OHIO Department of INSURANCE

ohio shopper's guide series

Health Insurance Guide:

How to Get the Most Out of Your Health Coverage

1-800-686-1526

www.ohioinsurance.gov

Bob Taft – Governor

Ann Womer Benjamin – Director

From Ohio Governor Bob Taft and Department of Insurance Director Ann Womer Benjamin:

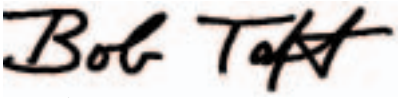
It is important to understand the available choices when selecting health insurance. Providing the proper coverage for our families and ourselves is important to everyone. The Ohio Department of Insurance has produced this **Ohio Shopper's Guide to Health Insurance** to help you make informed decisions when choosing health care coverage.

This guide describes the difference between individual and group coverage, examines Ohio's minimum coverage requirements and explains managed care plans. You will also find information on what to do if you change jobs or have a baby. We have information regarding your rights as a consumer and the responsibilities of insurance carriers conducting business in Ohio.

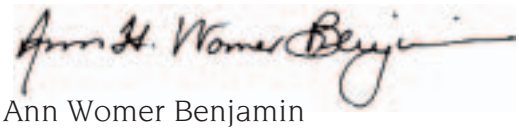
You will also find in this guide a comparison of consumer complaints the Department of Insurance has received about health insurance companies. It is important for all consumers to be comfortable with the companies to which they are entrusting the protection of their families.

If you have questions or need additional information, the Consumer Services Division of the Ohio Department of Insurance is ready to help you. Most questions or issues can be addressed by one of the department's expert individuals or referred for proper assistance. You can reach Consumer Services of the Ohio Department of Insurance at 1-800-686-1526 or by logging onto www.ohioinsurance.gov.

Sincerely,



Bob Taft
Governor



Ann Womer Benjamin
Director, Ohio Department of Insurance

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Table of Contents

The information in this guide was correct when it was printed. Changes may occur after printing. For more information, contact the Ohio Department of Insurance at 1-800-686-1526 or visit www.ohioinsurance.gov for additional insurance information.

Editor's Note: Words in MAROON are defined in the glossary on pages 55-57.

Chapter 1:
Health Insurance Basics

What Are My Health Insurance Options?

Health insurance is available to consumers in a variety of plans and coverages. Listed here are some of the most common.

1. Medical and Hospital Coverage

- **Major Medical**
  Pays the cost of hospital bills and medical bills. You pay any appropriate **co-payments** and **deductibles**. The policy covers only the eligible expenses listed.
- **Managed Care**
  Pays medical and hospital expenses as long as you use the plan's network of doctors and facilities. These plans cover basic care which is often not included in major medical coverage.
- **Hospital-Surgical**
  Pays only expenses directly related to hospitalization, which usually includes room and board plus doctors' charges.
- **Short-Term**
  This is coverage that lasts for only a specified length of time. For example, you might buy a six-month policy with major medical coverage for the months that you are between jobs. These policies do not cover pre-existing conditions.
- **Catastrophic**
  Has high limits but pays only after you have paid a high deductible, sometimes $2,500 or more.

2. Limited Purpose Coverage

- **Accident Only**
  Pays only when you are treated for accidental injury or if an accident causes death.
- **Disability Income**
  Pays a fixed amount for a specified period of time when you are unable to work because of an accident or illness.
- **Hospital Indemnity**
  Pays a flat amount (such as $100 per day) when you are hospitalized.
- **Long-Term Care**
  Pays to take care of you for an extended time in a nursing home or your own home. (See Ohio Shopper's Guide to Long-Term Care Insurance).
- **Medicare Supplement**
  Pays some medical expenses not paid by Medicare. (See Ohio Shopper's Guide to Medicare Supplement Insurance).
- **Special Need**
  Pays for health care not covered by typical major medical policies (for example, dental or vision care).
- **Specific Disease**
  Pays only for treatment for a disease or condition specifically named in the policy (such as cancer).
- **Home Health Care**
  Pays for health care delivered to you in your home.

What is Traditional Health Insurance?

Traditional health insurance is often called "**fee-for-service**" because the insurer pays the bills after you receive the service.

- You can use any doctor or hospital.
- The medical bills must be sent to the insurance company.
- You will likely have to pay a deductible before the policy begins to pay and co-payments each time you have a **claim**.
- If the policy pays less than the full bill, you may be responsible for paying the rest.

For more detailed information about traditional health insurance, see Chapter 2.

What Is Managed Care?

Managed care provides preventive care and other services that are basic to good health. Your out-of-pocket costs are generally less than traditional health insurance. Care is likely given by a network of doctors and hospitals under contract with the plan.

Your managed care plan could be through a traditional health insurance company, or you might be covered by a carrier that provides managed care plans only. Regardless, if you have a managed care plan, there is a provider network. Be sure to follow your plan's network rules when you need care.

For more detailed information about managed care, see Chapter 4.

Traditional Health Insurance

What Does Federally Eligible Mean and How Does It Apply?

Throughout this guide, it will be helpful to know if you qualify as a **federally eligible individual** (FEI).

You are a federally eligible individual (FEI) only if you

- Have 18 months of creditable coverage (see below),
- Were most recently covered by an employer group,
- Were not terminated from your group plan due to nonpayment of premium or fraud,
- Obtained new coverage by **midnight of the 63rd** day of your last coverage,
- Are not eligible for Medicare, Medicaid, or any other group coverage,
- Have exhausted all continuation of benefit options (**COBRA**), **AND**
- Do not have any other health insurance.

You are not federally eligible unless you meet ALL of these conditions.

What is Creditable Coverage?

Creditable coverage is proof, through a certificate issued by your former employer or insurer, that you were covered under your old plan. It reduces the time you would normally have to wait before the policy covers pre-existing conditions. The reduction is equal to the amount of time you were covered under the old plan.

You have creditable coverage if you were covered under any plan listed:

- A group health insurance plan
- Health insurance coverage
- Medicare or Medicaid
- Chapter 55 of Title 10, USC (CHAMPUS)
- Indian Health Medical Program
- A state health risk pool
- A health plan under Chapter 89 of Title 5, USC
- A public health plan
- A health plan under section 5(e) of the Peace Corps Act

How Do I Purchase Health Coverage?

Individual vs. Group Coverage

There are two basic ways to buy health coverage: as an individual or through a group. How you buy health coverage affects your rights and responsibilities.

Individual

vs.

Group

Coverage

Individual Coverage

- You contract directly with an insurance company just like insuring your home or car.
- You are the policyholder.
- Managed care plans call the contract-holder (the person in whose name the contract is written) a **subscriber**, member or enrollee
- Your individual policy can cover your entire family and each family member would be an **insured**.
- The insurance company needs approval from the Department of Insurance to increase rates.
- Any premium increase affects everyone who has the same kind of policy.
- Unless you have made false statements on your application, filed fraudulent claims or failed to pay your premiums on time, the company cannot cancel your policy because of your health or claims.
- Coverage must include specific minimum benefits (see pages 7-8).

See pages 52-53 for a directory of companies that sell individual policies.

Policy vs. Certificate
The master contract fully explains the health care plan's benefits and coverage. Your certificate is a summary and might not contain every detail.

More

Health

Insurance

Specifics

Group Coverage

- A **group insurance** policy may cover thousands of people, but it is still only one policy.
- Your employer or trade association is the master policyholder; you and your fellow employees are **certificate holders**.
- Each family member covered under your certificate is an insured.
- The master policyholder negotiates the terms of a group policy with the insurance company.

The master policyholder can

- Reduce or change the benefits and coverage,
- Increase your share of the premium,
- Switch to another insurance company, or
- Stop providing coverage completely!

In a group contract

- Rates for employer groups are negotiable and are not regulated by the Ohio Department of Insurance.
- The contract must include specific minimum benefits required by state law —other benefits are negotiated by the master policyholder.
- The master policyholder does not need consent of certificate holders to change companies or policies, cancel the policy or agree to new premiums or benefits.

Large and small employer group contracts

- May cover more than individual contracts.
- May have more generous benefits.
- Cannot reject an application because of poor health as long as the application is made during the eligibility period.

Large employer groups are defined as having more than 50 employees.
Small employer groups are defined as having 2 to 50 employees.

Chapter 2:
Traditional Health Policy Specifics

What is Traditional Health Insurance?

Traditional health insurance is often called "fee-for-service" because the insurer pays the bills after you receive the service.

- You can use any doctor or hospital.
- The medical bills must be sent to the insurance company.
- You will likely have to pay a deductible before the policy begins to pay and co-payments each time you have a claim.
- If the policy pays less than the full bill, you may be responsible for paying the rest.

What are Ohio's Minimum Coverage Requirements?

For the most part, insurance companies have the freedom to design their own benefit plans. However, the law does have some minimum requirements or mandates.

Alcoholism treatment
Every group policy must cover at least $550 per year for treatment of alcoholism, either in a treatment center or hospital or as an outpatient.

Mental illness: out-patient
If a group policy will pay for the treatment of a mental illness in a hospital, it must pay at least $550 per year for treatment as an outpatient.

Kidney dialysis: out-patient
If a policy covers dialysis in a hospital, it must have the same coverage for outpatient dialysis.

Specific practitioners
A policy cannot discriminate against specific licensed health professionals. If the policy covers a service (such as setting a broken arm or delivering a baby) it has to pay any licensed professional who legally performs the service.

These licensed professionals include

- Chiropractors
- Dentists
- Nurse-midwives
- Mechanotherapists
- Osteopaths
- Optometrists
- Podiatrists
- Psychologists

Off-label drug use
A policy that covers prescription drugs must pay for any legally approved drug your doctor prescribes, even if the government has not approved the drug for treating your particular disease or medical problem.

Pregnancy and maternity
Insurance companies are not required to offer maternity benefits.

When maternity coverage is provided, the pregnancy cannot be considered a pre-existing condition under any circumstance. However, under certain circumstances an insurer is permitted to impose a 270-day waiting period before maternity benefits are provided.

Note: Managed care plans **are** required to offer maternity benefits. See Chapter 4 for more information.

Mammograms
Every group or individual major medical policy must cover mammograms to screen for breast cancer in adult women.

Minimum

The frequency depends on age:
- Age 35-39: one mammogram only
- Age 40-49: one exam every two years unless the doctor says you have a high risk of breast cancer
- Age 50-64: one exam every year

Coverage

The policy will pay no more than $85 for each covered mammogram. Accredited facilities must accept this amount as full payment for the exam. However, your co-pays and deductibles may apply.

Requirements

Pap smears
Policies must pay for Pap smears, which are used to screen for cervical cancer. The law does not specify the number of exams or limit the amount a policy must pay for tests.

Coverage examples
To see how policies include these mandates, read Ohio's open enrollment model on page 17.

Are Prescription Drugs Covered In My Health Plan?

In Ohio, traditional health plans are not required to cover prescriptions. However, plans that do provide prescription coverage can exclude a specific drug or a specific class of drugs - such as birth control pills.

If your health plan covers prescriptions, it may have a list of drugs it will pay for. This list is called a formulary.

What are Deductibles and Co-Payments?

In addition to your monthly premium payments, most health policies require you to pay some share of the bills for covered expenses.

Deductible: A set amount that you have to pay toward covered expenses before the policy starts to pay. Some policies require you to pay a deductible for each incident.

Co-payment: Your share of the health care expenses. The policy might call this co-insurance.

Important: Deductibles and co-payments are separate items. Services and costs not covered by the policy do not satisfy deductibles or out-of-pocket maximums.

How Much Will My Out-Of-Pocket Expenses Be For Medical Services?

The insurance company typically pays a percentage of the usual, customary and reasonable (UCR) amount. The UCR is the amount the company believes to be a fair price for the medical services and may be less than the doctor's actual bill. The policyholder is then responsible for the balance.

Example: If the insurance company pays 80 percent of the UCR, you are responsible for the remaining 20 percent PLUS the difference between the doctor's actual bill and the UCR.

Ohio does not regulate UCR. Every company has its own way of determining the "usual and customary" amount for a service.

What Steps Should I Take When Filing a Claim?

Here are some steps to help you through the claim process.

Plan Ahead

- Review your policy or booklet carefully to be sure the service is covered
- Give claim forms to the provider with your policy number and other identifying information

Submit Claims Properly

- Make sure all information is complete and correct
- Mail it promptly—if you don't file within 6 months the claim may be denied
- Send it to the right address

How Do I Know If My Claim Is Complete?

After it receives and processes a completed claim, your insurance company has 30 days to pay or deny it. The tricky part is knowing when the claim is complete.

Here's the rule: The claim is complete when the company has received all the information it needs to decide whether to pay. The company must inform you within a reasonable amount of time when it needs any additional information to complete the claim.

Deductibles and Co-Payments

Explanation of Benefits Statement

What is an Explanation of Benefits (EOB) Statement?

After reviewing the claim, the insurance company sends you a statement explaining its decision. This statement is called the **Explanation of Benefits**, or EOB.

If Your Claim is Accepted and Paid

Depending on how you filed the claim, the company may send the check either to you or the doctor. You pay the deductible and co-payments.

If Your Claim is Denied

The reason for denial should be stated on the EOB. If you disagree

- Check your policy or benefits book for the company's appeal procedures.
- The company should be able to answer procedural questions about appeals over the phone.
- Your appeal should be in writing and may require information from your doctor.

Note: You must go through the company's internal appeal process before taking any other action.

If you're confused or believe the company has been unfair, call the Consumer Services Division at the Ohio Department of Insurance. Our health insurance experts can answer many questions over the phone. If you have a complaint we'll send you a complaint form. Return it and we'll do our best to help you. Call 1-800-686-1526.

Does a Family Policy Cover All Members of My Household?

The typical family policy or certificate covers all members of your immediate household unless there is a rider that specifically excludes one or more of your dependents. Small employer groups may not exclude family members.

If Both Parents Have Family Health Coverage Through Their Employer, Which Policy Insures Them and Their Children?

If you and your spouse both work and have family coverage through your employers' group policies, you and the children are probably covered by both policies.

Your insurance companies must follow Ohio's **Coordination of Benefits** (COB) rule to decide which plan is primary and how much each of the insurers must pay.

How Do I Know If My Or My Spouse's Plan Is Primary or Secondary?

When you are the patient, your employer's insurance is always primary and your spouse's plan is secondary for you.

When your children are the patients, the policies follow the birthday rule. The spouse with the first birthday in the calendar year has the primary plan.

If you are divorced or separated, you follow the court decree. If the decree doesn't say who is responsible for the children's health care, the parent with legal custody has the primary plan.

There are many different possible situations and Ohio's COB rules cover most of them. The Ohio rules should be described in your policy or benefits booklet.

Primary plan: This is the plan that pays first
Secondary plan: After the primary plan has paid its part, the secondary plan pays part (or all) of the amount that is left.

Example Using the Birthday Rule—Traditional Health Insurance
Joe and Wilma each have family coverage through their employer. Joe's birthday is January 10; Wilma's birthday is January 11. Joe's plan is primary for himself and the children. Wilma's plan is primary for herself and secondary for Joe and their children.

When Junior has a* $12,000 *hospital bill

- The bill first goes to Joe's plan, which says the usual, customary and reasonable (UCR) amount is $10,000 - the plan then pays the hospital $8,000.
- Wilma's plan now looks at the remaining bill and believes the UCR should have been only $9,000.
- But the rules say the secondary plan has to use the higher UCR, so Wilma's plan pays $2,000.
- Joe and Wilma pay the remaining $2,000 out of their own pocket.

If you are covered under a managed care plan, please see Chapter 4 for more information.

Can I Collect From Both Policies?

If you are covered by two policies that coordinate benefits, you are generally entitled to collect from both. However, the total amount you collect cannot be more than the usual, customary and reasonable (UCR) amount for the service. If the two companies have different UCRs, the limit is the higher of the two.

Ohio's Coordination of Benefits Rule

Are There Any Exceptions To Ohio's COB Rule?

Yes. Self-insured employers don't have to follow the Ohio rules. In fact, they may have an odd rule of their own. For example, they can make themselves secondary to coverage you don't even have! Here's how:

- Joe and Wilma are both eligible for employer plans.
- Wilma's plan covers them both so Joe doesn't join his.
- When Joe files a claim with Wilma's plan, it will subtract the amount that Joe's plan would have paid (even though he never joined it).

The result: Wilma's plan seldom pays very much on Joe's claims.

How Do I Add New Family Members to My Family Policy?

- New members of the family are added to a family policy at the moment of birth or adoption.
- If you don't have family coverage but you are starting a family, it's best to notify the company as soon as the child is born.
- New additions have the same coverage as other family members plus treatment for birth defects or abnormalities.
- You must notify the company of any new member within 31 days following their birth. You may be required to pay additional premiums.

Do Family Policies Cover Maternity For Dependent Daughters?

In most cases, if a family policy includes maternity benefits it must be the same for all family members, including your dependent daughter. However, the new grandchild's care is not covered by your plan.

Family

Policies

Does A Family Policy Provide Additional Coverage For Mentally Retarded or Handicapped Children?

Most group policies for family members stop covering children once they reach 18 or 21.

But, if your child is mentally or physically impaired the coverage must be continued for as long as your son or daughter continues to depend on you for maintenance and support.

Are Well Visit Appointments For Young Children Covered Under a Family Policy?

Every family policy (individual and group) must include Child Health Supervision that provides for complete physical exams, developmental assessments, anticipatory guidance, immunizations and lab tests from birth through age 8.

- $500 annual limit from birth to age 1
- $150 per year from age 1 through age 8
- No coverage is required after the child's 9th birthday

What Is Ohio Law Regarding Coverage For Mothers and Newborns?

The minimum in-patient coverage for mom and baby is:

- Normal vaginal delivery: 48 hours
- Cesarean delivery: 96 hours

Follow-up services are covered within 72 hours after discharge, if the mother and newborn leave the hospital prior to the **inpatient** time minimums shown above. Follow-up services include

- Physical assessment of the mother and baby
- Parent education and
- **Medically necessary** tests.

The law does NOT require

- Insurance contracts to pay for maternity care (however, the law does set minimum requirements for plans that do cover maternity)
- The child to be delivered in a hospital nor
- The mother or newborn to stay in the hospital.

What Services Are Not Covered Under A Traditional Health Insurance Policy?

Every traditional health plan has its own list of **exclusions** and limitations. This is only a sampling of some of the most common. Since each policy has its own version, you should read your policy or handbook very carefully.

Maternity

Coverage

Pre-Existing Conditions

The policy may make you wait before it will cover recent health problems, but it must follow Ohio rules.

6 Month "Look-Back"

The policy can limit or exclude coverage for any condition that was treated or diagnosed in the past six months before you applied for the new policy.

12 Month Waiting Period

The company can make you wait up to 12 months before it will cover a pre-existing condition. However, if your new policy's coverage starts within 30 days after another policy ends, the time you were covered by the old policy is deducted from the new policy's waiting period.

There will be no waiting period if you were continuously covered by the old policy for at least 12 months.

If you are a Federally Eligible Individual (FEI – see page 4), you will receive similar credit if you enroll in a new plan by **midnight of the 63rd day** after leaving your old plan. If you are not federally eligible, you will be credited as long as you enroll in the new plan within 31 days after leaving your old plan.

My Policy Will Not Cover A Procedure My Doctor Recommended Because It Isn't Considered "Medically Necessary." Is This Customary?

Many health policies exclude coverage for treatment that is not medically necessary because the company does not want to pay for unnecessary treatment. Medical necessity is a matter of judgment and your policy may not agree with your doctor's judgment of what treatment is medically necessary. In some cases, medical necessity disputes may be decided by an organization that is independent of the insurance company (see Chapter 7).

Am I Required To Notify My Insurance Company If I Am Planning a Hospital Stay?

Yes. Except in emergencies, most policies require you to tell the company before you check into the hospital. This is called pre-certification.

The steps should be spelled out in your policy or benefits booklet, including the phone number you or your doctor can call. The company may also require notification before you have elective surgery, visit specialists or have expensive tests such as a cat scan or MRI.

More

Health

Policy

Specifics

Does Pre-Certification Mean The Insurer Will Automatically Pay for My Hospital Stay?

No. Even if your doctor recommended hospitalization and you received a letter from the insurance company confirming that the treatment was "approved," the company may still reject your claim if it deems the treatment was not medically necessary. In other words, your symptoms may meet the criteria for the treatment proposed, but the treatment will be approved as to medical necessity only.

Sample Disclaimer (copied from a pre-certification approval letter)
"Our review and determination is limited to medical necessity. Accordingly, this approval does not guarantee payment of charges. Payment of benefits will be subject to all of the conditions, limitations and exclusions affecting coverage, as well as the patient's eligibility on the day of admission."

Moreover, even if medical necessity has been approved and surgery has been performed, the insurer could still deny payment based on factors the insurer might not confirm during pre-certification, such as:

- Whether you are being treated for a pre-existing condition that your new policy does not yet cover;
- Discrepancies between information provided by your doctor during pre-certification and your actual medical records;
- Whether the medically necessary treatment is covered by your policy; or
- Whether the patient was insured when services were performed (maybe you did not pay last month's premium or your child was the patient but is not included under the policy).

The company's pre-certification notice should make it clear what has and has not been approved.

If in doubt, ask... and get the answer in writing!

Is Pre-Certification Required If It's An Emergency?

No, pre-certification is not required in an emergency. Ohio laws define medical emergencies based on the actions a "prudent layperson" would take in such situations.

- A prudent layperson is someone with average knowledge of health and medicine
- An emergency is a condition of such strong pain and severe symptoms that a prudent layperson could reasonably expect that a lack of immediate medical attention would:
  - Place the person's health in serious risk,
  - In the case of pregnancy, place the baby's health in serious risk,
  - Cause serious damage to bodily functions, or
  - Cause serious damage to an organ or other body part.

What are Exclusion Riders or Waivers?

Individual policies may have amendments (riders) that permanently exclude coverage of medical problems related to specific conditions. Every health care policy has a long list of conditions or procedures that are and are not covered. Many plans are generous, but some can be restrictive.

Standard exclusions (in most policies)

- Treatment that is not medically necessary
- **Experimental** or investigational procedures or medications
- Sickness or injury as a result of war
- Attempted suicide or intentionally self-inflicted wounds
- Conditions resulting from your voluntary illegal activity
- Cosmetic surgery
- Conditions covered by workers' compensation

Other common limitations or exclusions

- Specific treatments: dental treatment for TMJ dysfunction, sex changes, sterilization, etc.
- Dental
- Vision (eye exams and glasses)
- Mental disorders and psychiatric care

Exclusion Riders or Waivers

Do Health Policies Have Benefit Limits?

Most traditional health insurance policies limit the total amount the policy will pay over the course of your lifetime. Once your medical bills have reached the company's set limit, you can no longer use your policy.

Annual limits are common for specific services in traditional health plans. For example, there may be a $550 annual limit on treatment for alcoholism.

Many traditional health policies also limit the amount you must pay each year. Once your payments add up to the annual out-of-pocket limit, the policy may pay 100 percent for the rest of that year.

Managed care plans cannot have a lifetime dollar limit on covered basic health care services. See Chapter 4 for more information about managed care.

Do Traditional Health Policies Cover Experimental Treatments?

Most policies do not cover experimental or investigational treatment. However, as medicine advances, experimental practices may become accepted practices.

Your doctor may be able to help you convince your insurance company that the procedure should no longer be on the company's experimental list. It is important to know that certain disputes about experimental treatments may be decided by an organization that is independent of the insurance company (see Chapter 7).

Sample policy language on experimental treatment

"We do not provide benefits for supplies, services or charges, which are experimental or investigative as determined by us based on current acceptable medical practices and procedures, or services not recognized as being within the generally accepted practice of medicine in the United States."

Consumer Complaints: Every insurance company that sells health insurance in Ohio must have an internal process to review complaints about its decisions. You must go through the company's internal process before the Ohio Department of Insurance can get involved.

Traditional Health Policies

What is Underwriting?

Underwriting is an insurance company's process for deciding how risky it will be to insure you. The company is trying to predict the likelihood that you will become sick or injured and file claims against the policy. Each company has its own underwriting standards. So, if you are applying for traditional health insurance, one company could reject your application while another might accept it.

What Information Is Used In The Underwriting Process?

Insurance companies rely heavily upon your answers to questions on the application form. When you apply for health insurance, the company will require you to give it permission to contact your doctors and hospitals and receive otherwise confidential information about your health. In most cases, the company can look back only six months into your health history.

What Conditions Might Cause My Application for Insurance to be Rejected?

Health conditions that can cause rejection of your application for a health insurance policy include:

- Heart Disease
- Diabetes
- Cancer
- AIDS
- Epilepsy
- Stroke
- Alcoholism

Always tell the whole truth! Be completely honest when you fill out a health insurance application. If the company discovers something you left out or falsified, it may cancel the policy or certificate and not pay your claims!

What Factors Are Considered In The Underwriting Process?

Age: The chances that you will become ill increase as you get older. Older people generally pay higher premiums and may have a harder time finding companies willing to insure them.

Health: If you've had cancer, heart attacks or other serious illnesses, a company may reject your application. It may not matter how healthy your doctor says you are now.

Occupation: Some jobs are more dangerous than others; the more hazardous your job, the more difficult it may be to buy insurance. If you work in an office or teach school, you will be easier to insure than a test pilot or coal miner.

Habits and Lifestyle: Insurance companies recognize that habits such as smoking or drinking can result in expensive health problems and may either charge higher rates or deny coverage.

Am I Able To Purchase Health Insurance If My Health is Poor?

In some situations, Ohio law requires companies to ignore health underwriting. During an open enrollment period a company cannot reject your application because of poor health.

When Is Open Enrollment For Traditional Health Plans?

According to Ohio law, every company that offers major medical coverage must hold open enrollment beginning each year on January 1. Open enrollment ends when the new members are one-half of one percent of a company's total enrollment.

For example, a company that insures 10,000 Ohioans could close open enrollment after accepting applications to cover 50 new people. Applications are received on a "first come, first served" basis.

The Lesson: Apply Early!

Insurance Tip: For a current list of companies offering guaranteed coverage, contact the Ohio Department of Insurance at 1-800-686-1526 or www.ohioinsurance.gov.

Am I Eligible For Traditional Open Enrollment?

You are eligible for a company's open enrollment coverage if

- You are not in the hospital for a chronic illness or permanent injury when you apply **AND**
- You are not covered by or eligible for any private or public health plan.

Information about managed care open enrollment can be found in Chapter 4.

I Have Never Had Health Coverage. Does The Law Require A Company To Issue An Individual Policy To Me?

No. The **Health Insurance Portability and Accountability Act** does not make this requirement, but Ohio law says you must be accepted if you apply during open enrollment.

Starting each year in January, all companies that sell individual major medical health policies (other than conversion policies) must accept open enrollment applicants. The insurers must accept new applicants up to the company's limit on a first come, first served basis. To qualify, you cannot be eligible for any other health insurance.

In addition, many managed care plans are required to hold open enrollment every year for at least 30 days. Managed care plans must accept applicants and their dependents up to the company's limit and on a first come, first served basis. See Chapter 4 for more information about managed care.

Open

Enrollment

Plans

Will My Premiums Be Higher If I Apply During Open Enrollment?

If you are a federally eligible individual (see FEI rules on page 4), the company can charge you twice the premium amount it charges people who do not come through open enrollment. If you are not a FEI, the company can charge you $2^1/_2$ times the premium amount it charges others.

When Will My Coverage Take Effect If I Apply During Open Enrollment And I Am Not A Federally Eligible Individual?

Coverage must take effect within 90 days after the company accepts your application. However, the policy may require you to wait one year before covering pre-existing conditions.

Will I Be Able To Renew My Health Insurance Policy After The Contract Expires?

Many health insurance contracts last one year. However, individual policies and employer groups are **guaranteed renewable**. At the end of the year, you have the right to renew your coverage.

When the company renews your policy, it has the right to change premiums and benefits to make them consistent with policies being sold to new customers.

However, you do not have the right to renew a policy if

- You have failed to pay premiums,
- You have committed fraud on the insurance company or misrepresented facts in your application or in claims, or
- The insurance company has stopped doing business in Ohio.

Open Enrollment Basic and Standard Plans

Basic and Standard plans from different companies do not have to be identical but they must include these features. This is an outline only. Not every benefit is shown.

	Basic Plan	Standard plan
Deductible (calendar year) *No family limit*	$1,000	$750
Emergency room deductible *Waived if admitted to hospital*	$75	$75
Co-payment	50/50	70/30 80/20 PPO-In 60/40 PPO-Out
Out-of-pocket limits Individual Family	 $5,000 None	 $5,000 None
Maximum limits Calendar year Lifetime per insured	 $50,000 None	 None $1,000,000
Mental/nervous/alcoholism & drug addiction Lifetime limit Calendar limit inpatient Calendar limit outpatient	 $5,000 $2,000 $550	 $10,000 $2,000 $550
Maternity and routine nursery *Benefits limited to complications only*	None	$3,000

Both Plans

Hospital Room and Board . . . . . .Average semiprivate rate.

Intensive Care . . . . . .Three times average semiprivate rate.

Maternity and Routine Nursery As described in Schedule of Benefits; includes dependent children if family policy.

Organ Transplant . . . . . .Lifetime maximum: $100,000.
(Heart, heart/lung, lung, liver, bone marrow, kidney, pancreas, and cornea)

Outpatient Physical Therapy . . . . . .$40 per visit; maximum of 20 visits per year.

Outpatient Prescription Drugs . . . . . .$2,500 per year.

Nursing Home/Home Care/Hospice . . . . . .$5,000 per year.

Skeletal Adjustment . . . . . .$25 per visit; maximum of 10 visits per year.

Preventive Care

Birth to age one . . . . . .$500 per year.
Age one through eight . . . . . .$150 per year.
Mammogram . . . . . .Ages 35-39: 1 exam.
Ages 40-49: 1 every 2 years (**exception: risk** factors for cancer).
Ages 50-64: 1 exam per year.

Pap Smear . . . . . .Covered.

Pre-Existing Conditions . . . . . .One-year waiting period.

• **For FEIs:** The one-year waiting period is reduced by creditable coverage. One year or longer of creditable coverage removes the pre-existing waiting period. But you must apply for **open enrollment** in the new health plan by **midnight of day 63** after your COBRA benefits end. If you try to enroll on day 64, you will no longer be eligible for creditable coverage.

• **For non-FEIs:** You will have to wait 12 months before the policy will pay for treatment of medical conditions treated during the six months before the policy's effective date.

Open Enrollment Basic and Standard Plans

Chapter 3:
Rate Regulation For Traditional Health Insurance

Rate

Regulation

How Are Insurance Rates Regulated?
Every company that sells **individual health insurance** in Ohio must file its rates with the Department of Insurance.

Does The Department Of Insurance Set The Rates And Tell Companies How Much They Can Charge?
No, each company calculates its own rates. The role of the Department is to ensure that the insurance companies meet Ohio's legal requirements.

I Know My Insurance Company Made A Profit Last Year. But Now It Says It Needs A Rate Increase Because It's Been Losing Money. Can Both Things Be True?
Yes. The company divides its policies into "blocks" or "types" and watches the income and expenses of each block separately. Everyone with the same kind of policy you have would get the same rate increase.

This means the company could be doing very well overall, but losing money (and entitled to a rate increase) on a specific block of business.

How Does A Company Get A Rate Increase Approved?
- The company files a proposal for new rates on specific policies, showing its anticipated income and expenses on those policies.
- The Department's rate experts (called "actuarial analysts") have 30 days to check the company's calculations.
- The analysts recommend disapproval if the proposed rates do not meet Ohio's legal requirements or if they find discrepancies in the company's calculations.
- If the Director of Insurance does not disapprove a rate within 30 days, the company's proposed rate goes into effect automatically.

What Are Ohio's Legal Requirements?
Premiums must be "reasonable" when compared to the benefits. The law says a rate is "reasonable" when it has been "calculated in accordance with sound actuarial principles."

A rate is actuarially sound when it provides the company with just enough income to pay its anticipated claims and operational expenses and to make a reasonable profit.

What Do Actuaries Consider?
- The company's statistics on income and expenses and its predictions of future claims and expenses are studied.
- One of the most important calculations is the company's "**loss** ratio."

What Is A Loss Ratio?
The **loss ratio** shows what portion of the total premiums the company collects is actually paid on customers' claims.

- A company with 65 percent loss ratio is spending 65 cents out of every dollar on claims.
- A company with 101 percent loss ratio is losing money - for every dollar it takes in, the company is spending $1.01 just to pay claims.

What Is An Acceptable Loss Ratio?

Acceptable loss ratios vary based on factors such as the kind of coverage and how long the policies have been in force.

What Happens To The Part Of The Company's Income That Isn't Spent On Claims?

That is the company's operating fund. It is used to pay business expenses (sales commissions, salaries, taxes, utility bills, advertising, etc.) as well as the company's profit.

You may not approve of how the company spends its money, but Ohio law does not give the Department of Insurance authority to tell the company how to use its operating expenses as long as the loss ratio is acceptable.

Does The Department Hold Hearings To Give The Public A Chance To Comment On A Company's Rate Request?

Generally not. Ohio law does not permit the Insurance Director to consider public opinion when determining whether to approve rates.

In 1990, the Ohio Supreme Court ruled that the Director "must approve the rate increase" unless there is "evidence that the rates were not calculated in accordance with sound actuarial principles."

How Often May An Insurance Company Request A Rate Increase?

As often as the company is able to support a rate increase. In reality, companies seldom submit more than one rate request per year.

What Can I Do If The New Rates Are More Than I Can Afford?

Shop around. Your current company may have a more affordable policy (fewer benefits and lower premiums). Or, another company could match your current benefits at a better price.

Regulations discussed above apply to individual health policies only. The rules are different if you are covered under a group policy.

How Are Small Employer Groups Regulated?

Ohio law restricts annual premium increases for policies that cover small employer groups (2-50 workers). Small groups must certify their rates' actuarial soundness with the State.

How are Other Groups And Self-Insured Employer Groups Regulated?

Large employers and most associations negotiate their rates with insurers without any involvement or approval by the Department of Insurance. Self-insured employers pay claims from their own "pockets" and can charge employees any rate they feel is appropriate.

Chapter 4:
Managed Care Specifics

Managed Care Specifics

What is Managed Care?

Managed care provides preventive care and other services that are basic to good health. It is a health care system that joins together the financing and delivery of health care services to covered individuals by arrangement with selected providers who furnish a broad set of health care services.

Your managed care plan could be through a traditional health insurance company, or you might be covered by a separate managed care plan (for example, an HMO). Either way, if you have a managed care plan, there is a provider network. Be sure to follow your plan's network rules when you need care.

What is a Health Insuring Corporation (HIC)?

HICs are defined as prepaid managed care plans that perform two functions: they provide health care and pay the bill (assume the risk). Ohio HICs are commonly called HMOs (Health Maintenance Organizations). Don't let the terms confuse you. State law gives the Ohio Department of Insurance regulatory authority over Health Insuring Corporations.

These managed care plans provide health services through a network of doctors, hospitals, laboratories, etc. Network providers may be either employees of the plan or have some other contract arrangement with the plan. Except in emergencies, you must receive your care from network members. You must choose a network doctor as your primary care physician (PCP) to manage all your health care.

What is a Preferred Provider Organization (PPO)?

It is easy to confuse a PPO with an HMO or HIC because both involve managed care. A PPO is a group of doctors, hospitals, and other health care providers who have contracts. To encourage you to use providers on the PPO list, you will usually have lower out-of-pocket expenses than if you use a provider that is not on the list.

Remember: HICs are HMOs and are regulated by the Ohio Department of Insurance, but PPOs are not.

What Are The Advantages Of Managed Care?

Typically, managed care plans have fewer out-of-pocket costs for the policyholder, including smaller co-payments and deductibles. Managed care plans also provide preventive care and often cover prescription drugs. When visiting in-network providers, claims are filed directly to the managed care company. In addition, every Health Insuring Corporation (HIC) must have formal procedures to appeal decisions in which you disagree.

Are There Disadvantages to Managed Care?

Yes. A managed care plan may not pay if you use a doctor or hospital outside its network or service area, and you may need a referral to see a specialist (although women cannot be required to get a referral in order to see their gynecologist). Managed care might not be your best choice if you travel regularly or want to cover dependents that live in another community. Also, you have no guarantee that doctors and hospitals in your managed care plan's network will stay in the network.

What Happens If My Doctor Leaves My Managed Care Plan's Network?

If your doctor (or other provider) leaves the plan, you must be notified within 30 days of the decision and your plan must help you find a new provider. If you were receiving treatment, you must be allowed to complete that treatment or receive help to move to a new provider for the completion of treatment.

If I Have A Managed Care Plan, Do I Need A Referral to See A Specialist?

Maybe. In many cases, your primary care provider must refer you to a specialist within the network in order for you to be covered. However, women cannot be required to get a referral in order to see their gynecologist. Also, the company MAY give you direct access to a network specialist who can treat you.

Your primary care physician (PCP) can give you a standing referral to a specialist if the PCP and specialist agree you need continuing care by the specialist. A specialist can also act as your PCP if it is determined that your condition requires care by the specialist over a long period of time. In this case, the health insuring corporation (HIC) must review your doctor's request and give you its decision within 7 days - the time frame required by Ohio law.

Am I Eligible to Purchase A Managed Care Plan?

If you wish to select a managed care plan, it's important to remember that each plan has a specific territory or "service area," and its own eligibility requirements. In Ohio, service areas are generally divided along county lines. Every county in Ohio is served by at least one HMO.

Eligibility may depend on certain factors

- Where you live
- Your employer or association
- Open enrollment regulations

For an up-to-date list of managed care health plans and which Ohio counties are served by each health plan, please contact the Ohio Department of Insurance toll-free at 1-800-686-1526 or on the web at www.ohioinsurance.gov.

What Should I Know Before Choosing A Managed Care Plan?

If you decide to purchase managed care insurance, your plan choices are limited to the plans that contract with your employer or serve your county. It's a good idea to check the provider directory to see what doctors and hospitals participate with the plan to see if your doctors are in the plan's network. However, it's important to remember this list can change at any time. You may also wish to visit and compare the network's facilities (clinics, hospitals) before making a final decision.

What Specific Services Must A Managed Care Plan Cover?

Every HMO Basic and Standard plan must insure "medically necessary" basic health care, which includes

- Basic physician services
- Inpatient hospital services
- Outpatient medical services
- Emergency health services
- Urgent care services
- Diagnostic laboratory services and diagnostic and therapeutic radiological services
- Preventive care, including
    - o Well-child care
    - o Periodic physicals
    - o Prenatal obstetrical care
    - o Voluntary family planning
    - o Infertility services
    - o Cytological exams and screening mammography

Other **covered services** include

- Limited inpatient and outpatient mental health and substance abuse services
- Skilled nursing care, hospice care or home health care when medically necessary and in lieu of hospitalization
- Limited prescription drug coverage
- Reconstructive surgery following mastectomies

Remember, even though managed care policies cover all the basic health care services listed above, medical necessity is a very important part of determining coverage. You may not be covered for a service or treatment if the HMO determines the procedure is not medically necessary (see below)!

For more information about HMO Basic and Standard plans, see page 30.

My Policy Will Not Cover A Procedure My Doctor Recommended Because It Isn't Considered "Medically Necessary." Is This Customary?

Many managed care plans exclude coverage for treatment that is not medically necessary because the company does not want to pay for unnecessary treatment.

Medical necessity is a matter of judgment and your policy may not agree with your doctor's judgment of what treatment is medically necessary.

In some cases, medical necessity disputes may be decided by an organization that is independent of the insurance company (see Chapter 7).

Are Prescription Drugs Covered In My Managed Care Plan?

In Ohio, managed care plans are not required to cover prescriptions. However, plans that do provide prescription coverage can exclude a specific drug or a specific class of drugs - such as birth control pills.

If your health plan covers prescriptions, it may have a list of drugs it will pay for. This list is called a formulary.

Ohio law requires managed care plans to follow the formulary guidelines below when they provide coverage for prescription drugs.

- Any formulary must be approved by a committee of pharmacists and doctors who prescribe drugs.
- Committee members can be in the plan's network or simply be licensed to practice in Ohio.
- You can get a drug that's not on the list (for your normal co-payment) if your doctor certifies the formulary alternative will not treat your condition effectively or that it could cause a bad reaction.

What Services Are Not Covered Under A Managed Care Health Plan?

Managed care plans must cover any basic health care treatment that is medically necessary. If the HMO determines a service you want is not medically necessary, payment for that service may be denied.

A managed care plan also usually excludes procedures it considers to be experimental, but in some situations coverage may be provided. See below for more about experimental treatments.

Contract language must be clear and must name exclusions specifically. Catch-all phrases (such as "anywhere" or “anytime") cannot be used to exclude or limit care.

Services Not Covered

What are Deductibles and Co-Payments?

In addition to your monthly premium payments, most plans require you to pay some share of the bills for covered expenses.

Deductible: A set amount that you have to pay toward covered expenses before the policy starts to pay. Some policies require you to pay a deductible for each incident.

Co-payment: Your share of the health care expenses. The plan might call this co-insurance.

Important: Deductibles and co-payments are separate items. Services and costs not covered by the policy do not satisfy deductibles or out-of-pocket maximums.

More

Managed

Care

Specifics

How Much Will It Cost Me For Medical Services?

You may be required to make a small co-payment whenever you use services within the network. If you follow the plan's rules, billing disputes are strictly between the doctor and the health insuring corporation (HIC). Under Ohio law, you are "**HELD HARMLESS**," and you aren't responsible for charges that are higher than what the plan pays.

Managed care plans must limit the amount of the co-payment to no more than 40 percent of the average cost of the provided service for basic health care services.

However, the managed care plan can charge you any dollar amount or percentage for supplemental services - that is, care other than basic care.

Once you've made the co-payment, the plan will pay the balance of the bill directly to the doctor or hospital.

What Steps Should I Take When Filing a Claim?

If you belong to a **managed care health plan**, the plan pays its network **providers** directly. As long as you use the network, you will not have to file insurance claims.

Does a Family Plan Cover All Members of My Household?

If you belong to a managed care plan, your dependent children must be covered even if they don't live with you.

If your child is treated by an out-of-area, non-network doctor, coverage may be limited to emergency service and urgent care.

If Both Parents Have Family Health Coverage Through Their Employer, Which Plan Insures Them and Their Children?

If you and your spouse both work and have family coverage through your employers' group plans, you and the children are probably covered by both plans.

The HMO must follow Ohio's Coordination of Benefits (COB) rule to decide which plan is primary and how much each of the plans must pay.

How Do I Know If My Or My Spouse's Plan Is Primary or Secondary?

When you are the patient, your employer's plan is always primary and your spouse's plan is secondary for you.

When your children are the patients, the plans follow the birthday rule. The spouse with the first birthday in the calendar year is the primary plan.

If you are divorced or separated, you follow the court decree. If the decree doesn't say who is responsible for the children's health care, the parent with legal custody has the primary plan.

There are many different possible situations and Ohio's COB rules cover most of them. The Ohio rules should be described in your policy or benefits booklet.

Primary plan: This is the plan that pays first
Secondary plan: After the primary plan has paid its part, the secondary plan pays part (or all) of the amount that is left.

Example Using the Birthday Rule

Joe and Wilma each have family coverage through their employer. Joe's birthday is January 10; Wilma's birthday is January 11. If their son Junior needs surgery, what happens if Joe and Wilma's different managed care plans require them to use network doctors and hospitals?

It can get complicated if no network doctors or hospitals that are in Joe's plan are also in Wilma's plan. However,

- Joe's plan is primary (using the birthday rule).
- If they prefer the hospital in Wilma's plan, they can take Junior there for his operation.
- When the hospital sends the bill to Joe's plan, it will reject the entire claim because the couple did not follow the plan's network rules.
- The unpaid bill then goes to Wilma's HMO.
- Since they followed all of its rules, Wilma's plan pays everything except their regular co-payment.

Caution: If Joe and Wilma had not followed the rules for either plan, neither would have paid.

How Do I Add New Family Members to My Family Plan?

- New members of the family are added to a family plan at the moment of birth or adoption.
- If you don't have family coverage but you are starting a family, it's best to notify the company as soon as the child is born.
- New additions have the same coverage as other family members plus treatment for birth defects or abnormalities.
- You must notify the company of any new member within 31 days following the birth. You may be required to pay additional premiums.

Do Managed Care Plans Have Waiting Periods For Pre-Exiting Conditions?

No. Managed care plans cannot make you wait before covering a **pre-existing condition**.

What If I Need Coverage For Something My Managed Care Network Doesn't Provide?

A plan must permit you to go outside its network for any basic or covered service it cannot provide through its network.

Primary and Secondary Plans

Am I Required to Use In-Network Hospitals In An Emergency?

No. You are not required to use the HMO's network of providers in the case of an emergency.

However, if your plan determines your condition was not an emergency, it could refuse to pay the emergency room bills.

That's why Ohio law requires an HMO to use the concept of a "prudent layperson" when determining whether to cover an emergency room visit. A prudent layperson is someone with average knowledge of health and medicine.

An emergency is a condition of such strong pain and severe symptoms that a prudent layperson could reasonably expect that a lack of immediate medical attention would

- Place the person's health in serious risk;
- In the case of pregnancy, place the baby's health in serious risk;
- Cause serious damage to bodily functions; or
- Cause serious damage to an organ or other body part.

"Emergency services" are defined as any of the health care services normally provided by a hospital's emergency room.

Managed Care Health Plans

When you have a medical emergency based on the "prudent layperson" definition, your managed care plan must pay your medical bills for that emergency, no matter where you receive the services. However, you may be responsible for paying some part of the services. In an emergency, you should go to the nearest hospital even if it is not covered in your plan's provider network.

Do Managed Care Health Plans Cover Experimental Treatments?

Managed care plans must have an internal process to determine whether an "experimental" treatment (or drug—if the plan offers prescription drug coverage) is safe and effective in treating a particular health condition (compared to the approved treatment).

- Decisions about experimental drugs and treatments must be made by doctors and other medical professionals.
- Evidence such as peer-reviewed literature and published opinions by medical experts must be reviewed.
- General decisions must be updated as new evidence becomes available.
- If you are denied coverage, the HMO must send you the reason in writing upon your written request.
- No drug or device can be considered "experimental" for a specific condition if the federal government has approved it as treatment for that condition.
- If you do not agree with what the HMO decides, you can appeal the decision - see pages 42-44 for more information about the appeal process.

Is The Underwriting Process Different For Managed Care Plans?

Yes! In a group plan, the managed care plan cannot reject individual members. If it accepts a group, the entire group must be covered. Under the Health Insurance Portability and Accountability Act (HIPAA), a carrier must continue to renew a group policy once it accepts the group. Health insuring corporations (HICs) must accept any small group that applies.

Managed care plans may use underwriting to reject an individual applicant, except during open enrollment or in the case of a newborn. HIPAA, however, states FEIs (see page 4) cannot be subjected to underwriting under ANY circumstance.

Who Regulates Managed Care?

The Ohio Department of Insurance regulates managed care carriers by state law. However, please note that the Ohio Department of Insurance does NOT regulate Medicare HMOs, which are governed by federal laws and regulations.

Please see Chapter 3 for general information about rate regulation in Ohio.

When Is Open Enrollment For Managed Care Plans?

Ohio law does not require EVERY managed care plan to offer open enrollment. However, plans that issue individual policies are required to offer open enrollment to eligible Ohioans. You are considered "eligible" in Ohio if you are not in the hospital for a chronic illness or permanent injury when you apply for coverage. Also, you must not be eligible for Medicare, Medicaid or continuation or conversion of a group policy. This rule does not apply to federally eligible individuals (see page 4).

Is Coverage Immediate?

No. Coverage will take effect no earlier than 90 days after the company accepts your application.

For an up-to-date list of managed care health plans and which Ohio counties are served by each health plan, please contact the Ohio Department of Insurance toll-free at 1-800-686-1526 or on the web at www.ohioinsurance.gov.

Open Enrollment Plans

Open Enrollment Basic and Standard Plans

Basic and Standard plans from different HMOs do not have to be identical but they must include these features. **This is an outline only.** Not every benefit is shown.

For a listing of the basic services ALL Basic and Standard plans must offer, see page 19.

	Basic Plan	Standard plan
Annual Individual Deductible	$1,000	$750
Annual Family Deductible	$2,000	$1,500
PCP Office Visits	$25 co-pay	$25 co-pay
Specialists Office Visits	$40 co-pay	$40 co-pay
Member Co-Insurance Percentage	40%	30%
Out-Of-Pocket Limits – Individual	$5,000*	$5,000*
Out-Of-Pocket Limits – Family	$10,000*	$10,000*
Emergency Room Services	$110/visit	$110/visit
Urgent Care Services	$45/visit	$45/visit
Emergency Ambulance Services	$110 per use	$110 per use
Inpatient Mental Health/Substance Abuse	5 day limit/year	5 day limit/year
Outpatient Mental Health/Substance Abuse	$550 limit/year	$550 limit/year
Prescription Drug Coverage	not offered	$1,000 limit/year per person $2,500 limit/year per family

*** Calculation of the member's out-of-pocket maximum does not include the individual and family deductibles, co-payments and coinsurance for inpatient or outpatient mental health or substance abuse services, prescription drugs, hospice care, home health care, skilled nursing care or the voluntary and unauthorized use of a non-participating specialist or facility.**

Both Plans

Inpatient Hospitalization ..... Annual deductible and co-insurance percentage.
Outpatient Hospital/Surgical Services ..... Annual deductible and co-insurance percentage.
Maternity and Routine Nursery ..... Same as any other illness.
Diagnostic Lab Services ..... Annual deductible and co-insurance percentage.
Diagnostic & Therapeutic Radiological Services ..... Annual deductible and co-insurance percentage.
Inpatient Mental Health And/Or Substance Abuse Services ..... Annual deductible and co-insurance percentage.
Outpatient Mental Health And/Or Substance Abuse Services ..... Annual deductible and co-insurance percentage.
Nursing Home/Home Care/Hospice ..... Annual deductible and co-insurance percentage.
Reconstructive Surgery Following Mastectomies ..... Hospital, physician and other services covered at levels set above.

Coverage is included for any covered person who is receiving benefits in connection with a mastectomy, who elects breast reconstruction for

- Reconstruction of breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce symmetrical appearance; and
- Prostheses and treatment of physical complication at all stages of mastectomy, including lymphedemas.

Chapter 5:
Leaving An Employer Group

When you leave an employer group, health insurance gets more complicated and more expensive. You will generally have two options: permanent conversion to an individual policy or temporary continuation of the group benefits.

What Are My Conversion Rights?

Unless your employer is self-insured, you may have the right to convert your group insurance certificate into Basic or Standard coverage provided by the group's insurance company or managed care plan. Your benefit limits won't exceed the group limits; you can keep the policy as long as you pay premiums.

You have conversion rights if you have been continuously insured for one year in the group and

- You leave the employer,
- You are a covered family member of a certificate holder who has died,
- You have reached the age limit for coverage under your parent's group or
- You divorce or separate from the certificate holder.

You must apply within 31 days of losing group coverage.

Example: For the past five years you've worked for Joe's Hardware and your family has been insured by Old Reliable Insurance Company or HMO.

- Within 31 days after leaving the job you apply to Old Reliable to convert to a family policy.
- The conversion policy might have fewer benefits and higher premiums than the group policy.
- Old Reliable must issue the policy regardless of your health.
- You can keep the individual policy as long as you pay premiums.

What Are My Continuation of Policy Rights?

You have the right to continue group coverage if you lose your current job. How you can buy the coverage usually depends on the number of people the company employed.

Continuation if you are laid off by a "small" employer

If you are laid off by a small employer (from 2 to 19 workers) you may have the right to continue under your employer's group coverage for six months because you are not eligible for COBRA (see below). To qualify, you must

- Be eligible for unemployment.
- Pay the plan's **FULL** cost (your share plus employer's share).
- Apply within 31 days of losing group coverage.
- Coverage lasts for 6 months only.

Continuation if you are laid off by a "large employer"

- **COBRA:** you have the right to continue in the group on a temporary basis after you (or your spouse or parent) leave an employer with 20 or more employees.
- Your former employer must notify you of your COBRA rights within 30 days after you leave the group.
- Once notified, you have 60 days to apply for continuation of coverage.
- If you do continue coverage, you are insured from the date group coverage ended, even if you wait until the 59th day to apply.

What Is COBRA?

COBRA is a federal law that gives you the right to continue in the group on a temporary basis after you (or your spouse or parent) leave an employer with 20 or more employees.

Employers of 20 or more workers must comply, including self-insured employers. However, COBRA does NOT apply to plans sponsored by the federal government and some church-related organizations.

What is COBRA?

Premium

You must pay the full group premium including any part your employer had been paying, plus 2 percent for administrative expenses.

Duration

COBRA coverage ends after either

- 18 months;
- 29 months if you became eligible for Social Security disability during the first 60 days of COBRA continuation;
- 36 months if you were insured through your spouse's or parent's job and the spouse or parent has become eligible for Medicare, died, divorced, or separated **OR**
- Your former employer goes out of business or stops offering a group plan to the employees.

Warning!
COBRA is not this simple! Your employer's personnel office should have a booklet that explains all of the twists and turns. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or on the Internet at www.dol.gov/ebsa.

Will an Illness Prevent Me From Getting New Insurance If I Change Jobs?

The 1997 federal health care reforms limit the right of group plans to discriminate against new employee members based on health. What you carry from your old job is your eligibility to join your new employer's plan-if your new employer offers health coverage.

If the new plan has a waiting period for pre-existing conditions, you will get credit for the time you were covered under your old plan. You will be eligible for such credit as long as you enroll in the new plan by **midnight of the 63rd day** after leaving the old plan.

What is HIPAA (The Portability Law)?

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that makes it easier for you to stay insured when you move from one job to another. HIPAA also establishes rules that identify "federally eligible individuals" (FEIs –see page 4).

"Portability" may be a confusing term because it sounds as if you can carry a plan from one job to another. But, you do NOT take your plan or benefits with you.

What you carry from your old job is your eligibility to join a health care plan when you arrive at your new job... if your new employer offers health insurance.

What is HIPAA?

How Does HIPAA Apply If I Am Moving From A Group Plan To Another Group Plan?

HIPAA applies if you are covered by your employer's health plan and you move to an employer that offers a health plan.

- Your new employer's plan must include any family member who was included with the old employer.
- You cannot be turned down or charged higher premiums because of a family member's health problems.
- Your new group plan may cost more.
- The new plan must have a special enrollment period if you add a dependent because of marriage, birth, adoption or loss of other coverage - any family member may enroll during a special enrollment period with no waiting period for coverage of pre-existing conditions.
- If you enroll a child within 31 days of birth or adoption, the group plan must cover all pre-existing health conditions.

Are There Different Rules If the Employer Offers Managed Care Group Coverage vs. Traditional Group Health Coverage?

Yes. If the new employer offers **managed care group health coverage**, the plan may have an "affiliation period," a time before the plan goes into effect which cannot be longer than 90 days after you complete the enrollment form. However, the plan CANNOT have a waiting period before it covers pre-existing conditions. All benefits must be covered on the date the plan goes into effect. Also, maternity benefits must be covered If the plan is full-service.

If your new employer offers **traditional group health coverage**, you can use creditable coverage (see below) to reduce a waiting period if the new plan has a waiting period for pre-existing conditions and you enroll in the new plan by **midnight of the 63rd day** after leaving the old plan. If you (or a family member) are pregnant when you switch jobs, the new plan will cover the pregnancy ONLY IF the new plan includes maternity coverage. Also, there may be a waiting period before you can enroll in the new plan. Waiting periods depend on a plan's specifics. Talk to your employer's benefits adviser.

What is Creditable Coverage?

What is Creditable Coverage?

Creditable coverage is proof, through a certificate issued by your former employer or insurer, you were covered under your old plan. It reduces the time you would normally have to wait before the policy covers pre-existing conditions. The reduction is equal to the amount of time you were covered under the old plan.

You have creditable coverage if you were under any plan listed:

- A full service group health insurance plan
- Medicare or Medicaid
- Chapter 55 of Title 10, USC (CHAMPUS)
- Indian Health Medical Program
- A state health risk pool
- A health plan under Chapter 89 of Title 5, USC
- A public health plan
- A health plan under section 5(e) of the Peace Corps Act

How Does HIPAA Apply If I Am Moving From A Group Plan To An Individual Plan?

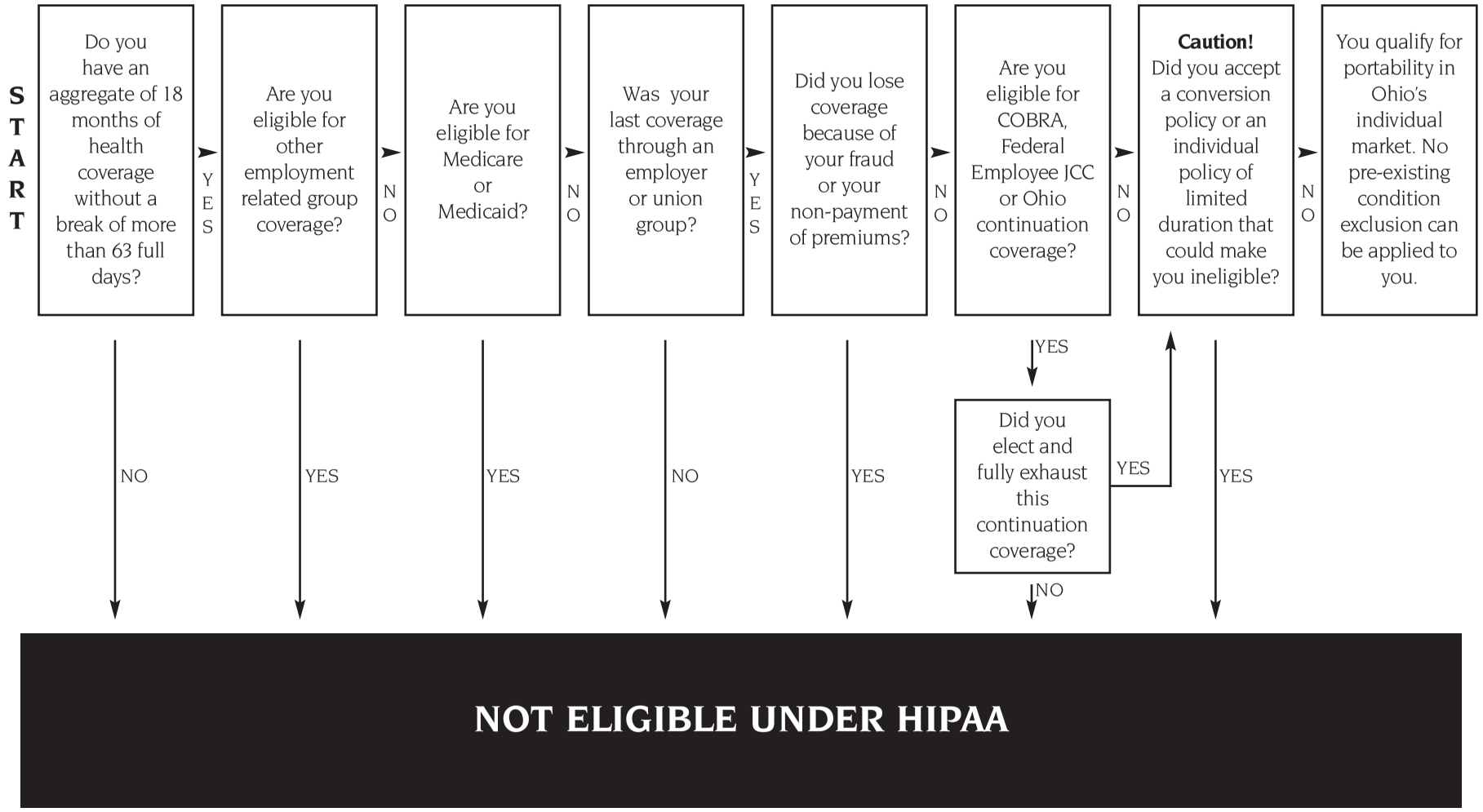
When leaving group insurance for an individual plan it will help to know if you are a "federally eligible individual" (FEI--see page 4).

If you qualify as an FEI, no insurance company offering individual coverage can reject your application for a Basic or Standard policy regardless of your health. Pre-existing conditions cannot be excluded. However, any insurer except the one that insured you before you lost coverage can reject your application if it has reached its enrollment limit.

If you do not qualify as an FEI, one of your options is open enrollment. In Ohio, insurers must hold open enrollment to give people who are not FEIs an opportunity to purchase health insurance. Conversion may also be an option. Within 31 days of the end of your group coverage you may be able to convert to any individual policy offered by the same company that covered the group.

Even if you do qualify as an FEI, conversion might be your best choice based on your situation. It's a good idea to consider all the options available to you before you decide.

GUARANTEED RIGHT TO PURCHASE INDIVIDUAL COVERAGE UNDER HIPAA



HIPAA

Guidelines

Health Insurance Portability and Accountability Act (HIPAA) Guidelines:

FEI (see page 4) – Based on Ohio Open Enrollment law, the following information on open enrollment and guaranteed issue coverage is for any individual with pre-existing health conditions who qualifies as a Federally Eligible Individual or FEI. To have immediate coverage, an FEI must be enrolled in either the Ohio Basic or Standard Health Plan by **midnight of the 63rd day** after losing the old coverage. The insurer must waive the pre-existing condition waiting period. You must provide a copy of the Certificate of Creditable Coverage from your previous insurance company to the new insurer in order to have the pre-existing condition period waived.

Non-FEI – Based on Ohio Open Enrollment law, if you have pre-existing health conditions but have not had health insurance within the last 63 days, **you may apply for coverage to the insurers below**. However, the company may impose a 90-day waiting period before coverage begins, and a 12-month exclusion waiting period for treatment for any pre-existing health conditions.

Company	Phone
American Community	1-800-991-2642
American Med. Sec.	1-800-753-1180
Anthem BCBS	1-800-318-8253
Celtic Life Ins. Co.	1-800-477-7870
Central Reserve	1-800-321-3997
Continental General	1-888-600-9331
Fidelity Security Life	1-800-446-1223
Fortis	1-888-575-3421
Freedom Life	1-800-387-9027
Golden Rule	1-800-444-8990
The Health Plan*	1-800-624-6961
Humana	1-800-257-3026
John Alden	1-800-328-4316
Kaiser Permanente*	1-800-686-7100
Life Investors	1-800-347-7082
Medical Mutual of Ohio	1-800-242-1936
National Health	1-800-237-1900
Nationwide	1-800-928-7378
Physicians Mutual	1-800-228-9100
Reserve National	1-800-654-9106
United HealthCare#	Call Collect 1-215-653-5385
World Insurance	1-800-786-7557

*You must live in a county where the plan is available. These plans are offered by Health Maintenance Organizations (HMOs). Call the plan for details.

#Plan has reached its annual quota for open enrollment. Insurers must accept a certain percentage of FEIs and non-FEIs each year. When an insurer has met its annual quota, it is not required to accept any additional enrollees until the following January. If you have questions, please call Consumer Services at the Ohio Department of Insurance: 1-800-686-1526.

Common Questions and Answers

I Heard There Are Different HIPAA Laws: One For Small Groups And A Different One For Large Groups. Is This True?

No. The federal law, HIPAA, applies to all group health policies - small employer, large employer and non-employer related groups. It also applies to self-insured plans and individual policies sold by traditional insurance companies or health insuring corporations (HICs).

Ohio law has at least the same requirements as HIPAA, except for self-insured plans, which are not subject to state law. There are some cases when Ohio law is more restrictive than the new federal law. When this happens, Ohio law governs.

Does The Law Require A Non-Employer Group Trust To Accept My Certificate Of Creditable Coverage?

No. A trust does not have to credit previous coverage against pre-existing exclusions. However, the law requires a group trust to issue you a certificate of creditable coverage when you leave the trust plan.

How Long After My Coverage Ends Should A Carrier Provide Me With A Certificate Of Creditable Coverage?

HIPAA provides that you receive a certificate automatically when coverage ends. Your old employer or insurer must issue the certificate within a "reasonable" period. In addition, upon your written request within 24 months after coverage ends, you must be issued a certificate whether or not you already received an "automatic" certificate.

What Are My Options For Conversion Or Open Enrollment As An FEI?

You can choose between Basic and Standard plans. The difference is that traditional insurance companies and managed care companies have varying basic and standard plans.

You have 31 days from the end of your COBRA continuation to apply for a conversion policy.

You have 63 days after continuation ends to apply for open enrollment with an insurer offering individual coverage. On day 64, prior creditable coverage no longer reduces pre-existing exclusions.

More Common Questions and Answers

I Have Health Coverage Through My Employer, But I Am Planning To Change Jobs. I Like My Current Coverage. Can I Keep It?

No. HIPAA does not allow you to carry coverage from one job to the next. The law also does not require your new employer to offer health insurance. If the new employer does offer health care it does not have to match your old plan.

HIPAA does allow you to give evidence that you had previous coverage. Your new employer must credit you for the previous coverage, if no more than 63 days has expired since your prior coverage terminated. This reduces any pre-existing exclusion period in the new employer's health plan for both you and your dependents.

I Am Covered Through My Self-Insured Employer. I'll Be Leaving That Job To Stay At Home, But I Have A Pre-Existing Condition. What Are My Options?

You can apply for individual coverage through open enrollment. You may do this as either a "Federally Eligible Individual" (FEI) or a non-FEI (see page 4). As an FEI, you must first exhaust any continuation of benefit options (COBRA).

When I Started My New Job There Was A 90-Day Waiting Period For Health Coverage. I Had A Claim On The 91st Day. The Insurance Company Denied The Claim, Saying Coverage Goes Into Effect The First Day Of The Month Following The 90-Day Period. Is This Right?

If you work for a small employer (from 2-50 employees), and coverage is provided by an insurance company, the law allows a service waiting period of not more than 90 days, at the employer's option.

The claim can be denied if coverage is provided by a traditional insurance company or managed care plan through a large employer (more than 50 employees).

Can Late Enrollees Be Denied Coverage?

No, they cannot be denied. However, a traditional insurance company may delay coverage for a late enrollee for as long as 12 months. In addition, an exclusion for pre-existing conditions can be imposed for an additional six months.

Managed care companies must accept late enrollees from covered groups during annual open enrollment.

Health insurance laws change often... so it's very possible that there will be different rules in effect when you obtain coverage for yourself and your family.

Chapter 6:

Medical Savings Accounts (MSAs) And Health Savings Accounts (HSAs)

What is a Medical Savings Account (MSA)?

Many employers allow employees to set aside money into a special "medical" savings account, earmarked to help pay eligible health care expenses, including the insurance policy deductible. In order to open an MSA, you must have and keep health insurance coverage. This can be either a group policy through your employer or an individual policy.

I Heard MSAs Are Being Phased Out, Is This True?

Up until December 31, 2003, federal law allowed consumers to form "Archer MSAs" to take advantage of federal tax breaks. However, Archer MSAs are being phased out in favor of HSAs (see next page) and new MSAs may not be formed after December 31, 2003. Archer MSAs existing as of December 31, 2003, may continue to operate and take advantage of federal tax savings. Or, an Archer MSA may also be rolled over into an HSA.

However, Ohio has its own MSA statute that allows consumers to take advantage of state tax savings. As of July, 2004, Ohio MSAs may still be opened.

How Does An Ohio MSA Work?

In 2003, you could deposit up to $3,575 into an Ohio MSA. This figure may increase from year to year and is set by the Ohio Department of Taxation.

The benefit to having an MSA is that you may earn a tax advantage by lowering your taxable income. Therefore, you can deduct your Ohio MSA deposit from the amount of your income that Ohio taxes. However, you will owe taxes on any amount you take out and use for non-eligible expenses. There may be federal tax issues to consider, so consult with your tax accountant if you open an MSA.

If you have an MSA, you may be able to lower your insurance premiums by increasing your deductible amount. You may also be able to set aside dollars to cover expenses that may not be covered under your current plan. You can open an Ohio MSA for each member of your family, and you may use money from your Ohio MSA to pay the first year premium and deductible for your adult child's health coverage.

What Is An MSA Administrator?

An Ohio MSA administrator keeps track of your account and pays your health care bills. The administrator must:

- Pay eligible expenses within 30 days after you submit the bills,
- Send you statements of your account (on request and yearly), and
- Tell the insurance company when you use Ohio MSA funds to pay policy deductible and co-payments.

Insurance companies, HMOs, banks, savings and loans, credit unions, CPAs and various other financial businesses can administer your Ohio MSA.

Does My Employer Need My Permission To Open An MSA In My Name?

Your employer does not need your permission to open an Ohio MSA in your name and pay part of your health benefit into the account. However, the employer must give you written notice explaining how this will affect your taxes.

What Happens To My MSA If I Leave or Change Jobs?

If you leave the employer (fired, laid off or resign) you have 60 days to request that the administrator either continue administering your Ohio MSA or transfer it to another Ohio MSA.

After 60 days without notice, the administrator closes your account and sends you the balance. The money then becomes taxable income.

What Is Considered An Eligible MSA Expense?

Money withdrawn from your Ohio MSA is eligible for the tax break only when it is used to pay eligible health care expenses.

The law defines eligible expenses as the cost of treatment prescribed by your doctor to prevent, cure or treat a disease. Your health insurance premium and deductible are also eligible expenses.

Medical

Savings

Accounts

What Are Health Savings Accounts (HSAs)?

HSAs are tax exempt accounts set up by an employer or individual to pay eligible health care expenses including insurance policy deductibles, co-payments and other out-of-pocket medical expenses. An HSA must be established with a high deductible health plan so that the HSA is used to pay routine expenses, and the plan is used to pay more significant expenses.

HSAs were created to replace Medical Savings Accounts (MSAs), another special account used to pay eligible health care expenses. Effective January 1, 2004, no new MSAs may be opened under federal law. However, existing MSAs may continue to be operated, or may be rolled over into an HSA.

HSAs allow employers and consumers to set aside funds on a tax free basis to pay health care expenses, including expenses that may not be covered by traditional health insurance. For example, HSAs may be used for vision and dental services, prescription drugs, over-the-counter drugs, long term care services and certain health insurance premiums in retirement.

Who Is Eligible To Open An HSA?

HSAs are open to anyone who:

- Is covered under a qualifying high deductible health plan.
- Is not covered by any other heath plan that is not a high deductible health plan (with some exceptions)
- Is not entitled to benefits under Medicare (generally, has not yet reached age 65), and
- May not be claimed as a dependent on another's tax return

High deductible plans must exceed $1,000 for single coverage, and $2,000 for family coverage. However, the plan may provide first dollar coverage for preventative health care services. Out-of-pocket expenses must be limited to $5,000 for single coverage and $10,000 for family coverage.

Who Can Contribute To My HSA?

Contributions may be made by the individual, an employer or a family member.

How Much Can Be Contributed To An HSA?

The annual HSA contribution is limited to the amount of your health plan's deductible, subject to a cap of $2,600 for single coverage and $5,150 for family coverage. Individuals over age 55 may contribute more.

Is The Money I Contribute To My HSA Tax Free?

Amounts contributed to an HSA, interest earned on the account and amounts used to pay eligible expenses are not taxed. However, amounts used to pay non-eligible expenses are taxed and may result in additional penalties.

What Are Eligible Health Care Expenses That Can Be Paid From My HSA?

An HSA may be used to pay for the diagnosis, cure, mitigation, treatment or prevention of disease; prescription and over-the-counter drugs; qualified long-term care services and insurance costs; COBRA coverage, qualified Medicare expenses (but not Medicare Supplement insurance); qualified health insurance costs for retirees; and more.

What Happens To My HSA If I Change Jobs?

You may take an HSA with you when you leave your employer.

Additional information on HSAs is available on the U.S. Department of Treasury website at www.treas.gov/press/releases/reports/1061hsafactsheet.pdf, or on the IRS web site at www.irs.gov/pub/irs-drop/n-04-2.pdf.

Chapter 7:
Appeals—When You Disagree with the Carrier

Appeal Procedures

If I Disagree With An Insurance Company's Decision, What Should I Do?

The internal appeal process is your first step if you want to appeal a carrier's decision. Ohio law requires an insurance company or health plan to have a state-approved internal procedure to review complaints. Your policy or certificate has specific details on your health carrier's review process. You can appeal any decision the carrier makes; however, whether you are entitled to an additional external (and independent) review depends on whether you are covered by a "traditional" or "managed care" plan.

How Do I Start An Appeal?

To initiate your plan's appeal procedures, contact the carrier to request a review through the internal review process. This process may have only one level or may have multiple levels before the internal process is completed. The carrier must notify you, in writing, of its final decision. You must complete all levels of the appeal process before the Ohio Department of Insurance will intervene.

What Is A Utilization Review?

Insurance carriers may use an internal process to decide if the health care services and procedures you're requesting are effective and appropriate. This is called a utilization review, and it is not required by Ohio law. However, carriers that do have the process must follow these guidelines:

- A "clinical peer," someone with medical credentials appropriate to the case, must conduct the review.
- Members and providers must have a toll-free phone number they can call to talk with the review staff.
- If you are denied coverage, the carrier must send you written notification with the main reason for denial and instructions for starting an appeal.
- Utilization review must follow a time frame.

A carrier conducts a utilization review in specific situations: BEFORE a treatment your doctor recommends, WHILE you are in the hospital or AFTER your treatment ends.

What If I Disagree With The Carrier's Decision?

If you are covered by a traditional health policy and the carrier denies a service or treatment, your case could be eligible for an external (independent) review.

If you are covered by a managed care (HMO) plan and the service or treatment has been denied, reduced or terminated, you may also be entitled to an external (independent) review.

What Is An Adverse Determination?

Adverse determination is what Ohio law calls care and coverage denials. If this happens, you can usually appeal the decision.

After An Adverse Determination, Will My Request Be Reviewed Outside the Carrier?

Ohio health carriers must allow certain appeals to be assessed by outside reviewers. If you complete the health carrier's utilization review process without getting approval for the service or treatment you want, your case may qualify for review by an organization that is independent of the insurance carrier (external review).

What Kind of Appeals Qualify for External Review?

Appeals denied through a carrier's internal process qualify for external review when

- The carrier has determined the service you want is not medically necessary,
- Your provider documents that the service (and all care related to the service) will cost you more than $500 if not covered, and
- You request external review within 60 days of being notified about the internal decision.

Laws also provide for important requirements that health insurance companies, HMOs and the people they insure must follow during an appeal.

To appeal a health plan decision, you must first contact your company or plan and go through its internal utilization review process.

Adverse

Determination

Who Will Conduct External Review?

An Independent Review Organization (IRO) carries out the review through a clinical peer (a medical professional with credentials appropriate to the case). The IRO is not affiliated with the carrier and is accredited by the Ohio Department of Insurance.

Who Pays For An External Review?

The carrier pays all external review fees.

Are Time Frames in Effect During An External Review?

Yes. Your request for an external review must be made within a specified period of time. Once the Independent Review Organization (IRO) has the needed information, their decision must be made within 30 days. Decisions must be expedited if your health condition is serious (see time frames below).

Is The Carrier Required to Allow an External Review If I Have A Terminal Illness?

Yes. The carrier must allow external review when

- The doctor concludes the illness is likely to cause death within two years.
- The doctor gives written opinion that
    - Standard treatments have not helped, OR
    - Standard treatments are not medically appropriate, OR
    - No standard treatment works as well as some other treatment.
- Coverage was denied because the company considers the doctor's recommended treatment to be experimental, AND
- The company's internal procedure has already denied coverage for the treatment.

All external reviews must follow this time frame:

- Your deadline to request external review after you are notified that the carrier has made a final denial = 60 days
- Once the IRO has all the information it needs, the IRO's deadline for making a binding decision = 30 days
- If your condition is serious, the IRO's deadline for a decision through expedited review = 7 days

External Review

What If My Appeal Does Not Qualify for an External Review?

For both traditional health and managed care plans, you may file a complaint with the Ohio Department of Insurance (ODI). However, you must complete the company's internal appeal process before ODI will intervene.

Refer to your policy or certificate for more details about your carrier's appeal process. If you have any questions about the external review process (also called Governor Taft's "Patient Protection Act"), call the Ohio Department of Insurance at 1-800-686-1526.

FYI: The carrier can decide to end the appeal at any time and pay for the disputed care.

We have not included every detail of Ohio's appeal process here. Review your contract or certificate for details of your appeal rights. You may also call the Ohio Department of Insurance at 1-800-686-1526.

Chapter 8:
Self-Insured Employers and Small Group Alliances

What Is A Self-Insured Plan?

If you work for a large company or a government agency, there is a good chance your health plan is self-insured. Instead of buying a group policy from an insurance company, a self-insured employer pays health care expenses out of the employer's own pocket. It's not insurance, although a self-insured plan may look to the employee just like insurance.

Self-insurance works best for companies that are large enough to offer good coverage and pay expensive claims for medical services such as open heart surgery, AIDS or hemophilia.

As long as claims are being paid you may not notice or care whether your employer has an insurance policy or is self-insured.

Does A Self-Insured Plan Have To Offer Specific Benefits?

Most state laws requiring specific health care plan benefits do not apply to self-insured plans.

Who Do I Contact If I Disagree With A Decision By My Self-Insured Plan?

The Ohio Department of Insurance cannot investigate complaints involving self-insured or self-funded plans. ERISA, a federal law, governs self-insured employers. The U.S. Department of Labor investigates complaints involving self-insured or self-funded plans.

Self-Insured Employers

- If you have a problem with your self-insured employer, contact:
  - The plan administrator
  - Your employer's benefits office
  - Your union representative
  - The U.S. Department of Labor
  - A private attorney

How to contact the U.S. Department of Labor:
U.S. Department of Labor
Employee Benefits Security Administration
200 Constitution Ave. NW
Room N5658
Washington, DC 20210
(202) 219-8776 or
1885 Dixie Highway, Suite 210
Fort Wright, KY 41011
(866) 444-3272

What Happens If My Self-Insured Employer Goes Bankrupt?

If your self-insured employer goes bankrupt, you become a creditor. Any unpaid health care claims will be treated like claims for unpaid wages. You might have to pay doctors and hospitals out of your own pocket.

Who Handles The Administration Of A Self-Insured Plan?

A self-insured employer normally hires a third-party administrator (TPA) to collect premiums, pay claims and handle other paperwork.

- Many insurance companies contract as TPAs with self-insured employers. This can disguise the fact that your plan is self-insured.
- The administrator's name appears along with the employer's on your benefits booklet and claim forms, just as if it were your insurance company.
- Your employer provides the money, decides what benefits to offer and what claims to pay. The TPA follows your employer's instructions.

What Are The Basic Differences Between Insured and Self-Insured Plans?

Self-Insured Plans

Insured Employer	Self-Insured Employer
Funds to pay claims	
The insurance company pays claims up to policy limits, using your premium payments backed up by reserves required by Ohio law.	Employer maintains its own health fund which may include contributions from employees. Employer may have a stop loss policy to protect the employer against large claims.
Benefits	
Must include specific benefits required by Ohio law (see page 7-8).	No specific benefit standards; limited to whatever the employer offers.
Processing your claims	
Insurance company or administrator	Employer or a third-party administrator (could be an HIC or an insurance company).
Conversion to individual policy	
Right to convert when you leave the group is guaranteed by Ohio law (see page 31)	Not available
COBRA continuation of coverage	
No difference between insured and self-insured; your right to continue as part of the group is guaranteed by federal laws (see page 32).	
Consumer complaints	
You can seek assistance from the Ohio Department of Insurance if you're not satisfied with the company's decisions.	Follow procedures established by the employer or the plan administrator. Contact the U.S. Department of Labor.
Bankruptcy	
Up to $100,000 in claims protected by the Ohio Life and Health Guaranty Fund. There is no such protection for Managed Care Companies.	You will be treated as a creditor in the employer's bankruptcy.
Other regulations	
Must comply with both federal and state law. Regulated by the Ohio Department of Insurance.	Exempt from many state regulations. Must comply with federal law (ERISA) Regulated by the U.S. Department of Labor.

What Is A Small Group Alliance?

When offering group plans, the rule is the larger the group, the better the benefits. This basic rule of health insurance can make it difficult for small employers or associations to find affordable coverage. One solution is for several small groups to combine their bargaining power and buy a single insurance coverage for all of their employees. To do this, the small employers and associations can form a "Health Care Alliance."

Alliances and insurance companies that contract with alliances must follow state law. Alliances may register with the Department of Insurance to assure they meet Ohio's legal requirements.

Who Can Create A Small Group Alliance?

- Groups must be a nonprofit company or association (such as a chamber of commerce or a trade association).
- Groups must have no ties to an insurance company or agency except as a customer buying coverage.

Who Can Join A Small Group Alliance?

- Any employer group, subject to alliance requirements.

What Qualifies As A "Small Employer"?

The employer must have fewer than 150 full-time employees with a majority working in Ohio. Full-time is defined as an employee who normally works at least 25 hours per week and 40 weeks per year.

If I Am A Small Employer, Are There Tax Advantages To Joining A Small Group Alliance?

Yes. A small employer who is part of an alliance can deduct from state income tax all of the premiums it pays to the insurance company.

What Can Alliances Do?

They can

- Negotiate with insurance companies for coverage for employees and retirees,
- Contract with other alliances to include members of one alliance in programs of another,
- Provide information about the alliance to small employers, and
- Solicit membership into the alliance.

Can Poor Health Prevent Me From Joining My Employer's Small Group Alliance?

Small group alliances cannot refuse membership to employees or their dependents due to poor health. Moreover, small group alliances cannot use medical underwriting to decide if a member is eligible for coverage.

However, the insurance company is able to reject applications for coverage and use medical underwriting. Companies can be held responsible for how claims are settled.

Are Insurance Companies Required To Offer Coverage To A Small Group Alliance?

No insurance company can be forced to agree to an alliance contract that the insurance company finds unacceptable. However, insurers are required to respond within 90 days to an alliance request that the insurance company propose a health care plan for the alliance. And, if no insurer makes a "reasonable" offer, the Director of the Department of Insurance can require companies to respond.

Registered Alliances (as of 3/22/04)

BBB Health Care Alliance	(330) 425-1870
Better Business Bureau-Central Ohio	(614) 486-6531 ext. 120
Builders Exchange Alliance	(216) 661-8300
COSE-GSI Alliance	(216) 592-2436
Dentist's Choice Health Care Alliance	(440) 717-1891
Greater Cincinnati Chamber of Commerce	(513) 579-3174
Greater Columbus Chamber of Commerce	(614) 225-6931
Independent Insurance Agents of Ohio	(614) 464-3100
Lancaster Fairfield County Chamber Alliance	(740) 653-8251
Ohio Chamber Alliance	(937) 296-0650
Ohio Council of Retail Merchants	(614) 221-7833
Ohio Land Title Association	(614) 235-5001
Ohio Optomeric Association	(614) 781-0708
Ohio State Medical Association	(614) 527-6762
OMEDA/OEDA Health Care Alliance	(614) 889-1309
OSBA Health Care Alliance	(800) 282-6556
PENN-OHIO	(412) 395-4023
(*Serving Columbiana, Mahoning and Trumbull Counties*)	
Southern Ohio Chamber Alliance	(937) 296-0650
United Way of the Greater Dayton Area Alliance	(937) 296-0650
United Way Health Care Alliance	(614) 227-2720
United Way Services	(216) 436-2111

Registered Alliances

This list of registered alliances may change. Call 1-800-686-1526 for an update.

Chapter 9:
Carrier Information

You can get the list of carriers licensed to sell insurance in Ohio by going to the Department web site (www.ohioinsurance.gov) or by calling 1-800-686-1526.

Note: The Ohio Department of Insurance does not rate or recommend insurance or managed care carriers!

What Are Private Rating Firms?

Several private firms specialize in evaluating the finances and services of insurance or managed care carriers. Each of these agencies has its own methods and standards and gives grades to the companies based on their judgment of how well the company is doing.

- The phone numbers and web site addresses below will connect you with some of the most popular rating firms.
- You may be charged for insurance company reports you get.
- Before you rely on any report, make sure you understand the rating system because each firm has its own grading system. For example, one firm may use "A+" as its top grade, while another may go all the way up to "A+++."

A.M. Best Company
Phone: (908) 439-2200
Web site: www.ambest.com

Fitch Investor's Service
Phone: 1-800-853-4824
Web site: www.fitchibca.com

Moody's Investor Service
Phone: (212) 553-0377
Web site: www.moodys.com

Standard & Poor's
Phone: (212) 438-1000
Web site: www.standardandpoors.com

Several of these publish books with their ratings, so you may also be able to find what you need at your local library.

Carrier

Information

What Should I Do If I Have A Dispute With My Health Carrier?

You do not need a lawyer to resolve most disputes with an insurance agent or a carrier. Insurance is a very competitive business. If you give the carrier a chance you will generally find the company is willing, if not eager, to straighten out problems.

- Start with the agent.
- If you're not satisfied, contact the carrier's customer service office. Most companies have toll-free telephone numbers for quick service.
- If customer service falls short of your expectations, ask about the company's procedures for appealing decisions (the appeals procedure should be spelled out in your policy or benefits booklet).

What If My Self-Help Efforts Fail?

If working directly with the carrier or agent doesn't satisfy your concerns, your next stop should be the Consumer Services Division of the Ohio Department of Insurance at 1-800-686-1526.

- Ask to speak with a health insurance analyst.
- He or she will answer questions over the phone and explain any additional steps you should take to resolve your own problem.
- Our staff will give you honest, unbiased answers. If it sounds as if the company has done nothing wrong, we'll tell you.

How Do I File A Complaint With The Ohio Department of Insurance?

- We'll send you a complaint form and instructions for filing a written complaint.
- We will send the carrier a copy of your complaint and ask them to resolve it or explain its position.
- Carriers are required by law to respond to the Department.
- Most carriers are very cooperative in resolving consumer complaints.
- We will review all of the facts to make sure the carrier has followed its contract with you, and that it has also complied with insurance rules and laws.

Does The Department Of Insurance Keep Track Of Consumer Complaints?

Yes. In 2003, more than 4,000 consumers complained to the Department about health insurance. If your complaint raises questions requiring us to contact the agent or carrier, we will register it as a "complaint." A complaint represents a customer who has been unhappy with the company or agent. It does not necessarily mean the company has broken the law or done anything wrong.

The next page has complaint records for health carriers. The "Complaint Ratio" column is designed to help make "apples-to-apples" comparisons easier.

What Are The Most Frequent Consumer Complaints About Health Plans?

- Claim denial
- Claim delay
- Unsatisfactory settlement offer
- Coverage question

You'll find additional information for consumers at the Ohio Department of Insurance web site: www.ohioinsurance.gov

Complaint Comparisons

Total # of consumer complaints the Ohio Department of Insurance received that were health insurance-related in 2003 . . **4232**

Total # of authorized health carriers in Ohio in 2003 . . . . . **1519**	Total # of authorized health carriers with complaints in 2003 . . . . . **241**	Total # of complaints in 2003 involving authorized health carriers **2983**	Total # of health carriers with 10 or more complaints in 2003 . . . **46**

Top 10 reasons for health insurance complaints

1. Claim denial (1806)
2. Claim delay (689)
3. Unsatisfactory settlement offer (457)
4. Coverage question (255)
5. Premium & rating issues (139)
6. Other (131)
7. Cancellation (98)
8. Premium refund due (89)
9. Premium notice & billing issues (84)
10. Usual, customary & reasonable (UCR) (83)

Total complaints represented by the above Top 10 reasons = 3831
That is 91% of the total (4232) health-related complaints registered in 2003

3831 / 4232 = 91% 0.9052457

Insurer	Total Complaints	Written Premiums	Complaint Ratio
COMMUNITY INSURANCE COMPANY	481	$2,933,896,328	0.16
MEDICAL MUTUAL OF OHIO	450	$1,480,296,619	0.30
UNITED HEALTHCARE OF OHIO INC	326	$1,323,434,773	0.25
HUMANA HEALTH PLAN OF OHIO INC	85	$402,631,897	0.21
QUALCHOICE HEALTH PLAN INC	76	$376,978,048	0.20
AETNA HEALTH INC	67	$271,661,904	0.25
UNITED HEALTHCARE INSURANCE COMPANY OF OHIO	63	$424,928,854	0.15
PARAMOUNT CARE INC	62	$440,611,491	0.14
NATIONWIDE LIFE INSURANCE COMPANY	57	$108,993,505	0.52
CONNECTICUT GENERAL LIFE INSURANCE COMPANY	51	$59,485,448	0.86
FORTIS INSURANCE COMPANY	49	$36,930,565	1.33
UNUM LIFE INSURANCE COMPANY OF AMERICA	47	$142,089,454	0.33
AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS	42	$86,978,858	0.48
KAISER FOUNDATION HEALTH PLAN OF OHIO	42	$441,868,014	0.10
UNITED AMERICAN INSURANCE COMPANY	37	$36,832,522	1.00
VANTAGE HEALTH PLAN INC	35	$5,455,111	6.42
CONTINENTAL CASUALTY COMPANY	30	$41,317,225	0.73
METROPOLITAN LIFE INSURANCE COMPANY	27	$119,654,941	0.23
CENTRAL RESERVE LIFE INSURANCE COMPANY	25	$62,358,901	0.40
HUMANA INSURANCE COMPANY	25	$156,366,268	0.16
CONTINENTAL GENERAL INSURANCE COMPANY	22	$12,970,395	1.70
MEGA LIFE AND HEALTH INSURANCE COMPANY, THE	22	$34,338,074	0.64
CONSECO SENIOR HEALTH INSURANCE COMPANY	21	$14,702,398	1.43
CONSECO HEALTH INSURANCE COMPANY	20	$19,746,140	1.01
GUARDIAN LIFE INSURANCE COMPANY OF AMERICA	20	$103,108,500	0.19
JOHN ALDEN LIFE INSURANCE COMPANY	20	$41,201,853	0.49
LIFE INSURANCE COMPANY OF NORTH AMERICA	20	$26,760,051	0.75
MEDICAL HEALTH INSURING CORPORATION OF OHIO	19	$120,508,189	0.16
SUMMACARE INC	19	$280,803,254	0.07
GOLDEN RULE INSURANCE COMPANY	18	$58,459,001	0.31
HOMETOWN HEALTH PLAN	18	$98,471,106	0.18
McKINLEY LIFE INSURANCE COMPANY	17	$97,782,876	0.14
UNICARE LIFE & HEALTH INSURANCE COMPANY	16	$36,402,211	0.44
UNITED HEALTHCARE INSURANCE COMPANY	16	$489,228,549	0.03
FAMILY HEALTH PLAN INC	15	$128,962,531	0.12
AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY	14	$42,860,558	0.33
AETNA LIFE INSURANCE COMPANY	13	$134,010,747	0.10
DELTA DENTAL PLAN OF OHIO INC	13	$108,244,387	0.12
MID-WEST NATIONAL LIFE INSURANCE COMPANY OF TENNESSEE	13	$6,607,541	1.97
NATIONAL STATES INSURANCE COMPANY	13	$3,524,738	3.69
PHYSICIANS MUTUAL INSURANCE COMPANY	13	$18,445,076	0.70
AULTCARE HMO	11	$13,937,971	0.79
FORTIS BENEFITS INSURANCE COMPANY	11	$49,077,441	0.22
JEFFERSON PILOT FINANCIAL INSURANCE COMPANY	11	$21,091,868	0.52
COLONIAL LIFE & ACCIDENT INSURANCE COMPANY	10	$25,110,232	0.40
SUMMIT INSURANCE COMPANY	10	$57,928,628	0.17
Total # of carriers with 10 or more health-related complaints = 46	**2,492**	**$10,997,055,041**	**0.23**

Carrier List: Who Covers What?
Group/Individual Traditional Health & Managed Care Plans

Key to using Chart

The company name is followed by its customer service phone number. Many phone numbers are toll-free.
An 'X' shows types of coverage the company reported it was selling when the survey was completed.
Individual plans are shown in the columns left of the gray divider. These columns represent:
(Left to Right): (1) Major Medical; (2) Hospital Insurance; (3) Hospital Indemnity; (4) Short-term Medical; (5) Disability
Group plans are shown in the columns right of the gray divider. These columns represent:
(Left to Right): (1) Small Employer (2-50 workers); (2) Large Employer (over 50); (3) Association/Non-employer;
(4) Medical Savings Accounts; (5) HIPAA information phone

COMPANY NAME	CUSTOMER PHONE	INDIVIDUAL					GROUP				
Aflac	1-800-425-2244					X					
Aid Association for Lutherans	1-800-225-5225					X					
Alta Health and Life	1-800-355-8431	X				X			X		X	1-800-355-8431
American Chambers Life	1-800-822-1805	X						X		X	X	1-800-822-1805
American Community Mutual	1-800-233-3444	X		X	X	X		X	X		X	1-800-233-3444
American Family	1-888-428-5433	X			X						
American Heritage Life	1-800-521-3535			X							
American National		X		X	X			X	X	X		
American National Life of TX		X			X			X	X	X		
American Union Life		X			X						X	
Bankers Life and Casualty	1-800-621-3724			X		X					
Bankers United Life Assurance	1-800-522-4961	X				X		X				1-800-522-4961
Central Benefits Mutual	1-800-777-3377	X	X			X		X	X			1-800-333-5711
Central Benefits National Life	1-800-777-3377	X	X			X		X	X			1-800-333-5711
Central Reserve Life	1-800-321-3997	X	X	X	X			X	X	X	X	1-800-321-3997
Central States H & L of Omaha	1-800-541-2363					X					
Central United Life	1-800-669-9030			X		X					
Cincinnati Equitable	1-800-229-2210	X			X	X		X	X			1-800-229-2210
Cincinnati Life						X					
Combined	1-800-225-4500			X		X					
Community (Anthem BCBS)		X	X	X				X	X	X		1-800-467-4663
Conseco Medical	1-800-884-1576	X						X		X	X	1-800-884-1576
Continental Assurance	1-800-822-5000			X		X			X	X		
Continental Casualty	1-800-822-5000			X		X			X	X		
Continental General	1-800-545-8905	X			X	X						1-800-545-8905
Employers Health	1-800-777-6940	X	X	X	X	X		X	X			1-800-777-6940
Epic Life	1-800-551-7263	X				X		X	X			1-800-551-7263
Federated Life	1-800-533-0472					X					
Fidelity Security Life	1-800-648-8624	X		X	X	X			X	X		(816) 968-0543
Fortis	1-800-800-8463	X			X			X		X	X	1-800-800-8463
Fortis Benefits	1-800-724-6614	X				X		X	X		X	1-800-767-8223
General American Life	(614) 761-1778	X		X		X			X			(614) 761-1778
Gerber Life	1-888-850-9399	X				X		X	X			1-888-850-9399
Golden Rule	1-800-444-8990	X	X	X	X			X		X	X	
Great-West Life and Annuity	1-800-355-8431	X				X			X		X	1-800-355-8431
GuideOne Life	1-800-247-4176 x2984					X						1-800-247-4176 x 2984
Hartford Fire	1-800-727-0721								X			
Hartford Life	1-800-727-0721				X	X			X	X		
Hartford Life and Accident	1-800-727-0721					X			X			
Hartford Life and Annunity	1-800-727-0721					X			X			
Horace Mann Life	1-800-999-1030					X		X	X			

Carrier List: Who Covers What?
Group/Individual Traditional Health Plans
(continued)

Illinois Mutual Life	1-800-437-7355					X						
John Alden Life	1-800-328-4316	X			X			X			X	1-800-328-4316
John Deere	1-800-447-0633	X						X	X			1-800-447-0633
Life Investors of America	1-800-522-4961	X			X	X		X		X		1-800-522-4961
Lutheran Brotherhood	1-800-990-6290					X						
McKinley Life	1-800-344-9959	X	X					X	X			
Medical Mutual of Ohio	1-800-362-4700	X						X	X		X	1-800-242-1936
Medico Life	1-800-228-6080					X						
Mennonite Mutual Aid Assoc.	1-800-348-7468	X								X	X	1-800-348-7468
Metlife	1-800-929-1492					X				X		1-800-929-1492
Minnesota Life						X			X	X		
MMA	1-800-348-7468	X						X	X	X	X	1-800-348-7468
Monumental Life	1-800-522-4961	X			X			X				1-800-522-4961
Mutual of Omaha	1-800-775-6000	X			X	X				X	X	1-800-775-6000
Mutual Protetive	1-800-228-6080					X						
National Health	1-800-237-1900		X							X		1-800-237-1900 X3154
National States	1-800-868-6788			X						X		
National Travelers Life	1-800-685-1123	X				X					X	1-800-685-1123
Nationwide Life	1-800-882-2822	X		X	X	X						1-800-882-2822
New England Life	1-800-355-8431	X				X			X		X	1-800-355-8431
New York Life		X		X		X				X	X	
Nippon Life	1-800-937-6542	X						X	X			1-800-937-6542
Northwestern Mutual Life						X						
Ohio National Life	1-800-366-6654					X		X	X			
Ohio National Life Assurance	1-800-366-6654					X						
Paul Revere Life	1-800-633-7490					X						
Pennsylvania Liife				X		X						
Peoples Benefit Life	1-800-356-6271			X								
PFL Life	1-800-522-4961	X						X				1-800-522-4961
Phoenix American Life	1-800-451-2513	X				X		X	X	X		1-800-451-2513
Phoenix Home Life Mutual	1-800-451-2513	X				X		X	X	X		1-800-451-2513
Pioneer Life	1-800-950-0084	X						X		X		1-800-950-0084
Principal Life						X		X	X			
Professional 1-800-289-1122				X		X						
Provident American Life	1-800-237-7767	X	X	X				X	X	X		1-800-237-7767
Provident Life and Accident	1-800-633-7490					X		X	X	X		
ReliaStar Life	1-888-558-1999	X	X	X	X	X				X		
Reserve National	1-800-654-9106		X	X						X		1-800-654-9106
Sentry Life	1-800-533-7827	X				X		X	X	X		1-800-533-7827
Standard Life and Accident	1-888-350-1488			X								1-888-350-1488
State Farm Mutual Auto		X	X	X	X	X						
Summit	1-800-822-4470	X	X	X				X	X			1-800-822-4470
Teachers Protective Mutual Life	1-800-555-3122					X						1-800-555-3122
Trustmark (Mutual)	1-800-285-7911	X	X	X	X	X		X	X	X	X	1-800-347-0889#1
Union Central Life	1-800-825-1551					X		X	X	X		
United American			X	X		X			X	X		(972) 529-5085
United of Omaha	1-800-775-6000	X				X		X	X			1-800-775-6000

Group/Individual Managed Care Plans

Health Maintenance Organizations (HMOs) offer an alternative to traditional insurance. You receive your basic health care from specific doctors and hospitals. HMOs accept individuals during their Open Enrollment Period regardless of any pre-existing health conditions, but they may refuse to accept people who qualify for coverage as federally eligible individuals under any of the following:

- An employer sponsored plan,
- Group continuation coverage, or
- Medicare (although some HMOs may cover this group).

Things to remember:
You must live in the HMO service area to apply;
Coverage may not start until 90 days after your month of enrollment;
An HMO may be granted a waiver or limit for their open enrollment period.

To get a current list of plans and counties served, please contact the Department of Insurance at (800) 686-1526 or on the Web at www.ohioinsurance.gov.

How to enroll:
Call the HMO serving your county (at the beginning of their expected date) to confirm their scheduled open enrollment will take place; apply early as applications are taken on a first come basis. You may request an application be mailed to your home address; you do not have to apply in person.

PLAN NAME	OPEN ENROLLMENT MONTH	TELEPHONE CONTACT
Aetna Health Inc.	Dec. 1 - Dec. 30	**(888) 892-5291**
AultCare HMO	April 1 - April 30	**(800) 344-8858**
		Local: (330) 438-6360
Anthem Blue Cross & Blue Shield	Sept. 1 - Sept. 30	**(800) 232-1785**
Connecticut General Life Insurance	Sept. 1 - Sept. 30	**(800) 578-5682**
HealthAssurance HMO	July 1 - July 30	**(800) 746-1441**
HMO Health Ohio	June 1 - June 30	**(800) 522-2066**
HomeTown Health Plan	Aug. 1 - Aug. 30	**(800) 426-9013**
Humana	Aug. 1 - Aug. 30	**(866) 714-9488**
Kaiser Permanente	Oct. 1 - Oct. 30	**(800) 467-6552**
Paramount Health Care	Jan. 1 - Jan. 30	**(800) 462-3589**
Prime Time Health Plan	Dec. 1 - Dec. 30	**(800) 577-5084**
QualChoice HMO	June 1 - June 30	**(800) 260-2643**
SummaCare, Inc.	March 1 - March 30	**(800) 821-9322**
Super Med HMO	June 1 - June 30	**(800) 522-2066**
The Health Plan	March 1 - March 30	**(800) 624-6961**
United HealthCare of Ohio, Inc.	Aug. 1 - Aug. 30	**(800) 606-0288**

The following managed care plans offer specialty or supplemental products. These plans are not required to hold open enrollment. They may sell to groups only.

PLAN NAME	TELEPHONE CONTACT
Cigna Dental Health of Ohio	**(800) 343-5845**
Compdent Corporation	**(800) 633-1262**
Delta Dental Plan of Ohio	**(800) 537-5527**
Dental Benefit Providers	**(301) 654-6900**
Dental Care Plus	**(800) 367-9466**
Great Lakes Delta Insurance	**(800) 537-5527**
Mount Carmel Behavioral Healthcare	**(614) 251-8242**
Superior Dental Care	**(800) 762-3159**
United Dental Care of Ohio	**(800) 262-5388**
United Concordia Dental Plans	**(800) 944-6432**
Vision Service Plan	**(800) 877-7195**

Chapter 10:
Glossary

Use this glossary to give you an idea of what insurance companies usually mean when they use these words.

> Read your policy: it's a contract!
> Different companies could have different definitions of these terms. You should read the policy's definitions section carefully.

Actual Charge - The dollar amount a health care provider bills to a patient for a particular medical service or procedure.

Approved Charge - The dollar amount on which an insurance company bases its payments and your co-payments. This may be less than the actual charge.

Beneficiary - A person who receives benefits of any insurance plan or policy.

Benefit Maximum - The most a health insurance policy will pay for a specified loss or covered service. The benefit can be expressed as either a period of time, a dollar amount or a percentage of the approved amount. Benefits may be paid to the policyholder or a third party.

Benefit Period - The time for which benefit payments from an insurance policy are available. A policy may include different benefit periods for different kinds of treatment or services.

Certificate Holder - An employee or other insured named under a group health insurance policy.

Chronic Condition - A continuous or prolonged illness or condition. Examples: asthma, diabetes, varicose veins.

Claim - A request for payment for services.

COBRA - Federal law requiring that workers who end employment for specified reasons have the option of purchasing group insurance through the employer for a limited period of coverage (usually 18 months, but in some cases 29 months or 36 months).

Conditionally Renewable - An insurance policy that the company will renew with each premium payment, as long as you meet certain conditions.

Coordination of Benefits (COB) - Provisions and procedures used by insurers to avoid duplicate payments when a person is covered by more than one policy.

Co-payment (co-insurance) - A specified dollar amount or percentage of covered expenses which an insurance policy or Medicare requires a beneficiary to pay toward eligible medical bills.

Covered Services - Services for which an insurance policy will pay.

Deductible - A specified dollar amount of medical expenses which the beneficiary must pay before an insurance policy will pay.

Enrollment Period - Period during which individuals may enroll for an insurance policy, Medicare, or Health Insuring Corporation /Health Maintenance Organization (HMO) benefits.

Exclusion - A procedure or condition which an insurance policy does not cover.

Experimental - Medical treatment which is not generally accepted within the medical profession. Insurance policies often do not cover these procedures. Companies often disagree with doctors on whether a specific procedure or treatment is experimental.

Glossary

Explanation of Benefits (EOB) - A statement from an insurance company showing which payments have been made on a claim.

Federally Eligible Individual (FEI) - A person who meets federal standards for continuing or obtaining health care coverage under HIPAA.

Fee For Service - Traditional insurance that does not place restrictions on which doctors you can use. The insurer pays for the expense you incur.

Free Look - The period during which you may reconsider the purchase of an insurance policy, cancel and get a full refund. Individual health policies have a free look of at least 10 days; Medicare supplement and long-term care policies have 30-day free look periods.

Grace Period - A specified period after a premium payment is due on an insurance policy, during which the policyholder may still make a payment. The policy remains in effect during the grace period.

Group Insurance - A contract between an insurer and an employer or association.

Guaranty Issue - An insurance policy that is issued to anyone, regardless of health.

Guaranteed Renewable - An agreement by an insurance company to insure a person for as long as premiums are paid.

Health Insurance Portability and Accountability Act (HIPAA) - Federal law that guarantees health care plan eligibility for people who change jobs, if the new employer offers group insurance. Effective July 1, 1997.

Health Insuring Corporation (HIC) - A new term for managed care insurers in Ohio. HICs include all Ohio HMOs and other companies that offer prepaid managed care. HICs are regulated by the Department of Insurance.

Health Savings Account (HSA) – A new health coverage option that is similar to a Medical Savings Account (MSA). A major advantage to an HSA is that savings may be carried over from calendar year to another.

Hospital Indemnity Policy - Pays a fixed dollar amount for each day you are in the hospital, regardless of actual hospital bills.

Individual Health Insurance - A contract between an insurance company and an insured person.

Inpatient - A person who has been admitted to a hospital or other health care facility to receive diagnosis, treatment or other health services.

Insured - An individual or organization protected by an insurance policy.

Lifetime Maximum - The total amount a policy will pay during an insured's lifetime.

Long-term Care (LTC) - The medical and social care given to one who has a severe chronic impairment over a long period of time.

Loss - The basis for a claim under an insurance policy. In health insurance, loss can refer to medical expenses (or, in a disability policy, loss of income) resulting from illness or injury.

Loss Ratio - The dollar amount an insurer pays in claims compared to the amount it collects from all customers in premiums. Loss ratio is usually shown as a percentage of claims for every dollar collected.

Medically Necessary - Treatments or services an insurance policy will pay for as defined in the contract. Check your policy for specific language defining medically necessary.

Medical Savings Account (MSA) - A special kind of account that is eligible for a tax credit when combined with catastrophic care insurance that has high deductibles.

Multiple Employer Welfare Arrangement (MEWA) - An organization of employers who "jointly self-insure" and pool funds to provide health care benefits for their employees. Ohio law requires a MEWA to either buy an insurance policy that covers its members' employees, or meet the financial standards for an insurance company.

Open Enrollment - A period of time when new subscribers may enroll in a health insurance plan regardless of their health.

Out-of-State Group Policies - A group policy that is sold outside of Ohio. Example: you may live in Ohio and be covered by a policy your group purchased in Indiana. That policy may be regulated by Indiana law rather than Ohio law.

Outpatient – A patient who receives care at a hospital or other health facility without being admitted to the facility. Outpatient care also refers to care given in other locations such as outpatient clinics.

Pre-existing Condition – Health conditions or problems that existed before health insurance was purchased. Check your policy for specific language defining pre-existing conditions.

Pre-certification – A requirement that you obtain the insurance company's approval before a medical service is provided. If you fail to follow the pre-certification procedures the company may reduce or deny claim payment. Please note: getting pre-certification does not guarantee claim payment. Also called Utilization Review.

Primary Payer – Health insurance policy that pays first when a person is covered by more than one insurance plan.

Provider – A person or organization that provides medical services, such as a doctor, hospital, x-ray company, home health agency, pharmacy, etc.

Rider – A legal document that modifies an insurance policy. Riders may either extend or decrease benefits, or add or exclude specific conditions.

Secondary Payer – Applies only when you have more than one health insurance plan. The secondary payer is the plan whose payments cannot be made until another plan (the primary payer) has processed the claim. (Also see Coordination of Benefits).

Self-insured Plan – An organization (usually an employer) that pays health care costs out of the organization's own pocket.

Specific Disease Policy – A health insurance policy that covers the expenses incurred only for a specific disease named in the policy. The most common type is cancer insurance. Also known as Dread Disease policy.

Underwriting – The process by which an insurer establishes and assumes risks. An insurance company is underwriting when it agrees to insure you because you are healthy or rejects your application because you have a history of health problems.

Usual, Customary and Reasonable (UCR) – The dollar amount a company has determined to be appropriate for a particular medical service. Each company develops its own UCR. It is often less than doctors actually charge.

Waiting Period – The time that must pass after becoming insured before the policy will begin to pay benefits for a pre-existing condition or specified illness. It may also refer to the time you must wait before you can get group health insurance from a new employer.

Waiver – An amendment to a health insurance policy that excludes coverage for a specific condition.

Other shopper's guides available from the **Ohio Department of Insurance:**

Annuities • Auto Insurance • Homeowner's Insurance
Medicare Supplement • Life Insurance
Long-Term Care Insurance

To request consumer publications
or ask questions about insurance, call

1-800-686-1526

Fax: (614) 644-3744 TDD Phone (614) 644-3745

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