primary care services; although some do. We tried to list when health departments offer dental services or comprehensive primary care. If the health department in your area does not appear to provide the care you need, you should call to check. Several health departments are trying to add additional services, especially dental care, or they may be able to refer you to care, even if it is not provided on-site.

Dental care is not available at many clinics. Clinics that do provide some level of dental services are indicated, but this does not mean they provide only dental care. Most provide medical care as well. Also note that these clinics may only provide very limited dental services.

Finally, some clinics are part of a network of clinics. In this case, the main organization or company's name is given for informational purposes.

Alamance County

Public Health Department
319 N. Graham-Hopedale Road,
Suite B
Burlington 27217
336-227-0101
Provides dental services

MH/DD/SAS Area Office
Alamance-Caswell Area
MH/DD/SA Authority
319 N. Graham-Hopedale Road,
Suite A
Burlington 27215
336-513-4200

Department of Social Services
319 N. Graham-Hopedale Road,
Suite C.
Burlington 27217
336-570-6532

Social Security Administration
2643 Ramada Road
Burlington 27215
336-226-8444

Legal Services
North State Legal Services
114 W. Corbin Street
Hillsborough 27278
919-732-8137
800-672-5834

Community Health Center
Charles Drew Community Health
Center
221 North Graham-Hopedale
Road
Burlington 27217
336-570-3739
Piedmont Health Services

Community Health Center
Scott Clinic
5270 Union Road
Burlington 27217
336-421-3247
Piedmont Health Services

Private Free Clinic
Open Door Clinic of Alamance
County
Graham-Hopedale Road
Burlington 27215
910-570-1300
Provides dental services

Greensboro AHEC
Moses Cone Health System
1200 North Elm Street
Greensboro, NC 27401-1020
Tel: 336-832-8025
Fax: 336-832-7591

Alexander County

Public Health Department

322 First Avenue S.W.
Taylorsville 28681
828-632-9704
Provides dental services

MH/DD/SAS Area Office

Foothills Area MH/DD/SA
Program
306 S. King Street
Morganton 28655
704-438-6230

Department of Social Services

334 7th Street SW
Taylorsville 28681
828-632-1080

Social Security Administration

231 1st Avenue SW
Hickory 28602
828-328-2166

Legal Services

Catawba Valley Legal Services
211 East Union Street
Morganton
828-437-8280

Northwest AHEC

Wake Forest University School of
Medicine
Medical Center Boulevard
Winston-Salem, NC 27157-1060
Tel: 336-713-7000
Fax: 336-713-7027

Alleghany County

Public Health Department

Appalachian District Health
Department
141 Health Center Drive
Boone 28607
828-264-4995
Provides primary care services to
all ages

MH/DD/SAS Area Office

New River Behavioral Health
Care
895 State Farm Road, Suite 508
Boone
828-264-9007

Department of Social Services

P. O. Box 247
Sparta 28675
336-372-2411

Social Security Administration

Federal Building, Room 101
207 W. Main Street
Wilkesboro 28697
336-667-8506

Legal Services

Legal Services of the Blue Ridge
171 Grand Boulevard
Boone 28607
828-264-5640

Farmworker Health Program, Migrant Health Center

Alleghany Partnership for
Children
176 North Main Street
P.O. Box 1832
Sparta 28675
336-372-6583

Northwest AHEC

Wake Forest University School of
Medicine
Medical Center Boulevard
Winston-Salem, NC 27157-1060
Tel: 336-713-7000
Fax: 336-713-7027

Anson County

Public Health Department

110 Ashe Street
Wadesboro 28170
704-694-5188
Provides primary care services to
all ages
Provides dental services

MH/DD/SAS Area Office

Sandhills Center for
MH/DD/SA Services
P. O. Box 9
West End
910-673-9111

Social Security Administration

1793 E. Broad Avenue
Rockingham 28379
910-895-9097

Legal Services

North State Legal Services
114 W. Corbin Street
Hillsborough 27278
919-732-8137
800-672-5834

Legal Services

North State Legal Services,
Branch Office
105 W. Wade Avenue
Pausons Building, Suite 206
Wadesboro 28170
704-694-2464
877-694-2464

Community Health Center

Anson Regional Medical Services-
Morven Medical
Highway 52 South
Morven 28119
704-851-9331

Department of Social Services

118 N. Washington Street
Wadesboro 28170
704-694-9351

Community Health Center
Anson Regional Medical Services-
Wadesboro Medical and Dental
203 Salisbury Street
P.O. Box 192
Wadesboro 28170
704-694-6700
Provides dental services

Charlotte AHEC
P.O. Box 32861
Carolinas Healthcare System
1366 East Morehead Street
Charlotte, NC 28204
Tel: 704-355-7820
Fax: 704-355-7825

Ashe County

Public Health Department
Appalachian District Health
Department
141 Health Center Drive
Boone 28607
828-264-4995

MH/DD/SAS Area Office
New River Behavioral Health
Care
895 State Farm Road, Suite 508
Boone
828-264-9007

Department of Social Services
150 Government Circle, Suite
1400
Jefferson 28640
336-219-2734

Social Security Administration
Federal Building, Room 101
207 W. Main Street
Wilkesboro 28697
336-667-8506

Legal Services
Legal Services of the Blue Ridge
171 Grand Boulevard
Boone 28607
828-264-5640

School-Based Health Center
Ashe Middle School
Sponsored by Appalachian
District Health Department

Northwest AHEC
Wake Forest University School of
Medicine
Medical Center Boulevard
Winston-Salem, NC 27157-1060
Tel: 336-713-7000
Fax: 336-713-7027

Avery County

Public Health Department
Toe River District Health
Department
861 Greenwood Road
Spruce Pine 28777
828-765-2368
Provides dental services

MH/DD/SAS Area Office
New River Behavioral Health
Care
895 State Farm Road, Suite 508
Boone
828-264-9007

Department of Social Services
P. O. Box 309
Newland 28657
828-733-8230

Social Security Administration
231 1st Avenue SW
Hickory 28602
828-328-2166

Legal Services
Legal Services of the Blue Ridge
171 Grand Boulevard
Boone 28607
828-264-5640

Northwest AHEC
Wake Forest University School of
Medicine
Medical Center Boulevard
Winston-Salem, NC 27157-1060
Tel: 336-713-7000
Fax: 336-713-7027

Beaufort County

Public Health Department
1436 Highland Drive
P.O. Box 579
Washington 27889
252-946-1902

MH/DD/SAS Area Office
Tideland Mental Health Center
1308 Highland Drive
Washington
252-946-8061

Department of Social Services
P. O. Box 1358
Washington 27889
252-975-5500

Social Security Administration

719 W. 15th Street
 Washington 27889
 252-946-0117

Legal Services

Pamlico Sound Legal Services
 213 Pollock Street
 New Bern 28650
 252-637-9502
 800-672-8213

Legal Services

Pamlico Sound Legal Services,
 Branch Office
 427 W. Evans Street
 Greenville 27858
 252-758-0113
 800-682-4592

Eastern AHEC

P.O. Box 7224, 2000 Venture
 Tower Drive
 Greenville, NC 27835-7224
 Tel: 252-744-8214
 Fax: 252-744-8596

Bertie County**Public Health Department**

Dyer and Harner Streets
 P.O. Box 189
 Elizabeth City 27907
 252-338-4400

MH/DD/SAS Area Office

Roanoke-Chowan Human
 Services Center
 Route 3, Box 22 A
 Ahoskie
 252-332-4137

Department of Social Services

P. O. Box 627
 Windsor 27983
 252-794-5320

Social Security Administration

1118 N. Academy Street
 Ahoskie 27910
 252-332-3413

Legal Services

Legal Services of the Coastal
 Plains
 610 East Church Street
 Ahoskie 27910
 252-332-5124
 800-682-0010

Community Health Center

Bertie County Rural Health
 Association
 Corner of Hospital Drive
 P.O. Box 628
 Windsor 27983
 252-794-3042

Community Health Center

Lewiston-Woodville Family
 Medical Center
 307 South Main Street
 P.O. Box 39
 Lewiston 27849
 252-348-2545
 Bertie County Rural Health
 Association, Inc.

**Community Health Center,
Migrant Health Center**

Windsor Family Medical Center
 306 Winston Lane
 Windsor 27983
 252-794-3042

Eastern AHEC

P.O. Box 7224, 2000 Venture
 Tower Drive
 Greenville, NC 27835-7224
 Tel: 252-744-8214
 Fax: 252-744-8596

Bladen County**Public Health Department**

300 Mercer Mill Road
 Elizabethtown 28337
 910-862-6900

MH/DD/SAS Area Office

Southeastern Regional Mental
 Health Center
 207 W. 29th Street
 Lumberton
 910-738-5261

Department of Social Services

P. O. Box 365
 Elizabethtown 28337
 910-862-6800

Social Security Administration

302 Liberty Street
 Whiteville 28472
 910-642-7182

Legal Services

Legal Services of the Lower Cape
 Fear
 201 N. Front Street
 Wilmington 28401
 910-763-6207
 800-672-9304

Southern Regional AHEC

1601 Owen Drive
 Fayetteville, NC 28304
 Tel: 910-678-7230
 Fax: 910-678-7279

Brunswick County

Public Health Department

25 Courthouse Drive
P.O. Box 9
Bolivia 28422
919-253-2250
919-457-5281

MH/DD/SAS Area Office

Southeastern Center for
MH/DD/SAS
P.O. Box 1230
Wilmington
910-796-3130

Department of Social Services

P. O. Box 219
Bolivia 28422
910-253-2077

Social Security Administration

1528 S. 16th Street
Wilmington 28401
910-815-4733

Legal Services

Legal Services of the Lower Cape
Fear
201 N. Front Street
Wilmington 28401
910-763-6207
800-672-9304

Private Free Clinic

Brunswick County Partnership
for Children
201 Village Road, Suite 300
P. O. Box 3050
Shalotte 28459
910-754-3333
Provides dental services

Private Free Clinic

New Hope Clinic
P.O. Box 10601
Southport 28461
910-457-6044

Coastal AHEC

P.O. Box 9025, 2131 S. 17th
Street
Wilmington, NC 28402-9025
Tel: 910-343-0161
Fax: 910-762-9203

Buncombe County

Public Health Department

35 Woodfin Street
Asheville
828-250-5203
Provides primary care services to
all ages
Provides dental services

MH/DD/SAS Area Office

Blue Ridge Center for
MH/DD/SAS
356 Biltmore Avenue
Asheville 28801
828-258-3500

Department of Social Services

P. O. Box 7408
Asheville 28802
828-250-5500

Social Security Administration

20 Regent Park Boulevard
Asheville 28806
828-251-9941

Legal Services

Appalachian Legal Services
29 Ravenscroft Drive
Asheville 28801
828-236-1080

Community Health Center

Western North Carolina
Community Health Services
10 Ridgelawn Road
Asheville 28806
828-285-0622
Western North Carolina
Community Health Services, Inc.

Community Health Center

Minnie Jones Family Health
Center
1 Granada Street
Asheville 28806
282-251-2455
Western North Carolina
Community Health Services, Inc.

Private Free Clinic

ABCCM Medical Ministry
155 Livingston Street
Asheville 28801
828-259-5339
Provides dental services

School-Based Health Center

Asheville High School
Sponsored by Buncombe County
Health Department

School-Based Health Center

Asheville Middle School
Sponsored by Buncombe County
Health Department

School-Based Health Center

Erwin Middle School
Sponsored by Buncombe County
Health Department

Mountain AHEC

501 Biltmore Avenue
Asheville, NC 28801-4686
Tel: 828-257-4400
Fax: 828-257-4768

Burke County

Public Health Department

700 E. Parker Road
P.O. Drawer 1266
Morganton
828-439-4413
Provides dental services

MH/DD/SAS Area Office

Foothills Area MH/DD/SA
Program
306 S. King Street
Morganton 28655
704-438-6230

Department of Social Services

P. O. Box 549
Morganton
828-439-2000

Social Security Administration

231 1st Avenue SW
Hickory 28602
828-328-2166

Legal Services

Catawba Valley Legal Services
211 East Union Street
Morganton
828-437-8280

Private Free Clinic

Good Samaritan Clinic
P.O. Box 3601
Morganton
828-439-9948

Northwest AHEC

Wake Forest University School of
Medicine
Medical Center Boulevard
Winston-Salem, NC 27157-1060
Tel: 336-713-7000
Fax: 336-713-7027

Cabarrus County

Public Health Department

1307 South Cannon Boulevard
Kannapolis 28083
704-920-1000
Provides dental services

MH/DD/SAS Area Office

Piedmont Area MH/DD/SAS
245 LePhillip Court
Concord 28025
704-721-7000

Department of Social Services

1303 South Cannon Boulevard
Kannapolis 28083
704-939-1400

Social Security Administration

830 Florence Street N.W.
Concord 28027
704-788-3130

Legal Services

Legal Services of the Southern
Piedmont
1431 Elizabeth Avenue
Charlotte 28204
704-786-4145
800-849-8009

Legal Services

Legal Services of the Southern
Piedmont, Branch Office
206-B N. Hayne Street
Monroe 28110
704-786-4145
800-849-8009

Legal Services

Legal Services of the Southern
Piedmont, Branch Office
133 Union Street
Concord 28025
704-786-4145
800-849-8009

Private Free Clinic

The Community Free Clinic
1018 Lee-Ann Drive NE
Concord 28025
704-782-0932
Provides dental services

Charlotte AHEC

P.O. Box 32861
Carolinas Healthcare System
1366 East Morehead Street
Charlotte, NC 28204
Tel: 704-355-7820
Fax: 704-355-7825

Caldwell County

Public Health Department

1966-B Morganton Boulevard,
S.W.
Lenoir 28645
828-757-1200
Provides primary care to all ages
Provides dental services

MH/DD/SAS Area Office

Foothills Area MH/DD/SA
Program
306 S. King Street
Morganton 28655
704-438-6230

Department of Social Services

1966-H Morganton Boulevard
SW
Lenoir 28645
828-757-1180

Social Security Administration

231 1st Avenue SW
Hickory 28602
828-328-2166

Legal Services

Catawba Valley Legal Services
 211 East Union Street
 Morganton
 828-437-8280

Private Free Clinic

Helping Hands Clinic of Caldwell
 County
 P.O. Box 621
 Lenoir 28645

Rural Health Center

Collettsville Medical Center
 NC Highway 90
 P.O. Drawer 9
 Collettsville 28611
 828-754-2400

Rural Health Center

Happy Valley Medical Center
 1345 NC Hwy 268
 P.O. Box 319
 Patterson 28661
 828-754-6850

Northwest AHEC

Wake Forest University School of
 Medicine
 Medical Center Boulevard
 Winston-Salem, NC 27157-1060
 Tel: 336-713-7000
 Fax: 336-713-7027

Camden County**Public Health Department**

Albemarle Regional Health
 Services
 711 Roanoke Avenue
 P.O. Box 189
 Elizabeth City 27909
 252-338-4400
 Provides dental services

MH/DD/SAS Area Office

Albemarle Mental Health Center
 and DD/SAS
 P.O. Box 326
 Elizabeth City 27907
 252-335-0431

Department of Social Services

P. O. Box 70
 Camden 27921
 252-331-4787

Social Security Administration

124 Rich Boulevard
 Elizabeth City
 252-338-1155

Eastern AHEC

P.O. Box 7224, 2000 Venture
 Tower Drive
 Greenville, NC 27835-7224
 Tel: 252-744-8214
 Fax: 252-744-8596

Legal Services

Legal Services of the Coastal
 Plains
 610 East Church Street
 Ahoskie 27910
 252-332-5124
 800-682-0010

Carteret County**Public Health Department**

Courthouse Square
 Beaufort 28516
 252-728-8401

MH/DD/SAS Area Office

Neuse Center for MH/DD/SAS
 P.O. Box 1636
 New Bern
 252-636-1510

Department of Social Services

P. O. Box 779
 Beaufort 28516
 252-728-3181

Legal Services

Pamlico Sound Legal Services
 213 Pollock Street
 New Bern 28650
 252-637-9502
 800-672-8213

Legal Services

Pamlico Sound Legal Services,
 Branch Office
 427 W. Evans Street
 Greenville 27858
 252-758-0113
 800-682-4592

Private Free Clinic

Broad Street Clinic Foundation
 500 North 35th Street
 Morehead City 28557
 252-726-4562

Eastern AHEC

P.O. Box 7224, 2000 Venture
 Tower Drive
 Greenville, NC 27835-7224
 Tel: 252-744-8214
 Fax: 252-744-8596

Social Security Administration

2836 Neuse Boulevard
 New Bern
 252-637-1703

Caswell County

Public Health Department

189 County Park Road
P.O. Box 1238
Yanceyville 27379
336-694-4129
Provides primary care services to all ages

MH/DD/SAS Area Office

Alamance-Caswell Area
MH/DD/SA Authority
319 N. Graham-Hopedale Road,
Suite A
Burlington 27215
336-513-4200

Department of Social Services

P.O. Box 1538
Yanceyville 27379
336-694-4141

Social Security Administration

1624 Way Street
Reidsville 27320
336-342-7796

Legal Services

North State Legal Services
114 W. Corbin Street
Hillsborough 27278
919-732-8137
800-672-5834

Community Health Center

Caswell Family Medical Center
439 US Highway 158 West
P.O. Box 1448
Yanceyville
336-694-9331

Community Health Center, Farmworker Health Program

Prospect Hill Health Center
140 Main Street
P.O. Box 4
Prospect Hill 27314
336-562-3311
<http://www.piedmonthhealth.org>
Piedmont Health Services
Provides dental services

Greensboro AHEC

Moses Cone Health System
1200 North Elm Street
Greensboro, NC 27401-1020
Tel: 336-832-8025
Fax: 336-832-7591

Catawba County

Public Health Department

3070 11th Avenue Drive SE
Hickory 28602
828-695-5800
Provides dental services

MH/DD/SAS Area Office

Mental Health Services of
Catawba County
3050 11th Avenue Drive, SE
Hickory 28602
828-326-5900

Department of Social Services

P. O. Box 669
Newton 28658
828-695-5600

Social Security Administration

231 1st Avenue SW
Hickory 28602
828-328-2166

Legal Services

Catawba Valley Legal Services
211 East Union Street
Morganton
828-437-8280

Private Free Clinic

Cooperative Christian Ministries
31 First Street
Hickory 28603
828-345-0854

School-Linked Health Center

Catawba County HD Center
Sponsored by Catawba County
Health Department

Northwest AHEC

Wake Forest University School of
Medicine
Medical Center Boulevard
Winston-Salem, NC 27157-1060
Tel: 336713-7000
Fax: 336-713-7027

Chatham County

Public Health Department

80 East Street
P.O. Box 130
Pittsboro 27312
919-542-8214
Provides primary care services to all ages
Provides dental services

MH/DD/SAS Area Office

Orange-Person-Chatham
MH/DD/SA Program
101 E. Weaver Street, Suite 300
Carrboro 27510
919-913-4000

Department of Social Services

P. O. Box 489
Pittsboro 27312
919-542-2759

Social Security Administration

1013 Spring Lane
Sanford 27330
919-775-1033

Legal Services

North State Legal Services
114 W. Corbin Street
Hillsborough 27278
919-732-8137
800-672-5834

Community Health Center
Haywood-Moncure Community
Health Center
7228 Pittboro-Monclure Road
Moncure 27559
919-542-4991
Piedmont Health Services
Provides dental services

Community Health Center
Siler City Community Health
Center
401-B North Ivey Avenue
Siler City 27344
919-933-8494
Piedmont Health Services

School-Based Health Center
Horton Middle School
Sponsored by Chatham County
Health Department

Greensboro AHEC
Moses Cone Health System
1200 North Elm Street
Greensboro, NC 27401-1020
Tel: 336-832-8025
Fax: 336-832-7591

Cherokee County

Public Health Department
228 Hilton Street
Murphy 28906
828-837-7486
Provides dental services

MH/DD/SAS Area Office
Smoky Mountain Center for
MH/DD/SAS
P. O. Box 127
Sylva 28779
828-586-5501

Department of Social Services
40 Peachtree Street, Suite 200
Murphy 28906
828-837-7455

Social Security Administration
80 Westgate Plaza
Franklin 28734
828-369-2684

Legal Services
Western North Carolina Legal
Services
1286 W. Main Street
Sylva 28779
828-586-8931
800-458-6817

Rural Health Center
Chatuge Family Practice
1251 Medical Parkway, # F
Murphy 28906
828-837-4202

School-Based Health Center
Hiwassee Dam Union School
Sponsored by Cherokee County
Health Department

Mountain AHEC
501 Biltmore Avenue
Asheville, NC 28801-4686
Tel: 828-257-4400
Fax: 828-257-4768

Chowan County

Public Health Department
Albemarle Regional Health
Services
711 Roanoke Avenue
P.O. Box 189
Elizabeth City 27909
252-338-4400
Provides dental services

MH/DD/SAS Area Office
Albemarle Mental Health Center
and DD/SAS
P.O. Box 326
Elizabeth City 27907
252-335-0431

Department of Social Services
P. O. Box 296
Edenton 27932
252-482-7441

Social Security Administration
124 Rich Boulevard
Elizabeth City
252-338-1155

Legal Services
Legal Services of the Coastal
Plains
610 East Church Street
Ahoskie 27910
252-332-5124
800-682-0010

Eastern AHEC
P.O. Box 7224, 2000 Venture
Tower Drive
Greenville, NC 27835-7224
Tel: 252-744-8214
Fax: 252-744-8596

Clay County

Public Health Department

Riverside Circle
P.O. Box 55
Hayesville 28904
828-389-8052

Provides dental services

MH/DD/SAS Area Office

Smoky Mountain Center for
MH/DD/SAS
P. O. Box 127
Sylva 28779
828-586-5501

Department of Social Services

P. O. Box 147
Hayesville 28904
828-389-6301

Social Security Administration

80 Westgate Plaza
Franklin 28734
828-369-2684

Legal Services

Western North Carolina Legal
Services
1286 W. Main Street
Sylva 28779
828-586-8931
800-458-6817

Rural Health Center

Chatuge Family Practice
Church Street
P.O. Box 1309
Hayesville 28904
828-389-6347

Mountain AHEC

501 Biltmore Avenue
Asheville, NC 28801-4686
Tel: 828-257-4400
Fax: 828-257-4768

Cleveland County

Public Health Department

315 Grover Street
Shelby 28150
704-484-5100

Provides primary care services to
children ages birth through 20
and pregnant women
Provides dental services

MH/DD/SAS Area Office

Pathways MH/DD/SA
2505 Court Drive
Gastonia 28054
704-867-2361

Department of Social Services

P.O. Drawer 9006
Shelby 28151
704-487-0661

Social Security Administration

707 Schenck Street
Shelby 28150
704-480-6202

Legal Services

Catawba Valley Legal Services
211 East Union Street
Morganton
828-437-8280

School-Based Health Center

Burns High School
Sponsored by Cleveland County
Health Department

School-Based Health Center

Crest High School
Sponsored by Cleveland County
Health Department

School-Based Health Center

Kings Mountain High School
Sponsored by Cleveland County
Health Department

School-Based Health Center

Shelby High School
Sponsored by Cleveland County
Health Department

Charlotte AHEC

P.O. Box 32861
Carolinas Healthcare System
1366 East Morehead Street
Charlotte, NC 28204
Tel: 704-355-7820
Fax: 704-355-7825

Columbus County

Public Health Department

Miller Building
P.O. Box 810
Whiteville 28472
919-640-6614

Provides primary care services to
all ages
Provides dental services

MH/DD/SAS Area Office

Southeastern Regional Mental
Health Center
207 W. 29th Street
Lumberton
910-738-5261

Department of Social Services

P. O. Box 397
Whiteville 28472
910-642-2800

Social Security Administration

302 Liberty Street
Whiteville 28472
910-642-7182

Legal Services

Legal Services of the Lower Cape
Fear
201 N. Front Street
Wilmington 28401
910-763-6207
800-672-9304

**Farmworker Health Program,
Migrant Health Center**
Columbus County Community
Health Center
209 West Virgil Street
Whiteville 28472
910-641-0202

Rural Health Center
Columbus County Community
Health
209 West Virgil Street
Whiteville 28472
910-641-0202

Coastal AHEC
P.O. Box 9025, 2131 S. 17th
Street
Wilmington, NC 28402-9025
Tel: 910-343-0161
Fax: 910-762-9203

Craven County

Public Health Department
2818 Neuse Boulevard
P.O. Drawer 12610
New Bern 28562
252-636-4960
Provides primary care to children
ages birth through 20
Provides dental services

MH/DD/SAS Area Office
Neuse Center for MH/DD/SAS
P.O. Box 1636
New Bern
252-636-1510

Department of Social Services
P. O. Box 12039
New Bern 28561
252-636-4900

Social Security Administration
2836 Neuse Boulevard
New Bern
252-637-1703

Legal Services
Pamlico Sound Legal Services
213 Pollock Street
New Bern 28650
252-637-9502
800-672-8213

Legal Services
Pamlico Sound Legal Services,
Branch Office
427 W. Evans Street
Greenville 27858
252-758-0113
800-682-4592

Private Free Clinic
MERCIClinic
1315 Tatum Drive
P.O. Box 15254
New Bern
252-633-1599

Private Pharmacy Assistance
Senior Pharmacy Program
3405 Trent Road
P.O. Box 14930
New Bern
252-638-3657

Eastern AHEC
P.O. Box 7224, 2000 Venture
Tower Drive
Greenville, NC 27835-7224
Tel: 252-744-8214
Fax: 252-744-8596

Cumberland County

Public Health Department
227 Fountainhead Lane
Fayetteville 28301
910-433-3700
Provides primary care services to
all ages
Provides dental services

MH/DD/SAS Area Office
Cumberland Area MH/DD/SA
Program
P. O. Box 3069
Fayetteville
910-323-0601

Department of Social Services
P. O. Box 2429
Fayetteville 28302
910-323-1540

Social Security Administration
111 Lamon Street
Fayetteville 28301
910-433-3022

Legal Services
Cumberland County Legal Aid
157 Gillespie Street
Fayetteville 28302
910-483-0400
800-824-5340

Legal Services
Lumbee River Legal Services
Corner of East Main & 2nd
Street
Pembroke 28372
910-521-2831
800-554-7852

Community Health Center
Stedman Family Dental Center
Highway 24 East
P.O. Box 368
Stedman 28391
910-483-3150
Stedman-Wade Health Services,
Inc.
Provides dental services

Community Health Center
Wade Family Medical Center
Highway 301 North
P.O. Box 449
Wade
910-483-6694
Stedman-Wade Health Services,
Inc.

Private Free Clinic
The CARE Clinic, Inc.
239 Robeson Street
P.O. Box 53438
Fayetteville 28305
919-485-0555
Provides dental services

Southern Regional AHEC
1601 Owen Drive
Fayetteville, NC 28304
Tel: 910-678-7230
Fax: 910-678-7279

Currituck County

Public Health Department

Albemarle Regional Health Services
711 Roanoke Avenue
P.O. Box 189
Elizabeth City 27909
252-338-4400
Provides dental services

MH/DD/SAS Area Office

Albemarle Mental Health Center and DD/SAS
P.O. Box 326
Elizabeth City 27907
252-335-0431

Department of Social Services

P. O. Box 99
Currituck 27929
252-232-3083

Social Security Administration

124 Rich Boulevard
Elizabeth City
252-338-1155

Legal Services

Legal Services of the Coastal Plains
610 East Church Street
Ahoskie 27910
252-332-5124
800-682-0010

Eastern AHEC

P.O. Box 7224, 2000 Venture Tower Drive
Greenville, NC 27835-7224
Tel: 252-744-8214
Fax: 252-744-8596

Dare County

Public Health Department

211 Budleigh Street
P.O. Box 1000
Manteo 27954
252-475-1089
Provides dental services

MH/DD/SAS Area Office

Albemarle Mental Health Center and DD/SAS
P.O. Box 326
Elizabeth City 27907
252-335-0431

Social Security Administration

124 Rich Boulevard
Elizabeth City
252-338-1155

Legal Services

Legal Services of the Coastal Plains
610 East Church Street
Ahoskie 27910
252-332-5124
800-682-0010

Eastern AHEC

P.O. Box 7224, 2000 Venture Tower Drive
Greenville, NC 27835-7224
Tel: 252-744-8214
Fax: 252-744-8596

Department of Social Services

P. O. Box 669
Manteo 27954
252-473-1471

Davidson County

Public Health Department

915 Greensboro Street
P.O. Box 439
Lexington 27292
336-242-2350
Provides dental services

MH/DD/SAS Area Office

Davidson County Area MH/DD/SA Program
211 W. Colonial Drive
Thomasville 27360
336-474-2700

Department of Social Services

P. O. Box 788
Lexington 27292
336-242-2500

Social Security Administration

1816 E. Innes Street
Salisbury 28146
704-633-9432

Legal Services

Central Carolina Legal Services
122 North Elm Street, Suite 700
Greensboro 27401
336-272-0148

Legal Services

Central Carolina Legal Services, Branch Office
6-B Fourth Street
Lexington 27293
336-249-7736

Private Free Clinic

Davidson Medical Ministries Clinic, Inc.
420 North Salisbury Street
P.O. Box 584
Lexington 27293
336-249-6215
Provides dental services

Northwest AHEC

Wake Forest University School of
Medicine
Medical Center Boulevard
Winston-Salem, NC 27157-1060
Tel: 336-713-7000
Fax: 336-713-7027

Davie County**Public Health Department**

210 Hospital Street
P.O. Box 848
Mocksville 27028
336-751-8700
Provides primary care services to
all ages
Provides dental services

MH/DD/SAS Area Office

CenterPoint Human Services
725 Highland Avenue
Winston-Salem
336-725-7777

Department of Social Services

P. O. Box 517
Mocksville 27028
336-751-8800

Social Security Administration

1816 E. Innes Street
Salisbury 28146
704-633-9432

Legal Services

The Legal Aid Society of
Northwest North Carolina
216 W. Fourth Street
Winston-Salem 27101
336-725-9166
800-660-6663

Private Free Clinic

Storehouse for Jesus Free
Medical Clinic
P.O. Box 216
Mocksville 27028
336-751-1060

Northwest AHEC

Wake Forest University School of
Medicine
Medical Center Boulevard
Winston-Salem, NC 27157-1060
Tel: 336-713-7000
Fax: 336-713-7027

Duplin County**Public Health Department**

340 Seminary Street
P.O. Box 948
Kenansville 28349
910-296-2130
Provides primary care services to
all ages
Provides dental services

MH/DD/SAS Area Office

Duplin-Sampson Area
MH/DD/SA Program
117 Beasley Street
P.O. Box 599
Kenansville
910-296-1851

Department of Social Services

P. O. Box 969
Kenansville 28349
910-296-2200

Social Security Administration

2605 Medical Office Place
Goldsboro 27534
919-735-6811

Legal Services

Legal Services of the Lower Cape
Fear
201 N. Front Street
Wilmington 28401
910-763-6207
800-672-9304

**Community Health Center,
Migrant Health Center**

Goshen Medical Center, Inc.
444 Southwest Center Street
P.O. Box 187
Faison 28341
910-267-1942
Goshen Medical Center, Inc.

**Community Health Center,
Migrant Health Center**

Plainview Health Services
360 East Charity Road
Rose Hill 28458
910-289-3086
Goshen Medical Center, Inc.

Rural Health Center

Warsaw Medical Center
107 North Center Street
Warsaw 28398
910-293-3401

Coastal AHEC

P.O. Box 9025, 2131 S. 17th
Street
Wilmington, NC 28402-9025
Tel: 910-343-0161
Fax: 910-762-9203

Durham County

Public Health Department

414 E. Main Street
Durham 27701
919-560-7650
Provides dental services

MH/DD/SAS Area Office

The Durham Center
200 N. Magnum Street
Durham 27701
919-560-7100

Department of Social Services

P. O. Box 810
Durham 27702
919-560-8000

Social Security Administration

Duke Forest Building
3308 Chapel Hill Boulevard
Durham 27707
919-541-5422

Legal Services

North Central Legal Assistance
Program
212 North Magnum Street
Durham 27702
919-688-6396
800-331-7594

Community Health Center

Lincoln Community Health
Center
1301 Fayetteville Street
P.O. Box 52119
Durham 27717
919-956-4000
Provides dental services

Private Pharmacy Assistance

Senior PHARMAssist
123 Market Street
Durham
919-688-4772

School-Based Health Center

Hillside High School
Sponsored by Lincoln
Community Center

School-Based Health Center

George Watts Elementary School
Sponsored by Duke University
School of Nursing

School-Based Health Center

Southern High School
Sponsored by Duke University
School of Nursing

Wake AHEC

William F. Andrews Center
3024 New Bern Avenue
Raleigh, NC 27610-1255
Tel: 919-350-8228
Fax: 919-350-7850

Edgecombe County

Public Health Department

2909 Main Street
Tarboro 27886
252-641-7531
Provides dental services

MH/DD/SAS Area Office

Edgecombe-Nash MH/DD/SAS
500 Nash Medical Arts Mall
Rocky Mount 27804
252-937-8141

Department of Social Services

3003 N. Main Street
Tarboro 27886
252-641-7611

Social Security Administration

2723 Sunset Avenue
Rocky
252-446-2242

Legal Services

Eastern Carolina Legal Services,
Branch Office
148 S. Washington Street, Suite
105
Rocky Mount 27802
252-442-0635
800-682-7902

Area L AHEC

P.O. Drawer 7368
1631 S. Wesleyan Boulevard
Rocky Mount, NC 27804-0368
Tel: 252-972-6958
Fax: 252-972-0419

Forsyth County

Public Health Department

799 Highland Avenue
Winston-Salem 27101
910-727-2434

MH/DD/SAS Area Office

CenterPoint Human Services
725 Highland Avenue
Winston-Salem
336-725-7777

Department of Social Services

P. O. Box 999
Winston-Salem 27102
336-727-2248

Social Security Administration

5205 University Parkway
Winston-Salem 27106
336-767-3736

Legal Services

The Legal Aid Society of
Northwest North Carolina
216 W. Fourth Street
Winston-Salem 27101
336-725-9166
800-660-6663

Private Free Clinic
Community Care Center
2135 New Walkerton Road
Winston-Salem 27101
336-723-7904
Provides dental services

Private Pharmacy Assistance
Crisis Control Ministry Pharmacy
200 East 10th Street
Winston-Salem 27101
336-724-7453

Private Pharmacy Assistance
Crisis Control Ministry
Pharmacy—East Forsyth Office
431 West Bodenhamer Street
Kernersville 27284
336-996-5401

School-Based Health Center
Independence High School
Sponsored by Wake Forest
University School of Medicine

School-Based Health Center
Mineral Springs Middle School
Sponsored by Wake Forest
University School of Medicine

Northwest AHEC
Wake Forest University School of
Medicine
Medical Center Boulevard
Winston-Salem, NC 27157-1060
Tel: 336-713-7000
Fax: 336-713-7027

Franklin County

Public Health Department
107 Industrial Drive, Suite C
Louisburg 27549
919-496-8110
Provides primary care services to
all ages, no Medicare
Provides dental services

MH/DD/SAS Area Office
Area MH/DD/SA Program of
VGFW
134 S. Garnett Street
Henderson 27536
252-430-1330

Department of Social Services
P. O. Box 669
Louisburg 27549
919-496-5721

Social Security Administration
943 West Andrews Avenue
Henderson 27536
252-438-8977

Legal Services
North Central Legal Assistance
Program
212 North Magnum Street
Durham 27702
919-688-6396
800-331-7594

Wake AHEC
William F. Andrews Center
3024 New Bern Avenue
Raleigh, NC 27610-1255
Tel: 919-350-8228
Fax: 919-350-7850

Gaston County

Public Health Department
991 W. Hudson Boulevard
Gastonia 28052
704-853-5260
Provides primary care to children
ages birth through 20
Provides dental services

MH/DD/SAS Area Office
Pathways MH/DD/SA
2505 Court Drive
Gastonia 28054
704-867-2361

Department of Social Services
330 N. Marietta Street
Gastonia 28052
704-862-7500

Social Security Administration
215 W. 3rd Avenue
Gastonia 28052
704-865-1439

Legal Services
Legal Services of the Southern
Piedmont
1431 Elizabeth Avenue
Charlotte 28204
704-786-4145
800-849-8009

Legal Services
Legal Services of the Southern
Piedmont, Branch Office
111 E. Third Avenue, Suite 200
Gastonia 28052
704-865-2357

**Federally Qualified Health
Center Look-Alike**
Bessemer City Health Care
Center
520 E.D. Wilson Road
P.O. Box 486
Bessemer City 28016
704-629-3465
Gaston Family Health Services,
Inc.

**Federally Qualified Health
Center Look-Alike**
Gaston Family Health Services,
Inc.
991 West Hudson Boulevard
Gastonia
704-853-5261
Gaston Family Health Services, Inc.
Provides dental service

Charlotte AHEC
P.O. Box 32861
Carolinas Healthcare System
1366 East Morehead Street
Charlotte, NC 28204
Tel: 704-355-7820
Fax: 704-355-7825

Gates County

Public Health Department
Hertford Gates District Health
Department
P.O. Box 246
Winton 27986
252-358-7833

MH/DD/SAS Area Office
Roanoke-Chowan Human
Services Center
Route 3, Box 22 A
Ahoskie
252-332-4137

Department of Social Services
P. O. Box 185
Gatesville 27938
252-357-0075

Social Security Administration
1118 N. Academy Street
Ahoskie 27910
252-332-3413

Legal Services
Legal Services of the Coastal
Plains
610 East Church Street
Ahoskie 27910
252-332-5124
800-682-0010

Rural Health Center
Gates County Medical Center
501 Main St.
P.O. Box 297
Gatesville 27938
252-357-1226

School-Based Health Center
Gates County High School
Sponsored by Gates County
Rural Health Service

Eastern AHEC
P.O. Box 7224, 2000 Venture
Tower Drive
Greenville, NC 27835-7224
Tel: 252-744-8214
Fax: 252-744-8596

Graham County

Public Health Department
Moose Branch Road
P.O. Box 546
Robbinsville 28771
828-479-7900
Provides dental services

MH/DD/SAS Area Office
Smoky Mountain Center for
MH/DD/SAS
P. O. Box 127
Sylva 28779
828-586-5501

Department of Social Services
P. O. Box 1150
Robbinsville 28771
828-479-7911

Social Security Administration
80 Westgate Plaza
Franklin 28734
828-369-2684

Legal Services
Western North Carolina Legal
Services
1286 W. Main Street
Sylva 28779
828-586-8931
800-458-6817

School-Based Health Center
Robbinsville High School
Sponsored by Graham County
Health Department

School-Based Health Center
Robbinsville Middle School
Sponsored by Graham County
Health Department

Mountain AHEC
501 Biltmore Avenue
Asheville, NC 28801-4686
Tel: 828-257-4400
Fax: 828-257-4768

Granville County

Public Health Department
Granville Vance District Health
Department
101 Hunt Drive
P.O. Box 367
Oxford 27565
919-693-2141

MH/DD/SAS Area Office
Area MH/DD/SA Program of
VGFWS
134 S. Garnett Street
Henderson 27536
252-430-1330

Department of Social Services
P. O. Box 966
Oxford 27565
919-693-1511

Social Security Administration
943 West Andrews Avenue
Henderson 27536
252-438-8977

Legal Services

North Central Legal Assistance
Program
212 North Magnum Street
Durham 27702
919-688-6396
800-331-7594

**Farmworker Health Program,
Migrant Health Center**

Stovall Medical Center
103 Durham Street
P.O. Box 40
Stovall 27582
919-693-1311

Wake AHEC

William F. Andrews Center
3024 New Bern Avenue
Raleigh, NC 27610-1255
Tel: 919-350-8228
Fax: 919-350-7850

Greene County**Public Health Department**

227 Kingold Boulevard, Suite B
Snow Hill 28580
252-747-8183

Department of Social Services

227 Kingold Boulevard, Suite A
Snow Hill 28580
252-747-5932

Social Security Administration

701 N. Queen Street
Kinston 28501
252-527-4823

MH/DD/SAS Area Office

Wilson-Greene Area
MH/MR/SAS
1709 S. Tarboro Street
P. O. Box 3756
Wilson
252-399-8021

Legal Services

Eastern Carolina Legal Services,
Branch Office
103 Ormond Avenue
Goldsboro 27533
919-731-2800
800-682-7900

**Community Health Center,
Migrant Health Center**

Kate B. Reynolds Pediatric
Center
205 Martin Luther King Parkway
P. O. Box 658
Snow Hill 28580
252-747-4199
Greene County Health Care, Inc.

**Community Health Center,
Migrant Health Center**

Student Health Services
Route 1, Box 11
P. O. Box 658
Snow Hill 28580
252-747-5841
Greene County Health Care, Inc.

**Community Health Center,
Migrant Health Center,
Farmworker Health Program**

Greene Community Health
Center
302 N. Greene Street
Snow Hill 28580
252-747-8162
Greene County Health Care, Inc.

School-Based Health Center

Greene Central High School
Sponsored by Greene County
Health Care, Inc.

Eastern AHEC

P.O. Box 7224, 2000 Venture
Tower Drive
Greenville, NC 27835-7224
Tel: 252-744-8214
Fax: 252-744-8596

Guilford County**Public Health Department**

232 N. Edgeworth Street
P.O. Box 3508
Greensboro 27401
336-641-7777
Provides primary care for ages 13
and older and pregnant women
Has several sites for its various
services, call
Provides dental services

Public Health Department

High Point
336-845-7777
Has several sites for its various
services, call
Provides dental services

MH/DD/SAS Area Office

Guilford County Area
MH/DD/SA Program
232 N. Edgeworth Street, 4th
Floor
Greensboro 27401
336-373-4981

Department of Social Services

P. O. Box 3388
Greensboro 27402
336-641-3813

Social Security Administration

6005 Landmark Center
Greensboro 27407
336-854-1809

Legal Services

Central Carolina Legal Services
122 North Elm Street, Suite 700
Greensboro 27401
336-272-0148

Private Free Clinic

Healthserve Ministry
1002 South Eugene Street
Greensboro 27406
336-271-5971
Provides dental services

Private Free Clinic

Community Clinic of High Point,
Inc.
904 N. Main Street
P.O. Box 5607
High Point 27262
336-841-7154

School-Based Health Center

Allen Middle School
Sponsored by Wesley Long-
Moses Cone Foundation

School-Based Health Center

Jackson Middle School
Sponsored by Wesley Long-
Moses Cone Foundation

School-Based Health Center

Smith High School
Sponsored by Wesley Long-
Moses Cone Foundation

School-Based Health Center

Giffin Middle School
Sponsored by Wesley Long-
Moses Cone Foundation

School-Based Health Center

Welborn Middle School
Sponsored by Wesley Long-
Moses Cone Foundation

School-Based Health Center

Andrews High School
Sponsored by Wesley Long-
Moses Cone Foundation

School-Based Health Center

Grimsley High School
Sponsored by Wesley Long-
Moses Cone Foundation

Greensboro AHEC

Moses Cone Health System
1200 North Elm Street
Greensboro, NC 27401-1020
Tel: 336-832-8025
Fax: 336-832-7591

Halifax County**Public Health Department**

Dobbs Street
P.O. Box 10
Halifax 27839
252-583-5021
Provides primary care to all ages

MH/DD/SAS Area Office

RiverStone Counseling and
Personal Development
210 Smith Church Road
P.O. Box 1199
Roanoke Rapids
252-537-6174

Department of Social Services

P. O. Box 767
Halifax 27839
252-536-2511

Social Security Administration

109 West Becker Drive
Roanoke
252-537-6191

Legal Services

Legal Services of the Coastal
Plains
610 East Church Street
Ahoskie 27910
252-332-5124
800-682-0010

Community Health Center

Twin County Rural Health
Center, Inc.
204 Evans Road
P. O. Box 10
Hollister
252-586-5151
Twin County Rural Health
Center, Inc.
Provides dental services

Private Free Clinic

Roanoke Valley Medical
Ministries Clinic
536 Jackson Street
P.O. Box 1344
Roanoke Rapids 27870
252-308-1261

Rural Health Center

Family Practice Associates
Hwy 125 West
P.O. Box 848
Weldon 27890
252-536-5000

Rural Health Center

Lake Gaston Medical Center
201 North Mosby Ave.
P.O. Box 250
Littleton 27850
252-586-5411

Rural Health Center

Scotland Neck Family Medical
Center
919 Junior High Rd.
P.O. Box 540
Scotland neck 27874
252-826-3143

Area L AHEC

P.O. Drawer 7368
1631 S. Wesleyan Boulevard
Rocky Mount, NC 27804-0368
Tel: 252-972-6958
Fax: 252-972-0419

Harnett County**Public Health Department**

307 Cornelius Harnett Boulevard
Lillington 27546
910-893-7550
Provides primary care to children
ages 2 and older

MH/DD/SAS Area Office

Lee-Harnett Area MH/DD/SA
Authority
130 Carbondon Road
Sanford
919-774-6521

Department of Social Services

311 Cornelius Harnett Boulevard
Lillington 27546
910-893-7500

Social Security Administration

111 Lamon Street
 Fayetteville 28301
 910-433-3022

Legal Services

East Central Community Legal
 Services
 219 Fayetteville Street Mall
 One Exchange Plaza, Suite 810
 Raleigh 27601
 919-828-4647

Legal Services

East Central Community Legal
 Services, Branch Office
 216 East Church Street
 Smithfield 27577
 919-934-5027
 800-682-1016

Community Health Center

Anderson Creek Dental Clinic
 6720 Overhills Road
 Spring Lake 28390
 910-436-3194
 The Western Medical Group, Inc.
 Provides dental services

Community Health Center

Anderson Creek Medical Clinic
 6750 Overhills Road
 Spring Lake 28390
 910-436-2900
 The Western Medical Group, Inc.

Community Health Center

Angier Medical Center
 84 Medical Drive
 Angier 27501
 910-639-2122
 The Western Medical Group, Inc.

Community Health Center

Boone Trail Medical Center
 1000 Medical Center Road
 Mainers 27552
 910-893-3063
 The Western Medical Group, Inc.

Southern Regional AHEC

1601 Owen Drive
 Fayetteville, NC 28304
 Tel: 910-678-7230
 Fax: 910-678-7279

Haywood County**Public Health Department**

2177 Asheville Road
 Waynesville 28786
 828-452-6675
 Provides dental services

MH/DD/SAS Area Office

Smoky Mountain Center for
 MH/DD/SAS
 P. O. Box 127
 Sylva 28779
 828-586-5501

Department of Social Services

486 East Marshall Street
 Waynesville 28786
 828-452-6620

Social Security Administration

20 Regent Park Boulevard
 Asheville 28806
 828-251-9941

Legal Services

Western North Carolina Legal
 Services
 1286 W. Main Street
 Sylva 28779
 828-586-8931
 800-458-6817

Private Free Clinic

Haywood Christian Ministry
 2489 Asheville Road
 Waynesville 28786
 828-456-4838

Private Free Clinic

The Good Samaritan Clinic of
 Haywood County
 112 Academy Street
 Waynesville/Canton
 828-648-8676

Mountain AHEC

501 Biltmore Avenue
 Asheville, NC 28801-4686
 Tel: 828-257-4400
 Fax: 828-257-4768

Henderson County**Public Health Department**

1347 Spartanburg Highway
 Hendersonville 28792
 704-692-4223
 Provides primary care for
 children ages 2 months through
 20 years and pregnant women

MH/DD/SAS Area Office

Trend Area MH/DD/SA
 Authority
 800 Fleming Street
 Hendersonville
 828-692-5741

Department of Social Services

246 Second Avenue East
 Hendersonville 28792
 828-697-5500

Social Security Administration

224 6th Avenue East
 Suite 2-C
 Hendersonville 28792
 828-692-0534

Legal Services

Appalachian Legal Services
 29 Ravenscroft Drive
 Asheville 28801
 828-236-1080

**Community Health Center,
Migrant Health Center**
Blue Ridge Community Health
Services, Inc.
Corner of Howard Gap and
Highway 64 East
Hendersonville 28973
828-696-8264
Blue Ridge Community Health
Services, Inc.

**Community Health Center,
Migrant Health Center**
Druid Hills Family Practice
Center
1801 Asheville Highway
Hendersonville 28791
828-696-0545
Blue Ridge Community Health
Services, Inc.

**Community Health Center,
Migrant Health Center**
George Bond Memorial Health
Center
Highway 47-A
Bat Cave 28710
828-625-9141
Blue Ridge Community Health
Services, Inc.

**Community Health Center,
Migrant Health Center**
William F. Stokes, Jr. Dental
Practice
Howard Gap Road and Highway
64 East
P.O. Box 5151
Hendersonville 28793
828-696-0512
Blue Ridge Community Health
Services, Inc.
Provides dental services

Private Free Clinic
Volunteer Resource Center
P.O. Box 1086
Hendersonville 28793
828-243-0138

School-Based Health Center
Apple Valley Middle School
Sponsored by Blue Ridge
Community Health Services, Inc.

Mountain AHEC
501 Biltmore Avenue
Asheville, NC 28801-4686
Tel: 828-257-4400
Fax: 828-257-4768

Hertford County

Public Health Department
Hertford Gates District Health
Department
P.O. Box 246
Winton 27986
252-358-7833

MH/DD/SAS Area Office
Roanoke-Chowan Human
Services Center
Route 3, Box 22 A
Ahoskie
252-332-4137

Department of Social Services
P. O. Box 218
Winton 27986
252-358-7830

Social Security Administration
1118 N. Academy Street
Ahoskie 27910
252-332-3413

Legal Services
Legal Services of the Coastal
Plains
610 East Church Street
Ahoskie 27910
252-332-5124
800-682-0010

School-Based Health Center
Hertford County Middle School
Sponsored by Roanoke-Chowan
Hospital

Eastern AHEC
P.O. Box 7224, 2000 Venture
Tower Drive
Greenville, NC 27835-7224
Tel: 252-744-8214
Fax: 252-744-8596

Hoke County

Public Health Department
429 E. Central Avenue
Raeford 28376
910-875-3717
Provides primary care to all ages

MH/DD/SAS Area Office
Sandhills Center for
MH/DD/SA Services
P. O. Box 9
West End
910-673-9111

Department of Social Services
P. O. Box 340
Raeford 28376
910-875-8725

Social Security Administration
111 Lamon Street
Fayetteville 28301
910-433-3022

Legal Services
Cumberland County Legal Aid
157 Gillespie Street
Fayetteville 28302
910-483-0400
800-824-5340

Legal Services

Lumbee River Legal Services
 Corner of East Main & 2nd
 Street
 Pembroke 28372
 910-521-2831
 800-554-7852

Southern Regional AHEC

1601 Owen Drive
 Fayetteville, NC 28304
 Tel: 910-678-7230
 Fax: 910-678-7279

Hyde County**Public Health Department**

U.S. 264 E. Business
 P.O. Box 100
 Swan Quarter 27885
 252-926-3561

MH/DD/SAS Area Office

Tideland Mental Health Center
 1308 Highland Drive
 Washington
 252-946-8061

Department of Social Services

P. O. Box 220
 Swan Quarter 27885
 252-926-3371

Social Security Administration

719 W. 15th Street
 Washington 27889
 252- 946-0117

Legal Services

Pamlico Sound Legal Services
 213 Pollock Street
 New Bern 28650
 252-637-9502
 800-672-8213

Legal Services

Pamlico Sound Legal Services,
 Branch Office
 427 W. Evans Street
 Greenville 27858
 252-758-0113
 800-682-4592

Rural Health Center

Ocracoke Health Center
 Hwy 12
 P.O. Box 543
 Ocracoke 27960
 252-928-1511

Eastern AHEC

P.O. Box 7224, 2000 Venture
 Tower Drive
 Greenville, NC 27835-7224
 Tel: 252-744-8214
 Fax: 252-744-8596

Iredell County**Public Health Department**

318 Turnersburg Highway
 Statesville 28677
 704-878-5300
 Provides dental services

MH/DD/SAS Area Office

Crossroads Behavioral Healthcare
 124-A Kapp Street
 P.O. Box 708
 Dobson 27017
 336-386-7425

Department of Social Services

P. O. Box 1146
 Statesville 28687
 704-873-5631

Social Security Administration

1320 Davie Avenue
 Statesville 28677
 704-872-8120

Legal Services

The Legal Aid Society of
 Northwest North Carolina
 216 W. Fourth Street
 Winston-Salem 27101
 336-725-9166
 800-660-6663

Private Free Clinic

Open Door Clinic
 1421 Wilmington Avenue
 Statesville 28677
 704-838-1108
 Provides dental services

Northwest AHEC

Wake Forest University School of
 Medicine
 Medical Center Boulevard
 Winston-Salem, NC 27157-1060
 Tel: 336-713-7000
 Fax: 336-713-7027

Jackson County

Public Health Department

538 Scotts Creek Road, Suite 100
Sylva 28779
828-586-8994
Provides dental services

MH/DD/SAS Area Office

Smoky Mountain Center for
MH/DD/SAS
P. O. Box 127
Sylva 28779
828-586-5501

Department of Social Services

Community Service Center, Suite
200
538 Scotts Creek Road
Sylva 28779
828-586-5546

Social Security Administration

80 Westgate Plaza
Franklin 28734
828-369-2684

Legal Services

Western North Carolina Legal
Services
1286 W. Main Street
Sylva 28779
828-586-8931
800-458-6817

Farmworker Health Program, Migrant Health Center

Jackson County Health
Department
538 Scotts Creek Road, Suite 100
Sylva 28779
828-586-8994

Mountain AHEC

501 Biltmore Avenue
Asheville, NC 28801-4686
Tel: 828-257-4400
Fax: 828-257-4768

Johnston County

Public Health Department

517 N. Bright Leaf Boulevard
Smithfield 27577
919-989-5200
Provides primary care to all ages

MH/DD/SAS Area Office

Johnston County Area
MH/DD/SA Authority
Highway 301 North
P. O. Box 411
Smithfield 27577
919-989-5500

Department of Social Services

P. O. Box 911
Smithfield 27577
919-989-5300

Social Security Administration

1329 N. Brightleaf Boulevard
Building D
Smithfield 27577
919-934-5888

Legal Services

East Central Community Legal
Services
219 Fayetteville Street Mall
One Exchange Plaza, Suite 810
Raleigh 27601
919-828-4647

Rural Health Center

Benson Area Medical Center
1204 North Johnson St.
P.O. Box 399
Benson 27504
919-894-2011

Wake AHEC

William F. Andrews Center
3024 New Bern Avenue
Raleigh, NC 27610-1255
Tel: 919-350-8228
Fax: 919-350-7850

Legal Services

East Central Community Legal
Services, Branch Office
216 East Church Street
Smithfield 27577
919-934-5027
800-682-1016

Jones County

Public Health Department

401 Highway 58 South
P.O. Box 216
Trenton 28585
252-448-9111
Provides primary care to children
ages birth through 20
Provides dental services

MH/DD/SAS Area Office

Neuse Center for MH/DD/SAS
P.O. Box 1636
New Bern
252-636-1510

Department of Social Services

P. O. Box 250
Trenton 28585
252-448-2581

Social Security Administration

2836 Neuse Boulevard
New Bern
252-637-1703

Legal Services

Pamlico Sound Legal Services
213 Pollock Street
New Bern 28650
252-637-9502
800-672-8213

Legal Services

Pamlico Sound Legal Services,
Branch Office
427 W. Evans Street
Greenville 27858
252-758-0113
800-682-4592

Eastern AHEC

P.O. Box 7224, 2000 Venture
Tower Drive
Greenville, NC 27835-7224
Tel: 252-744-8214
Fax: 252-744-8596

Lee County**Public Health Department**

106 Hillcrest Dr.
P.O. Box 1528
Sanford
919-718-4640, Ext. 5388
Provides dental services

MH/DD/SAS Area Office

Lee-Harnett Area MH/DD/SA
Authority
130 Carbondon Road
Sanford
919-774-6521

Department of Social Services

P. O. Box 1066
Sanford 27331
919-718-4690

Social Security Administration

1013 Spring Lane
Sanford 27330
919-775-1033

Legal Services

East Central Community Legal
Services
219 Fayetteville Street Mall
One Exchange Plaza, Suite 810
Raleigh 27601
919-828-4647

Legal Services

East Central Community Legal
Services, Branch Office
214-215 Hawkins Avenue, Room
212
Sanford 27330
919-774-6241

Private Free Clinic

Helping Hand Clinic
507 North Steele Street
Sanford 27330
919-776-6677

Wake AHEC

William F. Andrews Center
3024 New Bern Avenue
Raleigh, NC 27610-1255
Tel: 919-350-8228
Fax: 919-350-7850

Lenoir County**Public Health Department**

201 N. McLewean Street
P.O. Box 3385
Kinston 28501
252-526-4212

MH/DD/SAS Area Office

Lenoir County MH/DD/SA
Center
2901 N. Herritage
Kinston
252-527-7086

Department of Social Services

P. O. Box 6
Kinston 28502
252-559-6400

Social Security Administration

701 N. Queen Street
Kinston 28501
252-527-4823

Legal Services

Eastern Carolina Legal Services,
Branch Office
103 Ormond Avenue
Goldsboro 27533
919-731-2800
800-682-7900

**Community Health Center,
Migrant Health Center**

Kinston Community Health
Center
324 North Queen Street
P.O. Box 2278
Kinston 28502
252-522-9800
Kinston Community Health
Center, Inc.
Provides dental services

Eastern AHEC

P.O. Box 7224, 2000 Venture
Tower Drive
Greenville, NC 27835-7224
Tel: 252-744-8214
Fax: 252-744-8596

Lincoln County

Public Health Department

151 Sigmon Road
Lincolnton 28092
704-736-8634
Provides dental services

MH/DD/SAS Area Office

Pathways MH/DD/SA
2505 Court Drive
Gastonia 28054
704-867-2361

Department of Social Services

P. O. Box 130
Lincolnton
704-732-0738

Social Security Administration

215 W. 3rd Avenue
Gastonia 28052
704-865-1439

Legal Services

Catawba Valley Legal Services
211 East Union Street
Morganton
828-437-8280

Charlotte AHEC

P.O. Box 32861
Carolinas Healthcare System
1366 East Morehead Street
Charlotte, NC 28204
Tel: 704-355-7820
Fax: 704-355-7825

Macon County

Public Health Department

1830 Lakeside Drive
Franklin 28734
828-349-2081
Provides dental services

MH/DD/SAS Area Office

Smoky Mountain Center for
MH/DD/SAS
P. O. Box 127
Sylva 28779
828-586-5501

Department of Social Services

5 West Main Street
Franklin 28734
828-349-2124

Social Security Administration

80 Westgate Plaza
Franklin 28734
828-369-2684

Legal Services

Western North Carolina Legal
Services
1286 W. Main Street
Sylva 28779
828-586-8931
800-458-6817

Mountain AHEC

501 Biltmore Avenue
Asheville, NC 28801-4686
Tel: 828-257-4400
Fax: 828-257-4768

Madison County

Public Health Department

140 Health Care Lane
Marshall 28753
828-649-3531

MH/DD/SAS Area Office

Blue Ridge Center for
MH/DD/SAS
356 Biltmore Avenue
Asheville 28801
828-258-3500

Department of Social Services

180 South Main Street
P. O. Box 219
Marshall 28753
828-649-2711

Social Security Administration

20 Regent Park Boulevard
Asheville 28806
828-251-9941

Legal Services

Appalachian Legal Services
29 Ravenscroft Drive
Asheville 28801
828-236-1080

Rural Health Center

Hot Springs Health Clinic
66 NW US Hwy 25-70
Hot Springs 28743
828-622-3245
Provides dental services

Rural Health Center

Laurel Medical Center
80 Gunter Town Rd.
Marshall 28753
828-656-2611

Rural Health Center

Mars Hill Medical Center
119 Mountain View Rd.
P.O. Box 910
Mars Hill 28754
828-689-3507

Rural Health Center

Mashburn Medical Center
590 Medical Park Dr.
Marshall 28753
828-649-956

Mountain AHEC

501 Biltmore Avenue
Asheville, NC 28801-4686
Tel: 828-257-4400
Fax: 828-257-4768

Martin County

Public Health Department

Martin Tyrrell Washington
District Health Department
198 NC Highway 45 North
Plymouth 27962
252-793-3023

MH/DD/SAS Area Office

Tideland Mental Health Center
1308 Highland Drive
Washington
252-946-8061

Department of Social Services

P. O. Box 809
Williamston 27892
252-809-6400

Social Security Administration

102 Eastbrook Drive
Greenville 27858
252-758-1634

Legal Services

Pamlico Sound Legal Services
213 Pollock Street
New Bern 28650
252-637-9502
800-672-8213

Legal Services

Pamlico Sound Legal Services,
Branch Office
427 W. Evans Street
Greenville 27858
252-758-0113
800-682-4592

Eastern AHEC

P.O. Box 7224, 2000 Venture
Tower Drive
Greenville, NC 27835-7224
Tel: 252-744-8214
Fax: 252-744-8596

McDowell County

Public Health Department

Rutherford Polk McDowell
District Health Department
221 Callahan Koon Road
Spindale 28160
828-287-6100

MH/DD/SAS Area Office

Foothills Area MH/DD/SA
Program
306 S. King Street
Morganton 28655
704-438-6230

Department of Social Services

P. O. Box 338
Marion 28752
828-652-3355

Social Security Administration

20 Regent Park Boulevard
Asheville 28806
828-251-9941

Legal Services

Catawba Valley Legal Services
211 East Union Street
Morganton
828-437-8280

School-Linked Health Center

Teen Health Connection
Sponsored by Teen Health
Connection

Mountain AHEC

501 Biltmore Avenue
Asheville, NC 28801-4686
Tel: 828-257-4400
Fax: 828-257-4768

Mecklenburg County

Public Health Department

249 Billingsley Road
Charlotte 28211
704-336-3100
Provides dental services

MH/DD/SAS Area Office

Mecklenburg County Health, MH
and Community Services
429 Billingsley Road, 2nd Floor
Charlotte
704-336-2023

Department of Social Services

301 Billingsley Road
Wallace H. Kuralt Center
Charlotte
704-336-3150

Social Security Administration

5701 Executive Center Drive
Suite 200
Charlotte 28212
800-772-1213

Legal Services

Legal Services of the Southern
Piedmont
1431 Elizabeth Avenue
Charlotte 28204
704-786-4145
800-849-8009

Community Health Center

C.W. Williams Health Center
3333 Wilkerson Boulevard
P.O. Box 668093
Charlotte
704-393-7720
Metrolina Comprehensive Health
Center, Inc.

Community Health Center
Metrolina Midtown Medical
Office
1918 Randolph Road
Suite 670
Charlotte 28207
704-335-0304
Metrolina Comprehensive Health
Center, Inc.

Private Free Clinic
Nursing Center for Health
Promotion
UNC-Charlotte
9201 University City Blvd.
Charlotte 28223
704-687-3180

Charlotte AHEC
P.O. Box 32861
Carolinas Healthcare System
1366 East Morehead Street
Charlotte, NC 28204
Tel: 704-355-7820
Fax: 704-355-7825

Private Pharmacy Assistance
MedAssist of Mecklenberg
101 Eastway Drive, C-10
Charlotte 28213
704-536-9766, Ext. 111
<http://www.medassist.org>

Mitchell County

Public Health Department
Toe River District Health
Department
861 Greenwood Road
Spruce Pine 28777
828-765-2368
Provides dental services

Department of Social Services
P. O. Box 365
Bakersville
828-688-2175

Mountain AHEC
501 Biltmore Avenue
Asheville, NC 28801-4686
Tel: 828-257-4400
Fax: 828-257-4768

MH/DD/SAS Area Office
Blue Ridge Center for
MH/DD/SAS
356 Biltmore Avenue
Asheville 28801
828-258-3500

Social Security Administration
20 Regent Park Boulevard
Asheville 28806
828-251-9941

Legal Services
Legal Services of the Blue Ridge
171 Grand Boulevard
Boone 28607
828-264-5640

Montgomery County

Public Health Department
217 S. Main Street
Troy 27371
910-572-1393
Provides primary care for ages
birth through 61
Provides dental services

Social Security Administration
1925 E. Main Street
Albemarle 28001
704-982-9133

School-Based Health Center
East Middle School
Sponsored by FirstHealth of the
Carolinas

MH/DD/SAS Area Office
Sandhills Center for
MH/DD/SA Services
P. O. Box 9
West End
910-673-9111

Legal Services
Central Carolina Legal Services
122 North Elm Street, Suite 700
Greensboro 27401
336-272-0148

Greensboro AHEC
Moses Cone Health System
1200 North Elm Street
Greensboro, NC 27401-1020
Tel: 336-832-8025
Fax: 336-832-7591

Department of Social Services
P.O. Drawer N
Troy 27371
910-576-6531

School-Based Health Center
West Middle School
Sponsored by FirstHealth of the
Carolinas

Moore County

Public Health Department

705 Pinehurst Avenue
P.O. Box 279
Carthage 28327
910-947-3300

MH/DD/SAS Area Office

Sandhills Center for
MH/DD/SA Services
P. O. Box 9
West End
910-673-9111

Department of Social Services

P. O. Box 938
Carthage 28327
910-947-2436

Social Security Administration

1013 Spring Lane
Sanford 27330
919-775-1033

Legal Services

North State Legal Services
114 W. Corbin Street
Hillsborough 27278
919-732-8137
800-672-5834

Legal Services

North State Legal Services,
Branch Office
105 W. Wade Avenue
Pausons Building, Suite 206
Wadesboro 28170
704-694-2464
877-694-2464

Community Health Center

Benhaven Medical Center
985 NC 87 South
Cameron 28326
919-499-9422

Southern Regional AHEC

1601 Owen Drive
Fayetteville, NC 28304
Tel: 910-678-7230
Fax: 910-678-7279

Nash County

Public Health Department

214 S. Barnes Street
P.O. Box 849
Nashville 27856
919-459-9819

MH/DD/SAS Area Office

Edgecombe-Nash MH/DD/SAS
500 Nash Medical Arts Mall
Rocky Mount 27804
252-937-8141

Department of Social Services

120 Washington Street
P. O. Drawer 819
Nashville 27856
252-459-9818

Social Security Administration

2723 Sunset Avenue
Rocky Mount
252-446-2242

Legal Services

Eastern Carolina Legal Services,
Branch Office
148 S. Washington Street, Suite
105
Rocky Mount 27802
252-442-0635
800-682-7902

Community Health Center, Farmworker Health Program

Harvest Family Health Center
9088 Old Bailey Highway
Spring Hope 27882
252-237-9383
Wilson Community Health
Center, Inc.
Provides dental services

Area L AHEC

P.O. Drawer 7368
1631 S. Wesleyan Boulevard
Rocky Mount, NC 27804-0368
Tel: 252-972-6958
Fax: 252-972-0419

New Hanover County

Public Health Department

2029 S. 17th Street
Wilmington 28401
910-343-6591

MH/DD/SAS Area Office

Southeastern Center for
MH/DD/SAS
P.O. Box 1230
Wilmington
910-796-3130

Department of Social Services

1650 Greenfield Street
Wilmington 2840
910-341-4700

Social Security Administration

1528 S. 16th Street
Wilmington 28401
910-815-4733

Legal Services

Legal Services of the Lower Cape
Fear
201 N. Front Street
Wilmington 28401
910-763-6207
800-672-9304

Community Health Center

New Hanover Community Health Center
925 North Fourth Street
Wilmington 28401
910-343-0270
Provides dental services

Community Health Center

New Hanover Community Health Center, Inc.
925 North Fourth Street
Wilmington 28401
910-343-0270

Private Free Clinic

Tileston Outreach Health Center
412 Anne Street
Wilmington 28401
910-343-8736
Provides dental services

School-Based Health Center

Lakeside High School
Sponsored by Wilmington Health Access for Teens, Inc.

School-Linked Health Center

Wilmington Health Access for Teens
Sponsored by Wilmington Health Access for Teens, Inc

Coastal AHEC

P.O. Box 9025, 2131 S. 17th Street
Wilmington, NC 28402-9025
Tel: 910-343-0161
Fax: 910-762-9203

Northampton County**Public Health Department**

9495 NC 305 Highway
P.O. Box 635
Jackson 27845
252-534-5841

MH/DD/SAS Area Office

Roanoke-Chowan Human Services Center
Route 3, Box 22 A
Ahoskie
252-332-4137

Department of Social Services

P. O. Box 157
Jackson 27845
252-534-5811

Social Security Administration

109 West Becker Drive
Roanoke Rapids
252-537-6191

Legal Services

Legal Services of the Coastal Plains
610 East Church Street
Ahoskie 27910
252-332-5124
800-682-0010

Rural Health Center

Rich Square Medical Center
156 Main St.
P.O. Box 710
Rich Square 27869
252-539-2082

Rural Health Center

Roanoke Amaranth Community Health Group
1213 N. Church St. Ext.
P.O. Box 644
Jackson 27845
252-534-1661

Area L AHEC

P.O. Drawer 7368
1631 S. Wesleyan Boulevard
Rocky Mount, NC 27804-0368
Tel: 252-972-6958
Fax: 252-972-0419

Onslow County**Public Health Department**

612 College Street
Jacksonville 28540
910-347-7042

MH/DD/SAS Area Office

Onslow County Behavioral Healthcare
301 Johnson Boulevard
Jacksonville 28540
910-938-3546

Department of Social Services

1915 Onslow Drive Ext.
P. O. Box 1379
Jacksonville
910-455-4145

Social Security Administration

2836 Neuse Boulevard
New Bern
252-637-1703

Legal Services

Legal Services of the Lower Cape Fear
201 N. Front Street
Wilmington 28401
910-763-6207
800-672-9304

Private Free Clinic

Caring Community Clinic
615 College Street
Jacksonville 28540
910-938-1688

Rural Health Center

Rose Hill Medical Center
4088 S US HWY 117
Rose Hill 28458
910-289-3027

Eastern AHEC

P.O. Box 7224, 2000 Venture Tower Drive
Greenville, NC 27835-7224
Tel: 252-744-8214
Fax: 252-744-8596

Orange County

Public Health Department

300 West Tryon Street
Hillsborough 27278
919-732-8181, Ext. 2411
Provides dental services

Department of Social Services

300 W. Tryon Street
Hillsborough 27278
919-732-8181

Social Security Administration

Duke Forest Building
3308 Chapel Hill Boulevard
Durham 27707
919-541-5422

MH/DD/SAS Area Office

Orange-Person-Chatham
MH/DD/SA Program
101 E. Weaver Street, Suite 300
Carrboro 27510
919-913-4000

Legal Services

North State Legal Services
114 W. Corbin Street
Hillsborough 27278
919-732-8137
800-672-5834

Community Health Center

Carrboro Community Health Center
301 Lloyd Street
Carrboro 27510
919-942-8741
<http://www.piedmonthealth.org>
Piedmont Health Services

Community Health Center

Piedmont Women's Health Center
930 Airport Road, Suite 202
Chapel Hill 27514
919-933-3301

Private Free Clinic

Student Health Action Coalition,
UNC School of Medicine
063 McNider
CB#700
Chapel Hill 27599
919-893-6841
Provides dental services

Greensboro AHEC

Moses Cone Health System
1200 North Elm Street
Greensboro, NC 27401-1020
Tel: 336-832-8025
Fax: 336-832-7591

Pamlico County

Public Health Department

North Street
P.O. Box 306
Bayboro 28515
252-745-5111
Provides dental services

MH/DD/SAS Area Office

Neuse Center for MH/DD/SAS
P.O. Box 1636
New Bern
252-636-1510

Department of Social Services

P. O. Box 395
Bayboro 28515
252-745-4086

Social Security Administration

2836 Neuse Boulevard
New Bern
252-637-1703

Legal Services

Pamlico Sound Legal Services
213 Pollock Street
New Bern 28650
252-637-9502
800-672-8213

Legal Services

Pamlico Sound Legal Services,
Branch Office
427 W. Evans Street
Greenville 27858
252-758-0113
800-682-4592

Private Free Clinic

HOPE Clinic
P.O. Box 662
Oriental 28571
252-745-5760

Eastern AHEC

P.O. Box 7224, 2000 Venture
Tower Drive
Greenville, NC 27835-7224
Tel: 252-744-8214
Fax: 252-744-8596

Pasquotank County

Public Health Department

Albemarle Regional Health Services
711 Roanoke Avenue
P.O. Box 189
Elizabeth City 27909
252-338-4400
Provides primary care to children ages birth to 20
Provides dental services

MH/DD/SAS Area Office

Albemarle Mental Health Center and DD/SAS
P.O. Box 326
Elizabeth City 27907
252-335-0431

Department of Social Services

709 Roanoke Avenue
Elizabeth City 27907
252-338-2126

Social Security Administration

124 Rich Boulevard
Elizabeth City
252-338-1155

Legal Services

Legal Services of the Coastal Plains
610 East Church Street
Ahoskie 27910
252-332-5124
800-682-0010

Farmworker Health Program, Migrant Health Center

Albemarle Regional Health Services
709 Roanoke Avenue
P.O. Box 189
Elizabeth City 27907
252-948-0723

Private Free Clinic

Hope Clinic of Elizabeth City
P.O. Box 2071
Elizabeth City 27909
252-338-6773

School-Based Health Center

Elizabeth City Middle School
Sponsored by Albermarle District Health Department

School-Based Health Center

Northeastern High School
Sponsored by Albermarle District Health Department

School-Based Health Center

River Road Middle School
Sponsored by Albermarle District Health Department

Eastern AHEC

P.O. Box 7224, 2000 Venture Tower Drive
Greenville, NC 27835-7224
Tel: 252-744-8214
Fax: 252-744-8596

Pender County

Public Health Department

803 S. Walker Street
P.O. Box 1209
Burgaw 28425
910-259-1230
Provides primary care services to all ages
Provides dental services

MH/DD/SAS Area Office

Southeastern Center for MH/DD/SAS
P.O. Box 1230
Wilmington
910-796-3130

Department of Social Services

P. O. Drawer 1207
Burgaw 28425
910-259-1240

Social Security Administration

1528 S. 16th Street
Wilmington 28401
910-815-4733

Legal Services

Legal Services of the Lower Cape Fear
201 N. Front Street
Wilmington 28401
910-763-6207
800-672-9304

Rural Health Center

Black River Health Center
P.O. Box 130
Atkinson 28421
910-283-7783

Rural Health Center

Black River Health Services
301 S. Campbell St.
P.O. Box 1488
Burgaw 28425
910-259-6973

Rural Health Center

Maple Hill Medical Center
4811 NC Highway 50
Maple Hill 28454
910-259-6444

Coastal AHEC

P.O. Box 9025, 2131 S. 17th Street
Wilmington, NC 28402-9025
Tel: 910-343-0161
Fax: 910-762-9203

Perquimans County

Public Health Department

Albemarle Regional Health Services
711 Roanoke Avenue
P.O. Box 189
Elizabeth City 27909
252-338-4400
Provides dental services

MH/DD/SAS Area Office

Albemarle Mental Health Center and DD/SAS
P.O. Box 326
Elizabeth City 27907
252-335-0431

Department of Social Services

P. O. Box 107
Hertford 27944
252-426-7373

Social Security Administration

124 Rich Boulevard
Elizabeth City
252-338-1155

Legal Services

Legal Services of the Coastal Plains
610 East Church Street
Ahoskie 27910
252-332-5124
800-682-0010

Eastern AHEC

P.O. Box 7224, 2000 Venture Tower Drive
Greenville, NC 27835-7224
Tel: 252-744-8214
Fax: 252-744-8596

Person County

Public Health Department

325 South Morgan Street
Roxboro 27573
336-597-2204, Ext. 241
Provides dental services

MH/DD/SAS Area Office

Orange-Person-Chatham
MH/DD/SA Program
101 E. Weaver Street, Suite 300
Carrboro 27510
919-913-4000

Department of Social Services

P. O. Box 770
Roxboro 27573
336-599-8361

Social Security Administration

Duke Forest Building
3308 Chapel Hill Boulevard
Durham 27707
919-541-5422

Legal Services

North Central Legal Assistance Program
212 North Magnum Street
Durham 27702
919-688-6396
800-331-7594

Community Health Center

Person Family Medical Center
702 N. Main Street
P.O. Box 350
Roxboro 27573
336-599-9271
Person Family Medical Center, Inc.
Provides dental services

Wake AHEC

William F. Andrews Center
3024 New Bern Avenue
Raleigh, NC 27610-1255
Tel: 919-350-8228
Fax: 919-350-7850

Pitt County

Public Health Department

201 Government Circle
Greenville 27834
252-413-1300
Provides care to pregnant women only
Provides dental services

MH/DD/SAS Area Office

Pitt County MH/DD/SA Center
203 Government Circle
Greenville
252-413-1600

Department of Social Services

1717 W. Fifth Street
Greenville 27834
252-413-1101

Social Security Administration

102 Eastbrook Drive
Greenville 27858
252-758-1634

Legal Services

Pamlico Sound Legal Services
213 Pollock Street
New Bern 28650
252-637-9502
800-672-8213

Legal Services

Pamlico Sound Legal Services, Branch Office
427 W. Evans Street
Greenville 27858
252-758-0113
800-682-4592

Private Free Clinic

Greenville Community Shelter Clinic
1600 Chestnut Street
P.O. Box 8322
Greenville
252-758-9244

Private Free Clinic

Health Assist
 P.O. Box 6028
 Greenville
 252-816-7016

Private Free Clinic

Pitt County Indigent Care Clinic
 1413 SE Greenville Blvd.
 Greenville 27858

Eastern AHEC

P.O. Box 7224, 2000 Venture
 Tower Drive
 Greenville, NC 27835-7224
 Tel: 252-744-8214
 Fax: 252-744-8596

Polk County**Public Health Department**

Rutherford Polk McDowell
 District Health Department
 221 Callahan Koon Road
 Spindale 28160
 828-287-6100

MH/DD/SAS Area Office

Rutherford-Polk Area
 MH/DD/SA Authority
 271 Callahan Koon Road
 Spindale
 828-287-6110

Department of Social Services

500 Carolina Avenue
 Tryon 28782
 828-859-5825

Social Security Administration

224 6th Avenue East
 Suite 2-C
 Hendersonville 28792
 828-692-0534

Legal Services

Appalachian Legal Services
 29 Ravenscroft Drive
 Asheville 28801
 828-236-1080

Rural Health Center

Saluda Medical Center
 86 Greenville St.
 P.O. Box 577
 Saluda 28773
 828-749-4411

Mountain AHEC

501 Biltmore Avenue
 Asheville, NC 28801-4686
 Tel: 828-257-4400
 Fax: 828-257-4768

Randolph County**Public Health Department**

2222 S. Fayetteville Street
 Asheboro 27203
 336-318-6200
 Provides dental services

MH/DD/SAS Area Office

Randolph County MH/DD/SA
 Program
 110 W. Walker Avenue
 Asheboro
 336-633-7200

Department of Social Services

1512 N. Fayetteville Street
 Asheboro
 336-683-3000

Social Security Administration

157 K Dublin Square Road
 Asheboro 27203
 800-772-1213

Legal Services

Central Carolina Legal Services
 122 North Elm Street, Suite 700
 Greensboro 27401
 336-272-0148

Rural Health Center

MERCE Medical Center
 1831 N. Fayetteville St.
 P.O. Box 4248
 Asheboro 27204
 336-672-1300
 Provides dental services

Greensboro AHEC

Moses Cone Health System
 1200 North Elm Street
 Greensboro, NC 27401-1020
 Tel: 336-832-8025
 Fax: 336-832-7591

Richmond County**Public Health Department**

127 Caroline Street
 Rockingham 28379
 910-997-8300
 Provides dental services

MH/DD/SAS Area Office

Sandhills Center for
 MH/DD/SA Services
 P. O. Box 9
 West End
 910-673-9111

Department of Social Services

P. O. Drawer 518
 Rockingham 28379
 910-997-8480

Social Security Administration

1793 E. Broad Avenue
 Rockingham 28379
 910-895-9097

Legal Services

North State Legal Services
 114 W. Corbin Street
 Hillsborough 27278
 919-732-8137
 800-672-5834

Legal Services

North State Legal Services,
 Branch Office
 105 W. Wade Avenue
 Pausons Building, Suite 206
 Wadesboro 28170
 704-694-2464
 877-694-2464

Southern Regional AHEC

1601 Owen Drive
 Fayetteville, NC 28304
 Tel: 910-678-7230
 Fax: 910-678-7279

Robeson County**Public Health Department**

460 Country Club Road
 Lumberton 28358
 910-671-3200
 Provides primary care to all ages
 Provides dental services

MH/DD/SAS Area Office

Southeastern Regional Mental
 Health Center
 207 W. 29th Street
 Lumberton
 910-738-5261

Department of Social Services

435 Caton Road
 Lumberton 28358
 910-671-3500

Social Security Administration

220 Liberty Hill Road
 Lumberton 28358
 910-738-8123

Legal Services

Lumbee River Legal Services
 Corner of East Main & 2nd
 Street
 Pembroke 28372
 910-521-2831
 800-554-7852

Community Health Center

South Robeson Medical Clinic
 1212 S. Walnut Street
 Fairmont 28340
 910-628-6711
<http://www.robesonhealthcare.com>
 Robeson Health Care
 Corporation

**Community Health Center,
Farmworker Health Program**

C.I. Smith Family Dental Practice
 800 South Martin Luther King Jr.
 Drive
 Lumberton 28358
 910-738-4770
<http://www.robesonhealthcare.com>
 Robeson Health Care
 Corporation
 Provides dental services

**Community Health Center,
Farmworker Health Program**

Julian T. Pierce Medical Center
 307 East Wardell Street
 P.O. Box 1629
 Pembroke 28372
 910-521-2816
<http://www.robesonhealthcare.com>
 Robeson Health Care Corporation

**Community Health Center,
Farmworker Health Program**

Lumberton Health Center
 901 North Chestnut Street
 Lumberton 28358
 910-739-1666
<http://www.robesonhealthcare.com>
 Robeson Health Care Corporation

**Community Health Center,
Farmworker Health Program**

Maxton Family Center
 610 East Martin Luther King Jr.
 Drive
 Maxton 28364
 910-844-5253
<http://www.robesonhealthcare.com>
 Robeson Health Care Corporation

School-Based Health Center

Purnell Swett High School
 Sponsored by Robeson County
 Health Department

Southern Regional AHEC

1601 Owen Drive
 Fayetteville, NC 28304
 Tel: 910-678-7230
 Fax: 910-678-7279

Rockingham County**Public Health Department**

P.O. Box 204
 Wentworth
 336-342-8143
 Provides primary care for all ages
 Provides dental services

MH/DD/SAS Area Office

Rockingham County Area
 MH/DD/SA Program
 Highway 405 NC 65
 P. O. Box 355
 Wentworth
 336-342-8316

Department of Social Services

P. O. Box 61
 Wentworth 27375
 336-342-1394

Social Security Administration

1624 Way Street
 Reidsville 27320
 336-342-7796

Legal Services

Central Carolina Legal Services
122 North Elm Street, Suite 700
Greensboro 27401
336-272-0148

Private Free Clinic

Free Clinic of Reidsville and
Vicinity, Inc.
315 South Main Street
P.O. Box 2668
Reidsville
336-349-3220
Provides dental services

Private Pharmacy Assistance

Rockingham Prescription
Assistance Program
105 Lawsonville Avenue
P.O. Box 2668
Reidsville
336-349-2343

School-Based Health Center

McMichael High School
Sponsored by Morehead
Memorial Hospital

School-Based Health Center

Morehead High School
Sponsored by Morehead
Memorial Hospital

School-Based Health Center

Reidsville High School
Sponsored by Morehead
Memorial Hospital

School-Based Health Center

Rockingham County High School
Sponsored by Morehead
Memorial Hospital

Greensboro AHEC

Moses Cone Health System
1200 North Elm Street
Greensboro, NC 27401-1020
Tel: 336-832-8025
Fax: 336-832-7591

Rowan County**Public Health Department**

1811 East Innes Street
Salisbury 28146
704-633-0411
Provides primary care for all ages
Provides dental services

MH/DD/SAS Area Office

Piedmont Area MH/DD/SAS
245 LePhillip Court
Concord 28025
704-721-7000

Department of Social Services

1236 W. Innes Street
Salisbury 28144
704-633-4921

Social Security Administration

1816 E. Innes Street
Salisbury 28146
704-633-9432

Legal Services

Central Carolina Legal Services
122 North Elm Street, Suite 700
Greensboro 27401
336-272-0148

Legal Services

Central Carolina Legal Services,
Branch Office
6-B Fourth Street
Lexington 27293
336-249-7736

Private Free Clinic

Community Care Clinic of
Rowan County
315-G Mocksville Avenue
Salisbury 28144
704-636-4523
Provides dental services

Private Free Clinic

Good Shepard's Clinic
120 North Jackson Street
Salisbury 28144
704-636-7200

Northwest AHEC

Wake Forest University School of
Medicine
Medical Center Boulevard
Winston-Salem, NC 27157-1060
Tel: 336-713-7000
Fax: 336-713-7027

Rutherford County**Public Health Department**

Rutherford Polk McDowell
District Health Department
221 Callahan Koon Road
Spindale 28160
828-287-6100

MH/DD/SAS Area Office

Rutherford-Polk Area
MH/DD/SA Authority
271 Callahan Koon Road
Spindale
828-287-6110

Department of Social Services

P. O. Box 237
315 Fairground Road
Spindale 28160
828-287-6199

Social Security Administration

707 Schenck Street
Shelby 28150
704-480-6202

Legal Services

Appalachian Legal Services
29 Ravenscroft Drive
Asheville 28801
828-236-1080

Private Pharmacy Assistance

Senior Care Pharmacy
193 Callahan-Koon Road
Spindale 28160
828-286-4222

Mountain AHEC

501 Biltmore Avenue
 Asheville, NC 28801-4686
 Tel: 828-257-4400
 Fax: 828-257-4768

Sampson County**Public Health Department**

360 County Complex Road
 Clinton 28328
 910-592-1131
 Provides primary care to children
 ages 2 and older

MH/DD/SAS Area Office

Duplin-Sampson Area
 MH/DD/SA Program
 117 Beasley Street
 P.O. Box 599
 Kenansville
 910-296-1851

Department of Social Services

P. O. Box 1105
 Clinton 28328
 910-592-4137

Social Security Administration

111 Lamon Street
 Fayetteville 28301
 910-433-3022

Legal Services

East Central Community Legal
 Services
 219 Fayetteville Street Mall
 One Exchange Plaza, Suite 810
 Raleigh 27601
 919-828-4647

Legal Services

East Central Community Legal
 Services, Branch Office
 216 East Church Street
 Smithfield 27577
 919-934-5027
 800-682-1016

**Community Health Center,
Migrant Health Center**

Tri-County Community Health
 Council, Inc.
 3331 Easy Street
 P.O. Box 227
 Newton Grove 28366
 Provides dental services

Rural Health Center

Four County Medical Center
 P.O. Box 89
 Harrells 28444
 910-532-4106

Rural Health Center

Newton Grove Medical Center
 P.O. Box 726
 Newton Grove 28366
 910-594-1063
 Provides dental services

Southern Regional AHEC

1601 Owen Drive
 Fayetteville, NC 28304
 Tel: 910-678-7230
 Fax: 910-678-7279

Scotland County**Public Health Department**

1405 West Boulevard
 P.O. Box 69
 Laurinburg 28352
 910-277-2440

MH/DD/SAS Area Office

Southeastern Regional Mental
 Health Center
 207 W. 29th Street
 Lumberton
 910-738-5261

Department of Social Services

P. O. Box 1647
 Laurinburg 28353
 910-277-2525

Social Security Administration

220 Liberty Hill Road
 Lumberton 28358
 910-738-8123

Legal Services

Lumbee River Legal Services
 Corner of East Main & 2nd Street
 Pembroke 28372
 910-521-2831
 800-554-7852

Southern Regional AHEC

1601 Owen Drive
 Fayetteville, NC 28304
 Tel: 910-678-7230
 Fax: 910-678-7279

Stanly County**Public Health Department**

1000 North First Street, Suite 3
 Albemarle 28001
 704-982-9171
 Provides primary care to all ages
 Provides dental services

MH/DD/SAS Area Office

Piedmont Area MH/DD/SAS
 245 LePhillip Court
 Concord 28025
 704-721-7000

Department of Social Services

1000 North First Street, Suite 2
 Albemarle 28001
 704-982-6100

Social Security Administration

1925 E. Main Street
 Albemarle 28001
 704-982-9133

Legal Services

Legal Services of the Southern
 Piedmont
 1431 Elizabeth Avenue
 Charlotte 28204
 704-786-4145
 800-849-8009

Legal Services

Legal Services of the Southern
 Piedmont, Branch Office
 206-B N. Hayne Street
 Monroe 28110
 704-786-4145
 800-849-8009

Legal Services

Legal Services of the Southern
 Piedmont, Branch Office
 133 Union Street
 Concord 28025
 704-786-4145
 800-849-8009

Charlotte AHEC

P.O. Box 32861
 Carolinas Healthcare System
 1366 East Morehead Street
 Charlotte, NC 28204
 Tel: 704-355-7820
 Fax: 704-355-7825

Stokes County**Public Health Department**

Highways 8 and 89
 P.O. Box 187
 Danbury 27016
 336-593-2400
 Provides primary care to all ages

MH/DD/SAS Area Office

CenterPoint Human Services
 725 Highland Avenue
 Winston-Salem
 336-725-7777

Department of Social Services

P. O. Box 30
 Danbury 27016
 336-593-2861

Social Security Administration

5205 University Parkway
 Winston-Salem 27106
 336-767-3736

Legal Services

The Legal Aid Society of
 Northwest North Carolina
 216 W. Fourth Street
 Winston-Salem 27101
 336-725-9166
 800-660-6663

Northwest AHEC

Wake Forest University School of
 Medicine
 Medical Center Boulevard
 Winston-Salem, NC 27157-1060
 Tel: 336-713-7000
 Fax: 336-713-7027

Surry County**Public Health Department**

118 Hambry Road
 Dobson 27017
 336-401-8400
 Provides primary health care for
 ages birth through 20
 Provides dental services

MH/DD/SAS Area Office

Crossroads Behavioral Healthcare
 124-A Kapp Street
 P.O. Box 708
 Dobson 27017
 336-386-7425

Department of Social Services

118 Hamby Road
 Dobson 27017
 336-401-8700

Social Security Administration

117 Mayberry Mall
 Mount Airy
 336-789-8179

Legal Services

The Legal Aid Society of
 Northwest North Carolina
 216 W. Fourth Street
 Winston-Salem 27101
 336-725-9166
 800-660-6663

**Farmworker Health Program,
Migrant Health Center**

Surry County Health and
 Nutrition Center
 118 Hamby Road
 Dobson 27017
 336-401-8573

Private Free Clinic

Surry Medical Ministries Clinic
 813 Rockford Street
 P.O. Box 349
 Mount Airy 27030
 336-789-5058

School-Based Health Center

Gentry Middle School
 Sponsored by Surry County
 Health Department

Northwest AHEC

Wake Forest University School of
 Medicine
 Medical Center Boulevard
 Winston-Salem, NC 27157-1060
 Tel: 336-713-7000
 Fax: 336-713-7027

Swain County

Public Health Department

100 Teptal Terrace
Bryson City 28713
828-488-3198

MH/DD/SAS Area Office

Smoky Mountain Center for
MH/DD/SAS
P. O. Box 127
Sylva 28779
828-586-5501

Department of Social Services

P.O. Box 610
Bryson City 28713
828-488-6921

Social Security Administration

80 Westgate Plaza
Franklin 28734
828-369-2684

Legal Services

Western North Carolina Legal
Services
1286 W. Main Street
Sylva 28779
828-586-8931
800-458-6817

Mountain AHEC

501 Biltmore Avenue
Asheville, NC 28801-4686
Tel: 828-257-4400
Fax: 828-257-4768

Transylvania County

Public Health Department

Community Services Building
Brevard 28712
828-884-3135
Provides dental services

MH/DD/SAS Area Office

Trend Area MH/DD/SA
Authority
800 Fleming Street
Hendersonville
828-692-5741

Department of Social Services

205 E. Morgan Street
Brevard 28712
828-884-3174

Social Security Administration

224 6th Avenue East
Suite 2-C
Hendersonville 28792
828-692-0534

Legal Services

Appalachian Legal Services
29 Ravenscroft Drive
Asheville 28801
828-236-1080

Mountain AHEC

501 Biltmore Avenue
Asheville, NC 28801-4686
Tel: 828-257-4400
Fax: 828-257-4768

Tyrrell County

Public Health Department

Martin Tyrrell Washington
District Health Department
198 NC Highway 45 North
Plymouth 27962
252-793-3023

MH/DD/SAS Area Office

Tideland Mental Health Center
1308 Highland Drive
Washington
252-946-8061

Department of Social Services

P. O. Box 449
Columbia 27925
252-796-3421

Social Security Administration

719 W. 15th Street
Washington 27889
252- 946-0117

Legal Services

Pamlico Sound Legal Services
213 Pollock Street
New Bern 28650
252-637-9502
800-672-8213

Legal Services

Pamlico Sound Legal Services,
Branch Office
427 W. Evans Street
Greenville 27858
252-758-0113
800-682-4592

Rural Health Center

Columbia Medical Center
208 N. Broad St.
P.O. Box 189
Columbia 27925
252-796-0689

Eastern AHEC

P.O. Box 7224, 2000 Venture
Tower Drive
Greenville, NC 27835-7224
Tel: 252-744-8214
Fax: 252-744-8596

Union County

Public Health Department

1224 West Roosevelt Boulevard
Monroe 28110
704-296-4803
Provides primary care to ages 0-17, pregnant women
Provides dental services

MH/DD/SAS Area Office

Piedmont Area MH/DD/SAS
245 LePhillip Court
Concord 28025
704-721-7000

Department of Social Services

1212 West Roosevelt Boulevard
Monroe 28111
704-296-4300

Social Security Administration

5701 Executive Center Drive
Suite 200
Charlotte 28212
800-772-1213

Legal Services

Legal Services of the Southern
Piedmont
1431 Elizabeth Avenue
Charlotte 28204
704-786-4145
800-849-8009

Legal Services

Legal Services of the Southern
Piedmont, Branch Office
206-B N. Hayne Street
Monroe 28110
704-786-4145
800-849-8009

Legal Services

Legal Services of the Southern
Piedmont, Branch Office
133 Union Street
Concord 28025
704-786-4145
800-849-8009

Private Pharmacy Assistance

HealthQuest of Union County
412 East Franklin Street
Monroe
704-226-2050

Charlotte AHEC

P.O. Box 32861
Carolinas Healthcare System
1366 East Morehead Street
Charlotte, NC 28204
Tel: 704-355-7820
Fax: 704-355-7825

Vance County

Public Health Department

Granville Vance District Health
Department
101 Hunt Drive
P.O. Box 367
Oxford 27565
919-693-2141

MH/DD/SAS Area Office

Area MH/DD/SA Program of
VGFW
134 S. Garnett Street
Henderson 27536
252-430-1330

Department of Social Services

350 Ruin Creek Road
Henderson 27536
252-492-5001

Social Security Administration

943 West Andrews Avenue
Henderson 27536
252-438-8977

Legal Services

North Central Legal Assistance
Program
212 North Magnum Street
Durham 27702
919-688-6396
800-331-7594

Community Health Center

HealthCo, Inc.
One Opportunity Drive
Manson 27553
252-456-2181
Vance-Warren Comprehensive
Health Plan, Inc.
Provides dental services

Wake AHEC

William F. Andrews Center
3024 New Bern Avenue
Raleigh, NC 27610-1255
Tel: 919-350-8228
Fax: 919-350-7850

Wake County

Public Health Department

Wake County Human Services
10 Sunnybrook Road
P.O. Box 14049
Raleigh
919-212-7000
919-250-4400
Provides primary care to
children 0-19, and pregnant
women
Provides dental services

MH/DD/SAS Area Office

Wake County Human Services
P.O. Box 46833
Raleigh
919-212-7199

Department of Social Services

P. O. Box 46833
Raleigh 27602
919-212-7000

Social Security Administration

4405 Bland Road, Suite 150
Raleigh 27609
919-790-2782

Legal Services

East Central Community Legal Services
219 Fayetteville Street Mall
One Exchange Plaza, Suite 810
Raleigh 27601
919-828-4647

Community Health Center

Apex Family Medicine
212 South Salem Street
Apex 27502
919-362-5201
Wake Health Services, Inc.

Community Health Center

Burroughs Pediatrics
100 Sunnybrook Road
Raleigh 27610
919-231-3180
Wake Health Services, Inc.

Community Health Center

Rock Quarry Road Family
Medicine
1001 Rock Quarry Road
Raleigh 27610
919-833-3111
Wake Health Services, Inc.

Community Health Center

Horizon Health Center
220 Snow Avenue
Raleigh 27603
919-508-0777
Wake Health Services, Inc.

Warren County**Public Health Department**

544 W. Ridgeway Street
Warrenton 27589
252-257-1185

Department of Social Services

307 N. Main Street
Warrenton 27589
252-257-5000

Social Security Administration

943 West Andrews Avenue
Henderson 27536
252-438-8977

Community Health Center

Southern Wake Family Medicine
130 N. Judd Parkway NE
Fuquay-Varina 27526
919-557-1110
Wake Health Services, Inc.

**Farmworker Health Program,
Migrant Health Center**

Tarboro Road Family Medicine
102 N. Tarboro Road
Raleigh
(919) 829-1901

Private Free Clinic

Community Mental Health Clinic
228 West Edenton Street
Raleigh 27603
919-779-3979

Private Free Clinic

Open Door Clinic, Urban
Ministries of Raleigh
840 Semart Drive
P.O. Box 26476
Raleigh 27611
919-832-0820
Provides dental services

School-Linked Health Center

Wake Teen Medical Services
Sponsored by Wake Teen
Medical Services

Wake AHEC

William F. Andrews Center
3024 New Bern Avenue
Raleigh, NC 27610-1255
Tel: 919-350-8228
Fax: 919-350-7850

MH/DD/SAS Area Office

Area MH/DD/SA Program of
VGFW
134 S. Garnett Street
Henderson 27536
252-430-1330

Legal Services

North Central Legal Assistance
Program
212 North Magnum Street
Durham 27702
919-688-6396
800-331-7594

Community Health Center

Warren Health Plan
542 West Ridgeway Street
Warrenton 27589
252-257-3141
Vance-Warren Comprehensive
Health Plan, Inc.

Wake AHEC

William F. Andrews Center
3024 New Bern Avenue
Raleigh, NC 27610-1255
Tel: 919-350-8228
Fax: 919-350-7850

Washington County**Public Health Department**

Martin Tyrrell Washington
District Health Department
198 NC Highway 45 North
Plymouth 27962
252-793-3023

MH/DD/SAS Area Office

Tideland Mental Health Center
1308 Highland Drive
Washington
252-946-8061

Department of Social Services

P. O. Box 10
Plymouth 27962
252-793-4041

Social Security Administration

719 W. 15th Street
 Washington 27889
 252-946-0117

Legal Services

Pamlico Sound Legal Services
 213 Pollock Street
 New Bern 28650
 252-637-9502
 800-672-8213

Legal Services

Pamlico Sound Legal Services,
 Branch Office
 427 W. Evans Street
 Greenville 27858
 252-758-0113
 800-682-4592

Eastern AHEC

P.O. Box 7224, 2000 Venture
 Tower Drive
 Greenville, NC 27835-7224
 Tel: 252-744-8214
 Fax: 252-744-8596

Watauga County**Public Health Department**

Appalachian District Health
 Department
 141 Health Center Drive
 Boone 28607
 828-264-4995
 Provides primary care to all ages

MH/DD/SAS Area Office

New River Behavioral Health
 Care
 895 State Farm Road, Suite 508
 Boone
 828-264-9007

Department of Social Services

132 Poplar Grove Connector,
 Suite C
 Boone 28607
 828-265-8100

Social Security Administration

Federal Building, Room 101
 207 W. Main Street
 Wilkesboro 28697
 336-667-8506

Legal Services

Legal Services of the Blue Ridge
 171 Grand Boulevard
 Boone 28607
 828-264-5640

Private Pharmacy Assistance

Watauga County Hunger
 Coalition, Country Roads
 Pharmacy
 417 Meadowview Drive
 Boone 28607
 828-262-1628

Northwest AHEC

Wake Forest University School of
 Medicine
 Medical Center Boulevard
 Winston-Salem, NC 27157-1060
 Tel: 336-713-7000
 Fax: 336-713-7027

Wayne County**Public Health Department**

301 N. Herman Street
 Box CC
 Goldsboro 27530
 919-731-1000
 Provides dental services

MH/DD/SAS Area Office

Wayne County Mental Health
 Center
 301 N. Herman Street
 Goldsboro
 919-731-1133

Department of Social Services

301 N. Herman Street
 P. O. Box HH
 Goldsboro 27530
 919-580-4034

Social Security Administration

2605 Medical Office Place
 Goldsboro 27534
 919-735-6811

Legal Services

Eastern Carolina Legal Services,
 Branch Office
 103 Ormond Avenue
 Goldsboro 27533
 919-731-2800
 800-682-7900

**Community Health Center,
Migrant Health Center**

Community Health Services
 325 NC Highway 55 West
 P. O. Box 187
 Mount Olive 28365
 919-658-5900
 Goshen Medical Center, Inc.

Private Free Clinic

WATCH Mobile Unit
 2607 Medical Office Place
 Goldsboro 27534
 919-735-1251

Rural Health Center

Mount Olive Family Medicine
 Center
 238 Smith Chapel Road
 Mount Olive 28365
 919-658-4954

School-Based Health Center

Brogden Middle School
 Sponsored by Wayne Initiative
 for School Health

School-Based Health Center

Dillard Middle School
 Sponsored by Wayne Initiative
 for School Health

School-Based Health Center
Goldsboro Middle School
Sponsored by Wayne Initiative
for School Health

School-Based Health Center
Mt. Olive Middle School
Sponsored by Wayne Initiative
for School Health

Eastern AHEC
P.O. Box 7224, 2000 Venture
Tower Drive
Greenville, NC 27835-7224
Tel: 252-744-8214
Fax: 252-744-8596

Wilkes County

Public Health Department
306 College Street
Wilkesboro 28697
336-651-7450
Provides primary care to children
ages birth through 20
Provides dental services

MH/DD/SAS Area Office
New River Behavioral Health
Care
895 State Farm Road, Suite 508
Boone
828-264-9007

Department of Social Services
P. O. Box 119
Wilkesboro 28697
336-651-7400

Social Security Administration
Federal Building, Room 101
207 W. Main Street
Wilkesboro 28697
336-667-8506

Legal Services
Legal Services of the Blue Ridge
171 Grand Boulevard
Boone 28607
828-264-5640

Rural Health Center
Boomer Medical Center
4941 S. NC Hwy. 18
P.O. Box 238
Boomer 28606
336-921-2408

Rural Health Center
West Wilkes Medical Center
171 West Wilkes Medical Center
Road
Ferguson 28624
336-973-7897

School-Linked Health Center
MESH (Mobile Expanded School
Health)
Sponsored by Wilkes County
Health Department

Northwest AHEC
Wake Forest University School of
Medicine
Medical Center Boulevard
Winston-Salem, NC 27157-1060
Tel: 336-713-7000
Fax: 336-713-7027

Wilson County

Public Health Department
1801 Glendale Dr.
Wilson 27893
252-291-5470

MH/DD/SAS Area Office
Wilson-Greene Area
MH/MR/SAS
1709 S. Tarboro Street
P. O. Box 3756
Wilson
252-399-8021

Department of Social Services
P. O. Box 459
Wilson
252-206-4000

Social Security Administration
2111 Forest Hills Road W.
Wilson 27893
252-291-5965

Legal Services
Eastern Carolina Legal Services
409 N. Goldsboro Street
Wilson 27893
252-291-6851
800-682-7902

Community Health Center
Wilson Community Health
Center
303 E. Green Street
Wilson 27893
252-243-9800
Wilson Community Health
Center, Inc.

Rural Health Center
Wilson Community Health
Center
303 East Green Street
Wilson 27893
252-243-9800

Area L AHEC
P.O. Drawer 7368
1631 S. Wesleyan Boulevard
Rocky Mount, NC 27804-0368
Tel: 252-972-6958
Fax: 252-972-0419

Yadkin County

Public Health Department

217 E. Willow Street
Box 457
Yadkinville 27055
336-679-4203

Provides primary care to all ages
Provides dental services

MH/DD/SAS Area Office

Crossroads Behavioral Healthcare
124-A Kapp Street
P.O. Box 708
Dobson 27017
336-386-7425

Department of Social Services

P. O. Box 548
Yadkinville 27055
336-679-4210

Social Security Administration

5205 University Parkway
Winston-Salem 27106
336-767-3736

Legal Services

The Legal Aid Society of
Northwest North Carolina
216 W. Fourth Street
Winston-Salem 27101
336-725-9166
800-660-6663

Northwest AHEC

Wake Forest University School of
Medicine
Medical Center Boulevard
Winston-Salem, NC 27157-1060
Tel: 336-713-7000
Fax: 336-713-7027

Yancey County

Public Health Department

Toe River District Health
Department
861 Greenwood Road
Spruce Pine 28777
828-765-2368

Provides dental services

MH/DD/SAS Area Office

Blue Ridge Center for
MH/DD/SAS
356 Biltmore Avenue
Asheville 28801
828-258-3500

Department of Social Services

P. O. Box 67
Burnsville 28714
828-682-6148
828-682-2470

Social Security Administration

20 Regent Park Boulevard
Asheville 28806
828-251-9941

Legal Services

Legal Services of the Blue Ridge
171 Grand Boulevard
Boone 28607
828-264-5640

School-Based Health Center

Cane River Middle School
Sponsored by Toe River Health
District

School-Based Health Center

East Yancey Middle School
Sponsored by Toe River Health
District

Mountain AHEC

501 Biltmore Avenue
Asheville, NC 28801-4686
Tel: 828-257-4400
Fax: 828-257-4768

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