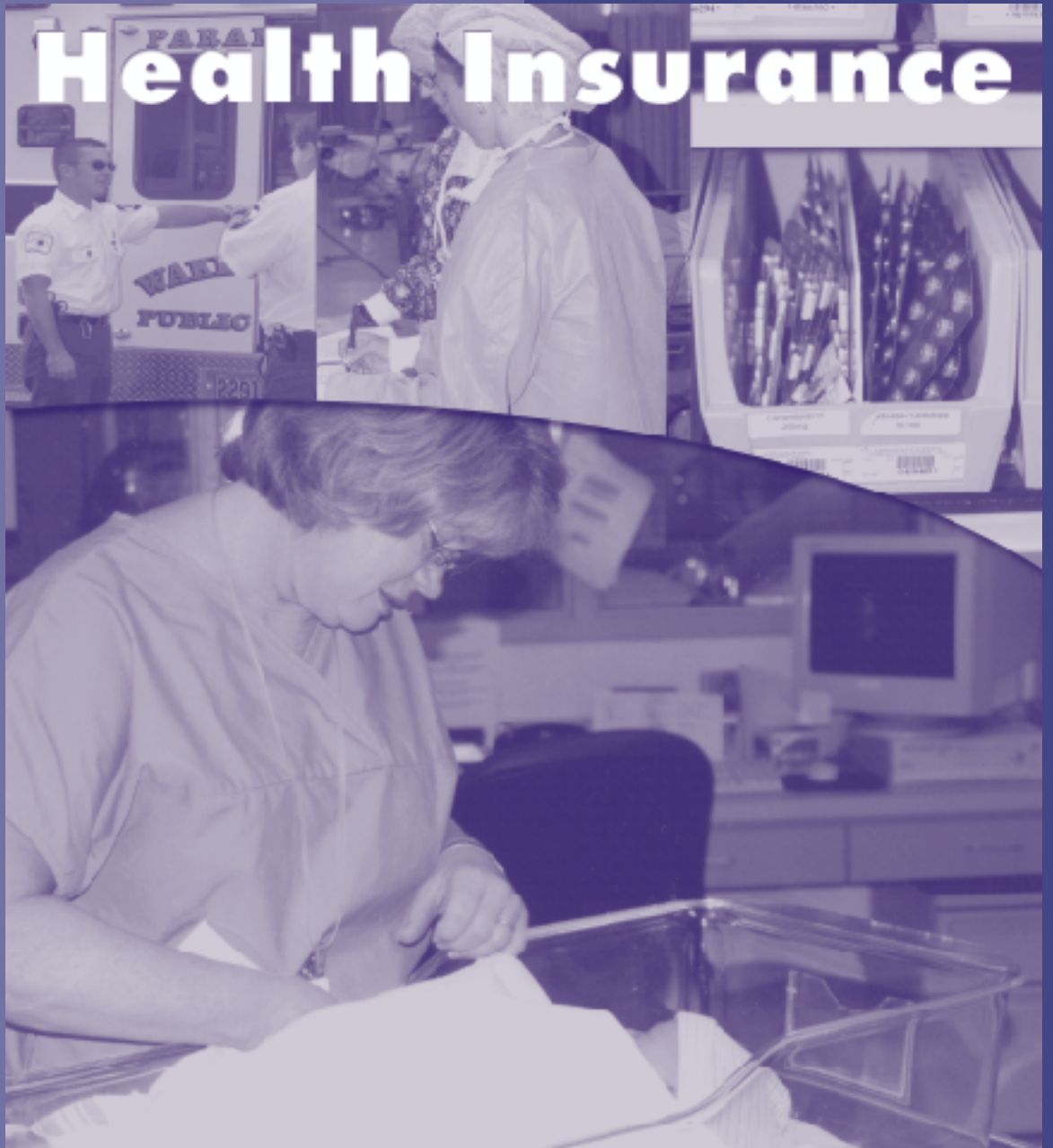


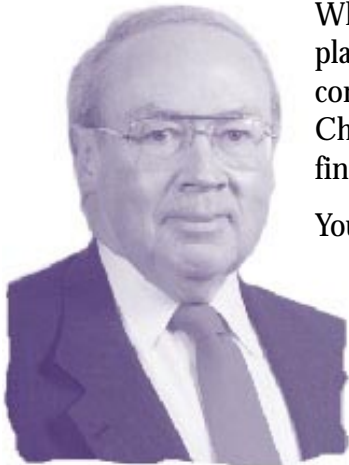
a consumer's guide to

Health Insurance



North Carolina
Department of Insurance
Jim Long, Commissioner

A Message from the Commissioner



Whether you are enrolling in a traditional health insurance plan or a managed care plan, you should know your rights. This guide is made available to North Carolina consumers to help you make informed choices when purchasing health insurance. Choosing a health insurance product is an important decision. I believe you will find this guide to be informative and helpful.

Your Department of Insurance is available to assist you through these complicated matters. I want every North Carolinian to know that help is available by calling our toll-free number, 1-800-546-5664.

A handwritten signature in blue ink that reads "Jim Long". The signature is written in a cursive, flowing style.

Jim Long
Commissioner of Insurance

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Types of Policies

When shopping for health insurance, choose the type that best fits your needs.

Major Medical Health Insurance

Major medical health insurance is offered in two basic forms — traditional and managed care.

Traditional Health Insurance

This type of policy is designed to cover and reimburse medical expenses such as hospitalization, doctor visits, surgery, diagnostic tests and prescription drugs. Traditional major medical policies usually require insureds to satisfy out-of-pocket deductibles and coinsurance provisions. These policies are commonly called indemnity or fee-for-service plans.

Traditional major medical plans allow insureds to obtain medical treatment from the doctor or hospital of their choice. Benefits are typically based on Usual, Customary and Reasonable (UCR) charges. These plans generally limit the insured's annual out-of-pocket expenses. A limit is also placed on the amount of benefits payable over the insured's lifetime (e.g., \$1 million, \$5 million and \$10 million lifetime maximum).

Managed Health Care Plans

The term “managed care” refers to health plans managing both cost and quality of health care services for their members. Ideally, managed care

plans provide proper medical care in the most cost-effective setting. Managed care plans also cover wellness and preventative services, such as routine physicals and health screenings. HMO, HMO Point of Service and PPO plans are the predominant types of managed care plans.

Some of the common methods used to manage cost and quality are:

- Contracting with doctors, hospitals and other health care providers in order to provide quality care at cost effective rates.
- Designing benefit plans that encourage or require plan members to use contracted providers.
- Reviewing medical treatments and services to determine medical appropriateness and clinical effectiveness (known as “Utilization Review”).

Requiring or encouraging members to use network providers enables plans to negotiate discounts on behalf of members, thus keeping costs down. Members' out-of-pocket expenses are generally higher for care received outside of the plan network. However, this may vary by plan. Some plans will not cover services received outside of the network (except for emergency services), while others cover some or all services out of network.

Referrals to Specialists

Managed care plans may require members to see their primary care physician (PCP) before seeing a specialist. If referral to a specialist is needed, the PCP can usually assist with the arrangements; however, it is the member's responsibility to verify with the plan that the referral has been approved.

Utilization Review (UR) Programs

Most plans, even traditional health insurance plans, make use of UR programs. UR programs use established medical review criteria to determine whether the plan will “certify” (authorize) a requested service, continue to provide coverage for on-going treatment or pay for a service that has already



been received. In utilization review programs, insurers must use documented clinical review criteria which are based on sound clinical evidence to determine whether services are “medically necessary” and, therefore, covered under the plan. Qualified health care professionals must be used to administer the UR program under the direction of a medical doctor, licensed in North Carolina.

Insurer Utilization Review responsibilities:

1. Routinely assess the effectiveness and efficiency of its UR program.
2. Coordinate the UR program with its other medical management activities including quality assurance, credentialing, provider contracting, data reporting, grievance procedures, customer satisfaction and risk management.
3. Provide a toll-free number or a collect call number to covered persons for access to its review staff in instances where pre-certification will be required.
4. Limit its requests for information to only information necessary to certify the admission, procedure or treatment, length of stay and frequency and duration of health care services.
5. Notify members (and their providers) of their decision whether or not to certify services within three business days of receiving all information regarding a request for services.
6. When an insurer denies a request, it must:
 - a. Issue a written noncertification decision that includes all of the reasons for the denial and a reference to the medical criteria used to deny the request;
 - b. Inform the member on how to request a copy of the medical criteria; and
 - c. Advise the member of the right to appeal the decision and explain how to file an appeal.
7. Have written procedures to address the failure or inability of a provider or covered person to provide all necessary information for review.

Health Maintenance Organization (HMO)

HMOs are organizations that provide or arrange for the delivery of health care services to their members in exchange for monthly premiums. These services typically include hospitalization, surgery, routine

doctor visits, diagnostic tests and prescription drug treatment. HMO enrollees usually incur a co-payment when receiving medical services and treatment.

Although some HMOs employ their own physicians and medical facilities, none of the HMOs presently operating in North Carolina do so. All of the HMOs in North Carolina contract with physicians and hospitals to deliver medical treatment and services to their members. One major benefit of HMO and HMO Point of Service Plans is that when you use a network provider, that provider cannot bill you for the difference between what the HMO pays and the actual charge.

HMO Plans

HMO members are generally required to seek health care treatment at designated hospitals, physicians, HMO facilities and other “in-network” providers, except in the case of emergency. Most HMO plans require PCP referrals in order to see a specialist, and all apply UR requirements.

HMO Point of Service (POS) Plans

POS plans are a specific type of HMO plan that uses a network of contracted providers. POS members may choose to seek out-of-network providers for certain defined services, but at a higher out-of-pocket cost, and plans may limit coverage to in-network providers for certain services. Frequently, HMO POS plan members must choose a primary care physician and obtain referrals to specialists from their PCP. But some POS plans are “open access” plans — which means that no PCP referral is required to see a specialist.

Preferred Provider Organization (PPO) Plans

Insurers that offer PPO plans contract with physicians, hospitals and other health care providers who agree to provide health care services at a lower cost in return for a stable volume of patients (insureds) or other incentives. The main difference between HMOs and PPOs is provider choice. PPO plan members may obtain care from a doctor or hospital that is not a preferred provider if they are willing to pay additional out-of-pocket expenses. However, PPO plan members may generally see specialists without any prior referral or authorization.

Supplemental Health Insurance

Supplemental health insurance provides limited coverage and benefits for specified losses. These contracts should not be used as a substitute for comprehensive health insurance coverage. Following are some examples of supplemental policies.

Cancer

Cancer policies provide limited benefits when the insured person is diagnosed with cancer (as defined in the policy contract). Most policies contain a schedule of benefits describing the amount of payments for covered cancer treatments. Benefits under these types of insurance plans are normally paid directly to the insured person.

Dental

Dental insurance provides benefits for care and treatment of the teeth and gums. Benefits vary from policy to policy, as some may cover 100 percent of preventative care (such as semi-annual check-ups, fluoride treatments, etc.) while others may only cover a portion of preventative care. Typically, dental insurance plans provide limited benefits for preventative, basic (e.g., fillings), major (e.g., cast restoration) and orthodontic services. There is normally an annual benefit maximum for covered services. Additionally, benefits for orthodontic procedures (e.g., braces, retainers, etc.) are usually very limited and have a lifetime benefit maximum.

Hospital Indemnity

Hospital indemnity policies provide benefits for each day of hospital confinement. The benefits are usually specified dollar amounts and are not based on actual expenses. These policies are supplementary type coverages and should not be used as a substitute for comprehensive health insurance.

Medicare Supplement

The federal Medicare program covers most (but not all) medical expenses for people age 65 and older. Individuals under age 65 receiving Social Security disability benefits are also covered under the program. A Medicare Supplement policy may be purchased to help pay for certain expenses such as deductibles, co-payments and other non-covered expenses. By law, only nine types of Medicare

Supplement policies may be sold, each of which offers a different combination of benefits. For information and counseling on Medicare Supplement policies, contact the Seniors' Health Insurance Information Program (SHIIP) at 1-800-443-9354 or visit the publication section of the Department of Insurance Web site, www.ncdoi.com.

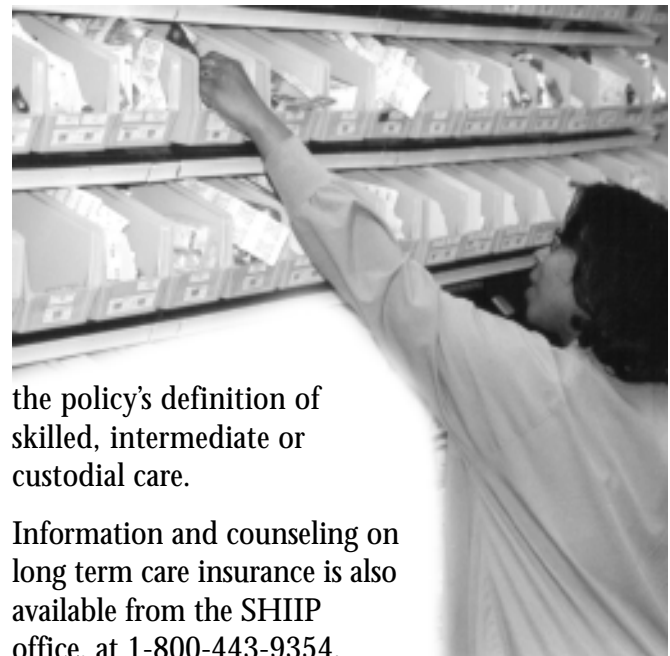
Specified Accident

Specified accident plans provide limited benefits for covered accidents. Loss of limb or sight in one or both eyes may also be covered. Policies such as these are not substitutes for comprehensive health insurance.

Long Term Care

Long Term Care policies generally provide benefits for skilled and intermediate nursing home care. Benefits for personal care (custodial care) may also be provided for care received in approved facilities. These policies usually pay a fixed amount per day while a person is in a nursing home. Most policies contain waiting periods, during which no benefits are paid. Some policies also cover alternative types of care such as home health care or adult day care. Some even cover home modification expenses.

Normally, these policies cover care received in facilities that are licensed by the state and/or participate in Medicaid and Medicare, and meet



the policy's definition of skilled, intermediate or custodial care.

Information and counseling on long term care insurance is also available from the SHIIP office, at 1-800-443-9354.

Individual Coverage Versus Group Coverage

Health insurance coverage is offered in the form of an individual policy or group coverage. The policyholder of an individual policy is the insured individual. Under a group arrangement, the group policyholder may be an employer, association, trustee, etc. Under group arrangements, the policyholder generally has the right to continue, terminate or request changes to the group plan which, in turn, affects the coverage of all individuals insured under the group. Under an individual policy contract, those rights rest with the insured individual.

Individual Health Insurance

With individual health insurance, you contract directly with the insurance company. You are the policyholder and a party to the insurance contract. Individual health insurance may cover one person or all eligible members of a family under one policy. Typically, individuals purchase this type of coverage when they are not employed or when their employer does not offer coverage and they are not otherwise eligible for group coverage. Also, individual health policies may be used to supplement Medicare. Although individual coverage is often more expensive than a group policy offering the same benefits, it can be an important means of assuring that a person has continuous coverage between jobs.

Except for a select group known as HIPAA-eligible individuals

(Health Insurance Portability



and Accountability Act), individual coverage may be fully underwritten by insurers — meaning that insurers may decline to offer coverage based on the individual's health information. However, once an individual is covered, an insurer may not terminate or refuse to renew an individual policy unless it offers to each affected individual the option to purchase any other individual health insurance policy offered by the insurer. This feature is known as “guaranteed renewability.” Please note that an insurer may terminate all individual health insurance policies with proper notice.

Group Health Insurance

Many employers offer group health insurance to their employees as an employment benefit. Some employers offer only one plan while others offer a choice of plans. No employer is required to offer health insurance. However, if insurance is made available, coverage must be offered to all eligible employees. (Eligibility requirements usually include an employee who is permanent and working 30 hours or more per week.)

Under group coverage, a master group policy is issued to the group policyholder and covered participants receive a certificate or handbook that summarizes the benefits and provisions outlined in the master group contract. Also, most group policies cover dependent family members.

Employers may require eligible employees to satisfy a waiting period of up to 90 days prior to being added to the plan. Under employer group health insurance plans, the employer is the policyholder and you are a plan participant. As the policyholder, the employer does not need the consent of plan participants to change insurers, make changes to the plan, cancel the policy or agree to new premiums or benefits. However, North Carolina law requires employers to provide 45 days notice to their employees when they plan to cease offering health insurance.

No insurer may cancel or refuse to renew coverage for eligible participants covered under a group health plan if it continues to cover the group.

Small Employer Group Health Coverage Reform Act

North Carolina's Small Employer Group Health Coverage Reform Act was enacted in 1992. The purpose of the Act is to promote the availability of accident and health insurance to small employers, eliminate abusive rating and underwriting practices and improve fairness in the marketplace.

All insurers who market or offer small group health insurance in North Carolina must offer all their plans to small employers who have two to 50 employees, provided they reside within the insurer's service area. Self-employed individuals do not have guaranteed access to all plans, but they must be offered two standardized plans established by state law (known as the Standard and Basic health plans) regardless of their health status.

North Carolina General Statutes define a "small employer" as any individual actively engaged in business that, on at least 50 percent of its working days during the preceding calendar year employed no more than 50 eligible employees, the majority of whom are employed within this state and is not formed primarily for purposes of buying health insurance and in which a bona fide employer-employee relationship exists.

A self-employed individual is defined as an individual or sole proprietor who derives a majority of his or her income from a trade or business carried on by the individual or sole proprietor which results in taxable income as indicated on IRS form 1040, Schedule C or F, and which generated taxable income in one of the two previous years.

Insurers have the right to verify whether small employer applicants and self-employed applicants meet the above stated definitions. Insurers will most likely request tax and business documents during the application process and may refuse to issue coverage if proper proof is not provided. Additionally, those documents may be requested periodically after coverage is issued to verify continued eligibility.

No insurer may single out a small group for termination or non-renewal if it will continue to serve other small groups in the same geographic area.

The Small Employer Group Health Coverage Reform Act also establishes limits on how much insurers can vary premiums from one small employer to another.

Small Groups

Small groups are those employers with one to fifty 50 employees, including self-employed individuals.

Large Groups

In North Carolina, large employer groups are those with more than 50 eligible employees.

Large employer groups may be fully underwritten, which means that insurers may ask for health information on employees and, based on the insurer's underwriting guidelines, choose whether to offer or decline coverage. However, individual participants cannot be individually underwritten or singled out, so a group must be covered or declined as a whole. Once coverage is issued, large employer groups have guaranteed renewal rights. In addition, large group premium rates usually are developed using past claims experience for each group.

Multiple Employer Welfare Arrangements (MEWAs)

MEWAs provide coverage to employees of multiple participating employers. MEWAs may purchase coverage from an insurer or may establish a self-insured (self-funded) health benefit plan. The North Carolina Department of Insurance regulates insurers in their sales of MEWA plans just as it does the sale of all other commercial insurance products. The Department of Insurance also licenses and regulates self-insured MEWAs.

The North Carolina Life and Health Insurance Guaranty Association does not cover self-insured health plan insolvencies (as it does licensed insurance companies). Therefore, if a self-insured MEWA fails, its participating employers may be held responsible for unpaid claims.

Full Insured versus Self-funded Group Health Plans

Fully Insured

Fully insured group health insurance programs are offered by licensed insurance companies. Such health insurance plans purchased in North Carolina are regulated by the North Carolina Department of Insurance. In the event a licensed insurance company becomes insolvent and must be liquidated, fully insured policyholders have protection under the Life and Health Guaranty Association of up to \$300,000 per person on covered claims and guaranteed policy values.

Self-Funded/Self-Insured

Some employers and labor unions provide group health benefits coverage for their employees or members through self-funded plan arrangements. Employers who choose to self-insure their employee health plan benefits are responsible for payment of claim liabilities and performing certain administrative functions ordinarily transferred to an insurance company under fully insured health insurance plans. Most often, self-funded plan sponsors contract with insurance companies or third party

administrators (TPAs) to provide administrative services; however, the employer or plan sponsor is ultimately responsible for seeing that claims are paid in accordance with plan provisions and ensuring the plan is properly administered.

The North Carolina Department of Insurance does not regulate self-insured, single-employer plans as they are not subject to state insurance laws. In addition, the North Carolina Life and Health Insurance Guaranty Association does not cover self-insured plan liabilities in the event of plan insolvency. Single employer and union sponsored self-funded health plans are regulated by the U.S. Department of Labor's Pension and Welfare Benefits Administration under the guidelines of the Employees' Retirement Income Security Act (ERISA) of 1974.

As noted on the previous page, self-insured MEWAs, which cover multiple employers, are licensed and regulated by the North Carolina Department of Insurance, but are not covered under the Guaranty Association.

What Happens if I Lose my Employer Group Coverage?

Continuation of coverage may be available in one of the following ways when leaving an employer: COBRA continuation, State Continuation and conversion coverage.

COBRA (Consolidated Omnibus Budget Reconciliation Act)

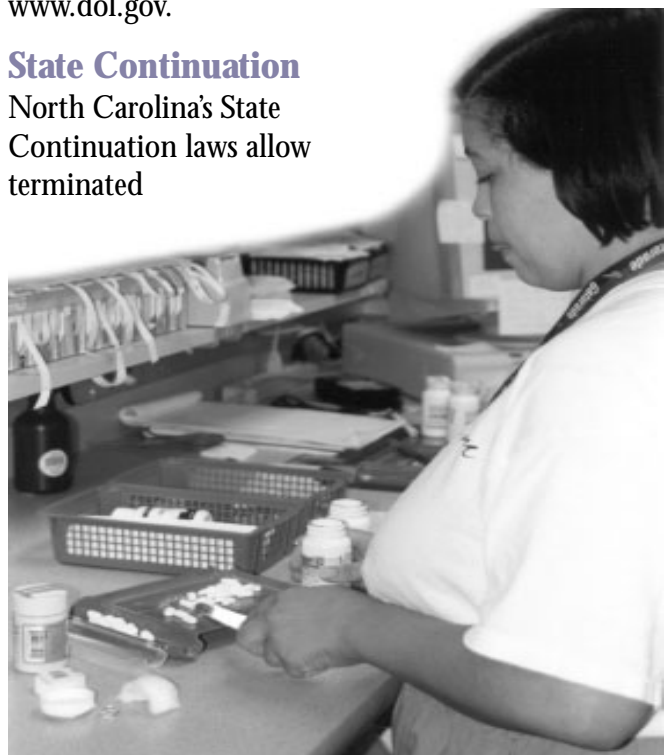
Federal COBRA Continuation law applies to employer groups covering 20 and more employees. This law generally allows eligible enrollees the right to continue under the employer group health plan for up to 18 months. The continuation period can be extended beyond the 18-month period in some situations. COBRA continuation law applies to both insured and self-funded plans; however, it does not apply to church plans, plans covering less than 20 employees or plans covering federal employees. Detailed information concerning your rights under the federal COBRA laws can be obtained from the Pension and Welfare Benefits Administration Division of the U.S. Department of Labor, Atlanta

Regional Office at (404) 562-2156. For a complete list of publications provided by the PWBA call their hotline at 1-800-998-7542 or visit the U.S.

Department of Labor's Web site at www.dol.gov.

State Continuation

North Carolina's State Continuation laws allow terminated



employees and members to continue coverage under their employer's group health plan when they terminate employment or lose their eligibility under the plan.

Under State Continuation guidelines, employees who terminate employment for any reason, whose hours are reduced or who lose eligible employee status may continue their basic health insurance coverage for up to 18 months. Upon termination or loss of eligible status, dependants covered by the policy will also be able to continue coverage for 18 months. Unlike COBRA, State Continuation laws do not provide for extensions of coverage beyond 18 months under any circumstances.

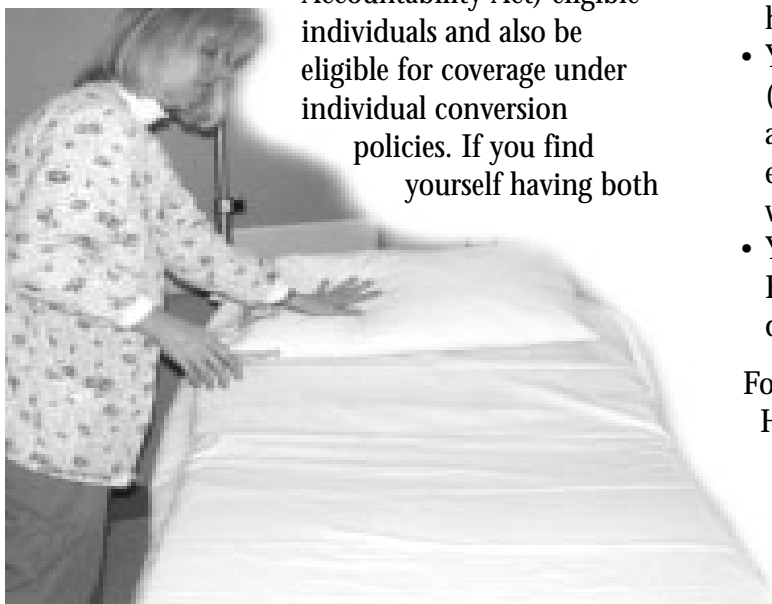
In order to obtain more information about State Continuation contact the North Carolina Department of Insurance toll free at 1-800-546-5664. "Consumer's Guide To State Continuation" is available on the Internet at www.ncdoi.com.

Conversion

All insurers that sell group health insurance plans must offer an individual conversion policy to individuals who lose coverage under the group plan. Conversion policies cannot impose a pre-existing exclusion for conditions covered under the prior group plan.

Conversion plans may cost substantially more than your previous group plan. Some people may qualify as HIPAA (Health Insurance Portability and

Accountability Act) eligible individuals and also be eligible for coverage under individual conversion policies. If you find yourself having both



of these options, you should carefully compare the premiums and benefits and choose the plan that best meets your needs.

HIPAA "Guaranteed Issue" Individual Health Insurance

All private insurance companies that sell individual health insurance must offer a choice of at least two plans for qualified HIPAA eligible individuals. Those two plans must contain benefits that are similar to the insurer's other plans. Companies that choose not to designate two plans for HIPAA eligible individuals must offer them a choice of all their individual insurance policies. However, there are no restrictions on the rates that insurers can charge HIPAA eligible individuals for these plans, so long as there is an actuarial basis for the rates. This means that the policies HIPAA eligible persons are entitled to buy tend to be rather expensive.

To qualify as a "HIPAA eligible individual," you must meet all of the following requirements:

- You must have had at least 18 months of continuous "creditable coverage," of which at least the last day must have been under an employer group health plan.
- You must have used up any COBRA or State Continuation coverage for which you were eligible.
- You must not be currently eligible for coverage under Medicare, Medicaid or another group health plan.
- You must not presently have health insurance. (If, however, you know your group coverage is about to end, you can apply as a HIPAA eligible individual for coverage to go into effect when your group coverage ends.)
- You must apply for health insurance as a HIPAA eligible individual no later than 63 days after losing your group coverage.

For more information on this topic, see "Your HIPAA Rights and Guide to Individual Health Insurance" on the Department of Insurance's Web site.

Government Sponsored Health Insurance NC Health Choice for Children

NC Health Choice for Children (the State of North Carolina Children's Health Insurance Program) is a program funded by the federal and state governments. NC Health Choice may be stopped at any time if federal money is no longer available. A child with no health insurance under the age of 19 who lives in the State of North Carolina may be covered depending on how much income his or her family earns a year. Departments of social services and health departments in each county in the state decide if a child qualifies for coverage under NC Health Choice. In order to obtain more information about this program, contact the North Carolina Division of Medical Assistance toll free at 1-800-367-2229. Information can also be found on the Internet at www.dhhs.state.nc.us/dms/cpcont.htm.

Medicaid

Medicaid provides medical assistance to low-income families and individuals of all ages participating in cash assistance programs. The federal and state governments jointly finance Medicaid. In North Carolina, all 100 counties contribute to the non-federal share of costs.



All states, the District of Columbia and some U.S. territories have Medicaid programs. Medicaid programs are governed by federal guidelines but vary in eligibility criteria and covered services. In North Carolina, each county determines eligibility for Medicaid benefits.

For individuals who qualify for both Medicaid and Medicare, Medicaid pays Medicare cost-sharing amounts and fills in many gaps in Medicare's benefit package, especially in the area of long-term care services and prescription drugs. In order to obtain more information about this program contact your local Department of Social Services (DSS). You will find them in the phone book under government agencies. You may go to the DSS to apply or ask them to send you an application in the mail. Applications are also available at the local health department. You may complete the application yourself and return it in person or mail it to the DSS.

If you cannot locate the phone number for your local DSS or if you have further questions regarding Medicaid eligibility, call the Office of Citizen Services CARE-LINE Information and Referral Service toll-free at 1-800-662-7030. For local calls or calls from outside of North Carolina, dial (919) 733-4261. The Office of Citizen Services has a dedicated TTY line at 1-877-452-2514 or for local TTY or TTY calls from outside of North Carolina, dial (919) 733-4851 for the deaf and hearing impaired.

Medicare

Medicare is a federal health insurance program for people age 65 years or older, certain people with disabilities and people with permanent kidney failure treated with dialysis or a transplant.

Medicare has two parts: Part A, hospital insurance, and Part B, medical insurance. For more information concerning Medicare and Medicare supplements, contact the Seniors' Health Insurance Information Program (SHIIP) toll-free at 1-800-443-9354 or visit our Web site at www.ncdoi.com.

Mandated Benefits and Other Plan Requirements

Mandated Benefits

North Carolina law requires insurance carriers to include certain benefits in health insurance policies offered in this state. Some of these benefits are:



Covering Children

Adding Newborn Infants and Adopted or Foster Children

Coverage for newborn children, newly adopted children and newly placed foster children who are covered under a policy as a dependent are considered to be covered from the moment of birth or moment of placement in a home as long as the policy was in effect within the proper time period. When coverage is in effect from the moment of birth or placement, exclusions and waiting periods for pre-existing conditions may not be applied. If your policy that is in place before the birth or placement of your child will automatically cover your new child without additional premium (e.g., your policy already covers an unlimited number of children or covers up to two children and the new child is your second), then the policy is considered to be in place at the moment of birth or placement, and coverage is in effect at that time regardless of whether you notified your insurer of your new child. However, notifying your insurer prior to or soon after birth or placement is a good idea in order to avoid questions and delays regarding claims. If your policy that is in place prior to the birth or

Emergency Services

Every insurer must cover emergency services necessary to screen and stabilize the insured and may not require prior authorization of the services if a prudent layperson acting reasonably would believe an emergency medical condition exists. A managed care plan cannot require the use of network providers or require prior authorization for emergency medical services or treatment. Co-payments and deductibles generally apply.

Minimum Hospital Stay Following Childbirth

Health benefit plans that provide maternity and childbirth benefits are required to cover both the mother and her newborn child for a minimum of 48 hours of inpatient stay after normal childbirth or a minimum of 96 hours for inpatient stay following a cesarean section, as long as the physician determines that inpatient care is appropriate. Unless the child is

placement of your new child will not automatically cover them without additional premiums (e.g., your policy does not currently cover children or covers only one child and you are adding a second child), you must notify your plan prior to birth or placement or within 30 days of birth or placement, for the coverage to be in effect from the moment of birth or placement. If coverage is not in effect from birth or placement, your plan may exclude or place a waiting period on coverage for pre-existing conditions, including birth defects.

Mentally Retarded or Physically Handicapped Children

The age limitation for dependant children will not terminate coverage for a child that is and continues to be:

1. Incapable of self-sustaining employment by reason of mental retardation or physical handicap; and
2. Chiefly dependant on the policyholder for support and maintenance.

Policy guidelines must be followed to properly notify the insurance company of any request to continue coverage for qualified children.

covered as a dependent under the plan of one of its parents, coverage for the newborn's care will end after 48 hours (or 96 hours for a cesarean section). State law does not require health insurance plans to offer maternity care.

Mammograms and Pap Smears

Every policy must cover pap smears and low-dose screening mammography.

Bone Mass Measurement

Health benefit plans must cover scientifically proven and approved bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass in certain "qualified" individuals. Qualified individual means:

1. An individual who is estrogen-deficient and at clinical risk of osteoporosis or low bone mass.
2. An individual with radiographic osteopenia anywhere in the skeleton.
3. An individual who is receiving long-term glucocorticoid (steroid) therapy.
4. An individual with primary hyperparathyroidism.
5. An individual who is being monitored to assess the response to or efficacy of commonly accepted osteoporosis drug therapies.
6. An individual who has a history of low-trauma fractures.
7. An individual with other conditions or on medical therapies known to cause osteoporosis or low bone mass.

Diabetes Treatment and Services

Policies must cover medically appropriate and necessary diabetes treatment and services. Outpatient self-management training and educational services, equipment, supplies, medications and laboratory procedures used to treat diabetes must be covered.

Mastectomy Length of Stay and Reconstructive Breast Surgery Following Mastectomy

Insurers must allow the patient's physician and the patient to determine how long she will remain in the hospital following a mastectomy.

Coverage must be provided for reconstructive breast surgery following a mastectomy performed in the course of treating cancer or breast disease.

Customary Benefits

The following expenses are usually covered under most health benefit plans. However, please keep in mind these items are not required to be covered.

- Hospital charges
- Laboratory fees and expenses
- X-rays and diagnostic test expenses
- Surgical expenses
- Anesthesia expenses
- Physical therapy expenses
- Physicians fees
- Out-patient treatment expenses
- Prescription drug expenses
- Maternity expenses
- Transportation expenses

Other expenses may be covered and those listed may not be covered in full.

Chemical Dependency

All group health insurers must offer benefits for the care and treatment of chemical dependency.

Contraceptives

Every insurer providing a health benefit plan that provides coverage for prescription drugs or devices must provide coverage for prescription contraceptive drugs or devices. This includes outpatient contraceptive services if outpatient care is provided. Religious employers may request an exemption.

Newborn Hearing Screening

Effective March 1, 2002, all health insurers are required to cover hearing screenings for newborn children, subject to the deductibles, co-payments and coinsurance that generally apply to other services covered by the plan.

Clinical Trials

Effective March 1, 2002, all health insurers are required to cover medically necessary expenses for phase II, III and IV clinical trials that are not directly related to conducting the trial itself, that are not provided by the parties conducting the trial and that would be covered if provided outside of a clinical trial. To be covered, the trials must meet certain minimum medical and scientific requirements.

Other Plan Requirements

Network Adequacy

Managed care plans must maintain adequate provider networks that include providers and facilities within a reasonable distance from where plan members live or work, and those providers must have appointments available without unreasonable delay. If a network does not offer reasonable access to a provider capable of delivering the type of services needed without unreasonable delay, the plan must allow its members to receive needed care from providers who are not in the network and cover those services at the same level that network services are covered. Whether access to providers and appointments is “reasonable” in a particular case is based on the type of care that is needed and the availability of providers and appointments within the network compared to providers and appointments outside of the network but within the same local area.

Exceptions to Drug Management Requirements

All health plans that use a closed prescription drug formulary (i.e. no coverage is provided for those drugs not on the formulary list), must cover those drugs not on the formulary on an exception basis when:

- A plan member’s physician notifies the insurer that the formulary drug has been used to treat the patient for the condition in question; and
- The drug was either ineffective in treating the condition, harmful to the patient or is reasonably expected to be harmful to the patient and, therefore, an alternative drug not on the formulary is necessary to treat the condition.

And, effective March 1, 2002, restricted access drugs (those formulary drugs that are covered only with prior approval of the insurer or covered only after other specified formulary drugs have been tried without success) must also be covered on an exception basis, without prior approval or first having to try other formulary drugs, when:

- A plan member’s physician certifies to the insurer that the formulary drug has been used to treat the patient for the same condition previously; and

- The drug was either ineffective or was harmful to the patient and is expected to be harmful if used again.

Standing Referrals to Specialists

Managed care plans that require members to obtain a referral from their Primary Care Physician (PCP) before seeing a specialist must have a system to allow a PCP to issue a standing referral, for up to 12 months, if the patient has a serious or chronic condition that is degenerative, disabling or life-threatening and ongoing specialty care is necessary.

Transitional Coverage when a Provider Leaves the Network (Continuity of Care)

Effective March 1, 2002, managed care plans must allow members to continue receiving treatment from network providers who are leaving the plan network, for a period of time to allow for continuity of care while the member changes providers. This coverage is dependent upon several conditions being met, including:

1. The member:
 - had a serious acute condition that requires treatment to avoid death or permanent harm at the time they were notified that the provider was leaving the network (up to 90 days of transitional coverage is provided);
 - had a chronic condition that is life-threatening, degenerative or disabling and requires treatment over a prolonged period of time at the time they were notified that the provider was leaving the network (up to 90 days of transitional coverage is provided);
 - was in at least the second trimester of pregnancy at the time they were notified that the provider was leaving the network (transitional coverage is provided through delivery and up to 60 days of postpartum care);
 - was scheduled for surgery, organ transplantation or other inpatient care prior to being notified of the provider’s termination (transition coverage is provided through the completion of the

procedure or stay and up to 90 days of post-discharge care related to the hospital stay); or

- is terminally ill and not expected to live longer than six months at the time that the provider will actually leave the network (transition coverage is provided for the remainder of the member's life);
2. The provider who will no longer be in the network must agree to continue treating the patient and to accept the plan's payment rates and comply with other plan requirements; and
 3. The member must, within 45 days of being notified that their provider will be leaving the network, notify the insurer of their plans to take advantage of this coverage.

The same rights to continuity of care described above apply when your employer changes from one health plan to another and the provider does not participate in the new plan. Continuity of care

requirements do not apply when you choose to change plans.

Specialists as Primary Care Provider

Effective March 1, 2002, managed care plans that require the use of a PCP must allow members who have a serious or chronic condition that is degenerative, disabling or life-threatening and requires ongoing specialty care, to select a specialist to act as their PCP, subject to the insurer agreeing that the specialist is capable of coordinating the patient's care and the specialist agreeing to abide by the insurer's rules for PCP.

Direct Access to Specialists

Managed care plans are required to allow female members who are 13 years old or older direct access to an OB/GYN for OB/GYN services without a referral from a PCP.

Beginning March 1, 2002, managed care plans are required to allow all members who are under the age of 18 to select a network pediatrician as their PCP.

Standard Policy Provisions, Limitations and Exclusions

Review and study your policy. It is important for you to understand your rights, obligations, what is covered and what is not covered. Some common provisions, limitations and exclusions are:

Free-Look Period

When applying for an individual health insurance policy, you may return the policy to the company within the free look period and receive a complete refund of all premiums paid if you are not satisfied for any reason. The minimum free look period is 10 days beginning with the date of policy delivery. Returning the policy during the free look period voids all benefits from its inception.

Premium Payment Grace Period

Health insurance policies must allow policyholders a grace period after each premium due date for purposes of accepting premium payments during which time the policy remains in full force and effect. However, if a premium is not paid prior to the expiration of the grace period the policy will lapse. Benefits typically terminate on the last day of

the premium period for which premiums have been paid. The industry norm for premium grace periods is 31 days. In some rare instances, the grace period might be less than 31 days.

Deductible

The deductible is an initial amount members must pay on covered medical expenses. For example, a health plan may require a \$250 annual or a \$250 per illness deductible. Choosing a higher deductible may help lower your premium.

Coinsurance

Coinsurance is the amount that must be paid by the insured (usually stated as a percentage of the charges, i.e., 20 percent coinsurance), in addition to the deductible, on covered claims. For example, a policy may pay 80 percent of the approved charges; therefore the insured's coinsurance liability will be 20 percent of approved charges.

Note: Some plans, when covering services out of network, base their payment and members' coinsurance on approved or "allowed" amounts. In

addition to coinsurance, members may be subject to “balance billing” by the provider for the difference between allowed and actual charges. Members of an HMO who receive care from a network provider should *never* be subject to balance billing. Check your member handbook for an explanation of whether and when you may be subject to balance billing. If you are in a managed care plan, always check with your health plan before you pay any bill from your provider that includes more than your expected coinsurance or co-payment.

Co-Payment

This is a set amount (such as \$10 or \$20) that insureds are required to pay directly to the provider when they receive covered medical treatment and services under a managed care plan.

Coordination of Benefits

The Coordination of Benefits provision is a method of coordinating benefits payable under more than one health insurance plan so that insurance benefits provided by multiple plans do not exceed allowable medical expenses or eliminate patient incentives to contain costs.

Pre-existing Conditions

A health plan may refuse to pay for treatment of health conditions that existed prior to your enrollment in a health plan.

Both federal and state laws place time limits on pre-existing condition exclusion periods for group health plans. Under federal and state law, a pre-existing condition is a health condition for which you received medical advice or treatment for within six months prior to enrolling. The maximum pre-existing condition exclusion period for timely enrollees is 12 months. An 18-month pre-existing condition exclusion period may be imposed on persons who did not enroll when they were first eligible to do so (late enrollees).

If you have an individual major medical plan, a pre-existing condition may be defined as a health condition for which you received medical advice, diagnosis, care or treatment within 12 months immediately prior to the effective date of your plan. The maximum pre-existing conditions waiting period for individual coverage is 12 months.

Generally pre-existing condition waiting periods under both group and individual plans can be reduced by the length of time coverage was maintained under prior health insurance plans, provided there is no more than a 63-day lapse between plans.

Portability

For many years, people have been concerned about changing jobs and its effects on their health insurance. Previously, medical conditions covered under a prior plan often were not covered under replacement plans. Health Insurance Portability and Accountability Act’s (HIPAA) increased portability guarantees that insureds get “credit” for the time covered under a previous plan, provided there is no lapse of more than 63 days. Specifically, insurers must reduce any pre-existing condition limitation periods by the amount of time the insured was covered under prior creditable coverage.

Any coverage under a group plan (including COBRA or State Continuation), individual health insurance policy, Medicare or Medicaid or North Carolina’s Health Choice program or comparable children’s health plan offered by another state is considered “*creditable coverage*.” As proof of coverage, employers and/or insurers are required to provide a certificate of creditable coverage to insureds when coverage ends. That certificate is used to show a new health plan how much pre-existing credit they are entitled to. If your coverage with a plan ends for any reason, it is very important that you save this certificate of creditable coverage.

Benefits for pre-existing medical conditions cannot be denied under any plan’s pre-existing condition limitation provision if the insured has had creditable coverage for at least 12 months without a break (or lapse) in coverage of more than 63 days.

Incontestable Provision

Generally, insurers can contest the validity of a policy within the first two years after issue (or reinstatement) if an applicant’s answers to the application questions have been misstated or misrepresented and the misrepresentations are material to the insurer’s decision to issue the policy.

Lifetime Limits

Most health insurance policies limit the total amount the policy will pay over the course of your lifetime (such as \$1 million). Once this limit has been reached, policy benefits will cease.

Annual Limits

Annual limits restrict the total amount of benefits payable during the course of the year and usually pertain to a specific type of benefit or covered service.

Out-of-pocket Maximums

Many policies limit the total coinsurance amount you must pay each year. Once you reach the limit specified in your policy the insurance company will pay 100 percent of covered charges for the remainder of the year.

Note: Calculations for out-of-pocket maximums do not include any amounts you pay to cover the difference between allowed and actual charges and, when you reach your out-of-pocket maximum, the difference between allowed and actual charges will still be your responsibility IF your plan does not

protect you from balance billing. See note under “Coinsurance” on page 12.

Usual, Customary and Reasonable (UCR)

Insurance companies may base their health insurance benefits on Usual, Customary and Reasonable (UCR) charge determinations, if the practice is explained and the company’s right to do so is stated in the policy contract. Generally, UCR determinations are based upon claims and average charges received in connection with prior claims on other insureds.

Coverage Exclusions

Although you may purchase a plan that covers most medical, hospital, surgical and prescription drug expenses, no health plan will cover every conceivable medical expense you may incur.

Examples of typical exclusions:

- Vision care (eye exams, glasses, contacts, etc.)
- Hearing aids
- Dental care
- Cosmetic surgery
- Experimental treatments
- Specific Treatments (e.g., sterilization, acupuncture, etc.)

Shopping for Health Insurance

Most people buy their health insurance through their employer. When this is the case, your employer selects the insurance company or companies and decides which plan or plans will be available to you. Most employers that offer health insurance pay at least some of the premium for the employee, and some pay for part of the premium to cover their employees’ dependents. Since health benefits are a large expense for employers, they must choose between different types of plans and levels of benefits to determine which ones fit their budget. If your employer offers a choice of plans, you will still want to want to choose your plan with care.

Some people purchase individual health insurance. If this is the case for you, it is important to select a product that meets your needs at an affordable and competitive premium.

Where to Shop

Since most insurance companies and many agents advertise, telephone directories, newspaper, radio, television and the Internet may provide information to assist you in purchasing insurance in your area. As with any major purchase, it is recommended that you shop around to make sure you get the most for your money.

Most agents are reputable professionals who are well trained in their area of expertise. Agents must be licensed to sell insurance in North Carolina. Choose one with whom you feel comfortable and who will answer your questions. To verify that an agent is licensed, contact the North Carolina Department of Insurance, Agent Services Division at (919) 733-7487. Likewise, companies must be licensed to conduct business in North Carolina. To verify that a

company is properly licensed, you may contact the Consumer Services Division at (919) 733-2032 or 1-800-546-5664.

Seek Unbiased Information

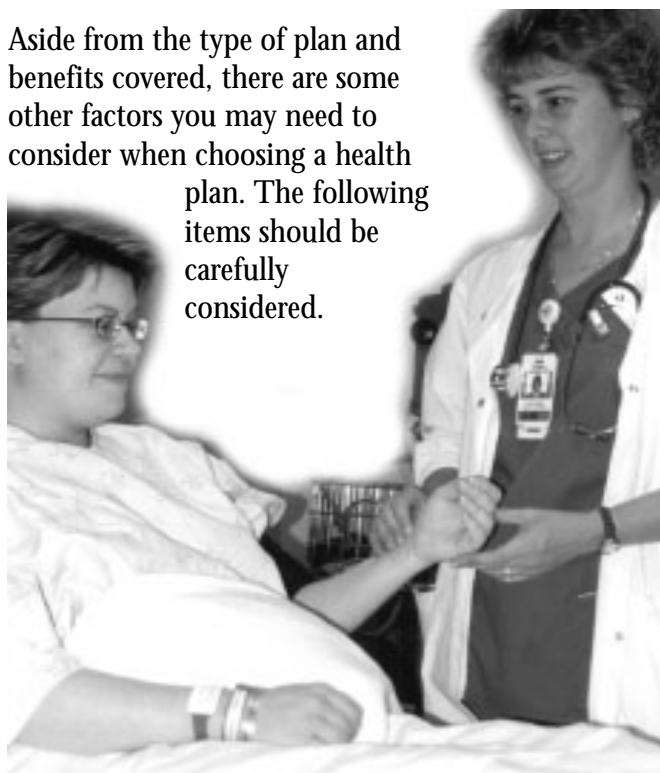
Information is available to consumers from a number of sources. These sources include consumer publications, public libraries, consumer groups and your North Carolina Department of Insurance.

Financial strength and ability to meet financial obligations to policyholders is very important. Independent organizations such as A.M. Best, Standard & Poor's, Moody's Investors Service and others publish financial ratings. You should consider checking with at least two organizations to evaluate a company's strength. The ratings for insurers can be found in most public libraries, by asking your agent or on the Internet. (Note: These agencies rate companies according to their present financial ability to pay claims, not by quality of products offered or by past or future ability to pay claims.)

The North Carolina Department of Insurance does not rate or recommend insurance companies, but will provide the date a company was licensed in North Carolina and its complaint ratio.

Choosing a Plan

Aside from the type of plan and benefits covered, there are some other factors you may need to consider when choosing a health plan. The following items should be carefully considered.



Premiums

The premium is the amount paid in consideration for an insurance policy. Health insurance premiums vary greatly. When considering plans from several companies, you should evaluate the benefits offered in relation to the premiums charged.

There are several factors that influence premium rates. Examples include:

- Coverage
- Medical care costs
- Age and gender
- Health and lifestyle (e.g., heart disease, obesity, tobacco use, etc.)
- Family size
- Geographic area

Other Out-of-Pocket Expenses

In addition to monthly premium payments, most health plans require you to pay a portion of covered expenses. Following are examples of out-of-pocket costs you should consider when selecting an insurance plan:

- Deductible
- Coinsurance
- Co-payment
- Balance billing for the difference between allowed and actual charges

Selecting the Right Managed Care Plan

If you have the option of choosing between two or more plans, you should carefully compare the differences. Aside from the obvious differences in covered benefits, benefit levels (how much the plan pays) and premiums, you should consider the following when deciding how plans may differ:

- Utilization Review (UR) programs
- Provider networks and their requirements
- Referrals to specialists
- Provider payment methods
- Quality assurance programs
- Provider network offered
- Member grievances and member satisfaction data

Before selecting a plan, review its documents carefully, call the plan for information and talk

with coworkers and friends about their experiences. Consider whether you may have to stop seeing a specific physician and choose another. Health plans are required by law to honor your request for a copy of the policy or evidence of coverage BEFORE you enroll. Information concerning coverage criteria for specific conditions, information on prescription drug formularies and coverage of experimental procedures is also available at your request. Also, verify whether your providers are in the plan network. Many health insurers place their provider directory on their company Web site.

Questions to Ask When Shopping for a Plan

- What does the plan cover? What is not covered?
- Will the plan cover preventative care, immunizations, well-baby care, substance abuse, organ transplants, vision care, dental care, infertility treatment, durable medical equipment or chiropractic care?
- Will the plan pay for prescriptions?
- Does the plan provide mental health benefits?
- Will the plan pay for long-term physical therapy?
- Do rates increase as you age?
- How often can rates be changed?
- How much do you have to pay when you receive health care services?
- Are there any limits on how much you are personally required to pay for health care services you receive?
- Are there any limits on the number of times you may receive a service?
- What are the restrictions on the use of providers or services under the plan?
- Does the health plan require you to see a provider in its network?
- Are the network providers conveniently located?
- Is the doctor you want to see in the network and accepting new patients?
- What do you have to do to see a specialist?
- How easy is it to get an appointment when you need one?
- Has the company had an unusually high number of consumer complaints?
- When calling the insurer, how long does it take to reach a real person?



What Causes Premium Rate Increases

Insurance companies raise premiums when the cost of claims rises. Examples of factors that may lead to increases include medical-cost inflation, increases in medical utilization and cost shifting.

- Medical-cost inflation measures increases in the price of medical care.
- Medical utilization measures the frequency medical treatment and services are obtained during a period of time.
- Cost shifting occurs when hospitals increase the amounts charged to paying

patients to offset the cost of care for indigent patients.

- For managed care plans, premiums increase with increases in the use of out of network providers.

Consumer preferences for increased choice of providers, less restrictions on care and increased mandated benefits all have the effect of increasing premiums due to higher prices paid to non-network providers and increased utilization of services.

Shopping Comparison Chart

Questions To Ask		Company Name	Company Name
1	How much is the deductible?	\$	\$
2	Do I have to pay a co-insurance amount? If so, how much?	Yes No \$	Yes No \$
3	Are there waiting periods before certain illnesses are covered?	Yes No	Yes No
4	Does the policy have an annual benefit maximum? If so, how much?	Yes No \$	Yes No \$
5	Does the policy have a lifetime benefit maximum? If so, how much?	Yes No \$	Yes No \$
6	What are the limits on: <i>Daily hospital room and board</i> <i>Medical tests or other hospital expenses</i> <i>Amount paid for doctor's visits</i>	\$ \$ \$	\$ \$ \$
7	What is not covered?		
8	Will the policy pay for: <i>Maternity care</i> <i>Prescriptions</i> <i>Immunizations</i> <i>Well baby care</i> <i>Vision care</i> <i>Dental care</i> <i>Infertility treatment</i> <i>Chiropractic care</i>	Yes No Yes No Yes No Yes No Yes No Yes No Yes No Yes No	Yes No Yes No Yes No Yes No Yes No Yes No Yes No Yes No

Additional questions for managed care comparison.

9	How much is the co-payment?	\$	\$
10	Are my doctors in the network?	Yes No	Yes No
11	Do I need a referral to see a specialist?	Yes No	Yes No
12	Are non-emergency, out-of-network services covered?	Yes No	Yes No
13	Are network providers conveniently located?	Yes No	Yes No
14	Is the doctor I want to see accepting new patients?	Yes No	Yes No
15	Does the plan allow providers to balance bill me for the difference between allowed and actual charges?	Yes No	Yes No

(This is only an example. You may need to tailor a comparison chart of your own to address your individual needs.)

Claims

Regardless of the type of plan you are covered under, when you do have to file a claim it is very important that you follow the rules of the plan. Under most managed care plans, network providers, rather than plan members, are responsible for filing claims. Insureds of traditional insurance plans frequently have to file most of their own claims. Following are some tips and suggestions to help you avoid problems and delays.

Before You Have a Claim

Plan Ahead

Read your policy or employee benefits booklet carefully to be sure what services are covered. Follow any managed care rules, such as the use of network providers. Give correct insurance information to your provider. If you, your spouse or your covered dependents have health care coverage under more than one group plan, you should review each employee benefit booklet to determine which policy is primary and which is secondary.

Pre-Certification

Many plans require you to contact the insurer for approval before you check into the hospital, have elective surgery, visit specialists or have expensive tests. The steps should be spelled out in your policy benefits booklet. Pre-certification does not necessarily guarantee the payment of your claims. However, if your plan pre-certifies a service, it cannot later deny coverage on the grounds that the service was not medically necessary, unless the pre-certification was granted based on false information from you or your provider.

Please note: An insurer cannot require pre-certification for emergency medical services or treatment.

Filing Claims

Submit Claims Properly

Find out if you or your provider needs to submit the claim. If you are required to submit the claim, review the information to be sure it is complete and correct before forwarding it to the insurance company. File it as soon as you receive the bill from

the provider. Send it to the correct address and keep a copy for your records.

Allow a Reasonable Time

An insurer must take action on a claim within 30 days after receipt. "Taking action" means the insurer must pay the claim, deny the claim or explain what is needed to complete the processing of the claim. If additional information was requested within 30 days, the insurer must pay or deny the claim within 30 days of receiving that additional information.

Explanation of Benefits

The Explanation of Benefits (EOB) is a statement sent to you from the insurance company explaining its claim determination and benefit calculation. Information provided on the EOB should be carefully analyzed in conjunction with your medical bills and policy contract. Any questions or discrepancies should be addressed with the insurance company promptly.

Member Appeals, Grievances and Requests for External Review

Appeals and Grievances

If you are dissatisfied with the manner in which your health insurance carrier processes, denies or responds to your claim, you may have the right to challenge your carrier's decision through an appeal and/or grievance. A guide describing the appeal and grievance provisions in North Carolina law is available through the Department of Insurance. Appeal and Grievance laws apply to all types of full service health plans, including traditional indemnity, HMO and PPO coverage. Provisions for expedited appeals are available for persons whose medical condition meets certain requirements. Details concerning your plan's appeal and grievance procedures should be included in your employee handbook, certificate of coverage and insurance policy.

New state laws go into effect in 2002 providing for increased assistance for consumers who are having problems with their health plan.

External Review of Health Plan Denials

Health insurance consumers have traditionally had one method of resolving complaints or disputes with their insurance companies, the appeals and grievance process. This policy of insurance companies ended with an internal review board gathered by the insurance company itself. On July 1, 2002, however, a secondary means of dealing with denial issues was introduced in the form of the Healthcare External Review Program.

This new unit of the Department of Insurance offers consumers an unbiased, unaffiliated review process for the consideration of denials. After completing the traditional two-level appeals and grievances process, consumers unsatisfied with the

results can apply for external review through the Department. If the request meets eligibility requirements, the case is referred to independent review panels who will determine if the health plan made the correct medical decision regarding the denial of services. These panels consist of qualified physicians and other medical professionals assembled by independent organizations that contract with the Department. Expedited reviews are also available when a case is deemed time sensitive in the interest of life threatening conditions.

For more information about the Healthcare External Review Program and eligibility requirements, see the Department Web site at www.ncdoi.com.

Consumer Tips

For Individual or Group Insurance:

- Make sure all claim forms are filled out promptly, completely and accurately.
- **READ YOUR POLICY** and keep it in a safe and secure place.
- Ask questions.

For Individual Insurance:

- Shop around. Compare plans from more than one company. Do not feel pressured to make a quick decision.
- Verify that the agent and company you choose to do business with are licensed in North Carolina.
- **DO NOT PAY CASH.** When you purchase a policy, make your check or money order payable to the insurance company, **NOT THE AGENT.** Be sure to get a receipt.
- Make sure you fully understand any policy you are considering and that you are comfortable with the company, agent and product.
- Do not sign an insurance application until you review it carefully to be sure all the answers are complete and accurate.

- Keep in mind that you have a minimum 10-day “free look” period. If you cancel during the free look period, the company must return your premium without penalty.

Disclosure

North Carolina law requires all insurers to clearly and truthfully disclose the following information in their marketing materials and all health insurance policies:

- A clear description of health insurance benefits
- A complete list of items and services that the health care plan does not cover (exclusions and limitations)
- An explanation of how the insurer will calculate their claim cost (their share of a claim) and your share, including an example of how they make that calculation
- Length of time you must wait in order to receive benefits if the policy contains pre-existing health conditions limitations
- Renewal terms and provisions
- Premium rate terms and provisions

Frequently Asked Questions

When I apply for insurance, what information will I be asked to provide?

To determine your eligibility, companies frequently ask for medical and personal information.

Can an insurance company void my policy if I made a mistake in completing the application?

Health insurance contracts may be voided within the first two years if the applicant provides incorrect answers to the application questions and the company's decision to issue the policy was based on the misrepresentations. Always verify that answers and information submitted on any application for insurance are complete and accurate.

What are my rights to continue my health insurance if I lose my job?

You may be able to continue your group health insurance for up to 18 months by means of COBRA or State Continuation. The employer and/or insurer cannot require you to pay more than 102 percent of your full group premium rate.

What is association group health insurance coverage?

Under an association group arrangement, the master group policy is typically issued to the association and coverage is offered to the association's members. Generally, each applicant must meet the company's underwriting guidelines. Applicants who fail to qualify may be denied coverage or exclusionary riders may be attached to the policy.

Am I guaranteed the right to purchase individual health insurance?

No, except under certain circumstances, insurance companies have the right to fully underwrite your application and determine whether you are an acceptable risk. If not, your application may be declined.

What is HIPAA (Health Insurance Portability and Accountability Act)?

HIPAA affects individuals who change from one employer group plan to another and those individuals who lose their eligibility for group coverage. Two of the most important changes are the allowance of "portability" and the availability of "guaranteed issue" individual health insurance.

Does the Department of Insurance set the rates and tell companies how much they can charge?

No, the North Carolina Department of Insurance does not have the authority to set rates. However, carriers are required to justify their rates and demonstrate that they are actuarially sound and not unfairly discriminatory.

I have a child who is going to be attending school outside my HMO's (or other managed care plan) service area. Will my child be covered?

Children who live and attend school outside the service area are subject to the same requirements as all other persons covered by the plan. The child must return to the plan's service area in order to receive full benefits. However, the plan must cover emergency treatment outside of the service area.

I am currently covered under my employer's HMO. I plan to leave my job and move to another state. Do I have any COBRA or N.C. State Continuation rights?

If you move out of the plan's service area, your coverage will most likely be terminated.

I have an exclusion rider on my individual health policy. How long will it remain in effect?

The rider will remain in effect for the length of time specified in the terms of the rider. If there is no time limitation specified, it will remain in effect for the duration of the policy unless the insurance company agrees to remove it.

The North Carolina Life and Health Insurance Guaranty Association

To protect North Carolina life and health insurance policyholders against insurer insolvency, the North Carolina General Assembly created the North Carolina Life and Health Guaranty Association. The Guaranty Association

provides up to \$300,000 of benefits per person (for guaranteed policy benefits) on covered policies in the unlikely event of insurer insolvency. The association is funded by insurers licensed to do business in North Carolina.

Consumer Services and Consumer Complaints

The goal of the Consumer Services Division is to respond promptly, clearly and courteously to questions and complaints from the public concerning insurance and to acquaint consumers with alternatives and courses of action which a citizen can pursue to solve a particular insurance problem.

If you have a problem or concern with an insurance company or agent, the North Carolina Department of Insurance stands ready to assist you.

A consumer complaint form is attached for your convenience on page 23.

What We Can Do To Help

1. Forward a copy of your complaint to the insurance company, if appropriate.
2. Obtain information or explanations on your behalf from the insurance company or its representatives. This may involve written and oral contact with such company or representatives.
3. Review in detail the information obtained from the company for compliance with statutes, regulations and policy contracts.
4. Serve as your advocate if we determine that the

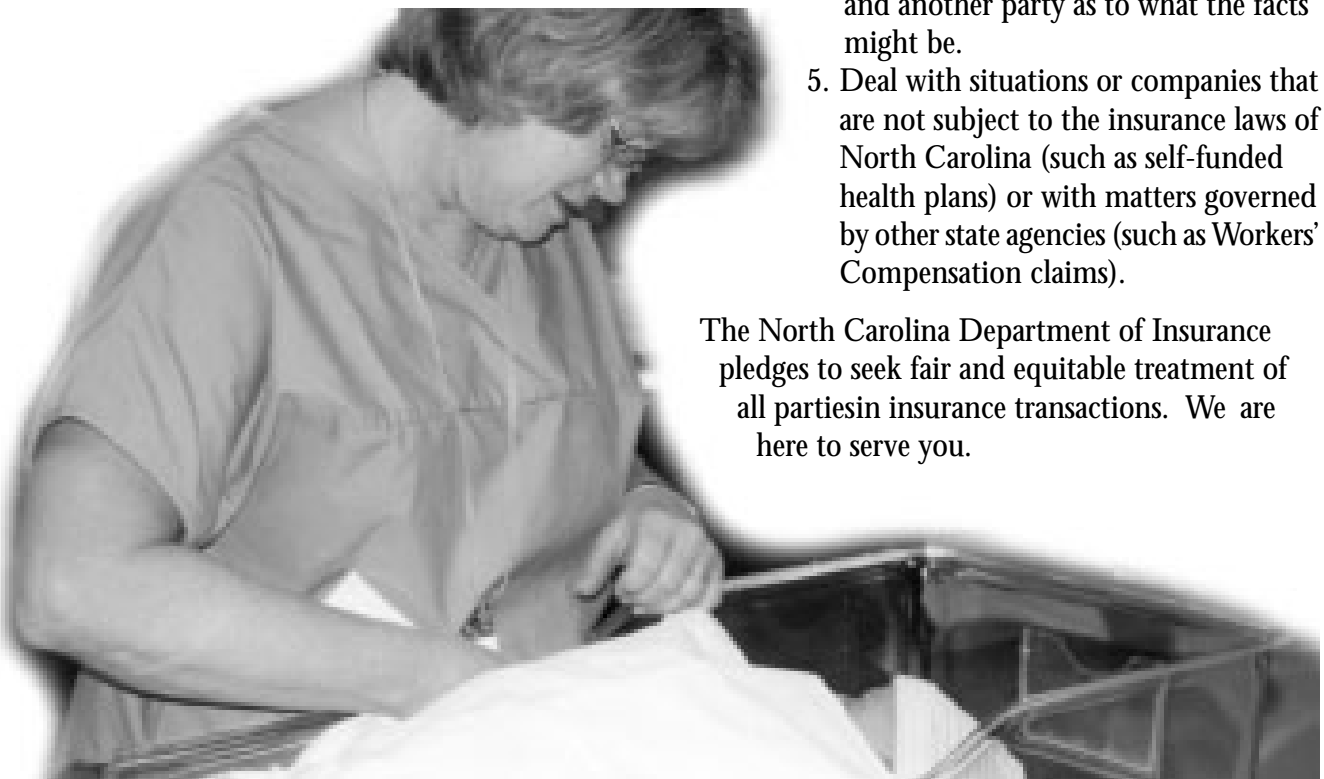
position of the insurance company or its representatives is unlawful.

5. Explain the provisions of your insurance policy contract, as appropriate.
6. Suggest to you actions or procedures that you may take which could aid in resolving your insurance problem.

What We Cannot Do

1. Assume the role as your legal representative, in or out of court.
2. Interfere in a pending lawsuit on your behalf.
3. Consult with you if you are represented by an attorney, unless it is with written permission of that attorney.
4. Make a decision as to disputes between you and your insurance company or their representatives which involve matters as to:
 - a. Who is negligent or at fault;
 - b. The facts surrounding the claim (that is, who might be telling the truth in the matter when accounts differ);
 - c. The value of a claim or the amount of money owed to you; or
 - d. Any other disagreements between you and another party as to what the facts might be.
5. Deal with situations or companies that are not subject to the insurance laws of North Carolina (such as self-funded health plans) or with matters governed by other state agencies (such as Workers' Compensation claims).

The North Carolina Department of Insurance pledges to seek fair and equitable treatment of all parties in insurance transactions. We are here to serve you.



Glossary

Appeal

State law allows you to challenge your health plan's noncertification and force the plan to formally review its decision. This review process is known as an "appeal." An appeal is available anytime a plan issues a noncertification. The appeal process is voluntary. Keep in mind that it is not considered a noncertification when your plan refuses to pay for a service that your certificate of coverage clearly states is not covered. In that case, the right to appeal does not apply.

Certificate of Creditable Coverage

A document prepared by the prior health insurer that discloses the beginning and ending dates of coverage. It is generally used to show a new health plan how much pre-existing condition limitation credit a new enrollee has earned.

Drug Formulary

A list of prescription medications that have been approved for use by the health plan. An open formulary allows coverage for non-formulary medications. A closed formulary limits coverage to those drugs in the formulary.

Emergency Care

Every insurer shall provide coverage for emergency services to the extent necessary to screen and stabilize the person covered under the plan and shall not require prior authorization of the services if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. Payment of claims for emergency services shall be based on the retrospective review of the presenting history and symptoms of the covered person.

Evidence of Insurability

Proof that an applicant is an acceptable risk to the insurance company.

Exclusions (Limitations)

Provisions in insurance policies that describe non-covered treatments and services or coverage limitations.

Experimental/Investigational

Until such time a treatment meets generally accepted standards of medical care in the community it may be considered experimental or investigational.

Grievance

In addition to noncertification appeals, your rights under North Carolina law extend to other complaints against your health plan. Such complaints, called

"grievances," can relate to any plan decision, policy or action related to the availability, delivery or quality of health care services; claims payment or handling; reimbursement for services or the contractual relationship between you and the plan.

Insolvency

The inability of a company to meet financial obligations or debts.

Insured

A person covered by an insurance contract.

Medically Necessary Services or Supplies

Those covered services or supplies that are:

1. Provided for the diagnosis, treatment, cure or relief of a health condition, illness, injury or disease and not for experimental, investigational or cosmetic purposes.
2. Necessary for and appropriate to the diagnosis, treatment, cure or relief of a health condition, illness, injury, disease or its symptoms.
3. Within generally accepted standards of medical care in the community.
4. Not solely for the convenience of the insured, the insured's family or the provider.

Primary Care Physician (PCP)

Doctors who provide general health care services and treatment. PCPs usually include family practitioners, general practitioners, pediatricians and internists.

Provider

A doctor, hospital, pharmacist or other health care professional or facility.

Provider Network

The doctors, hospitals, pharmacies and other health care professionals and facilities under contract with a health plan.

Rider

A modification or amendment to an insurance contract that may either expand, limit or exclude benefits.

Third Party Administrator (TPA)

A firm that provides administrative services to insurance carriers and/or employers.

Underwriter

A person employed by an insurance company who reviews applications for insurance and decides if the applicant is an acceptable risk.

How to Reach Us

How to Reach Us

You Can Reach the North Carolina Department of Insurance Consumer Services Division at:

(800)546-5664 Toll free
(919)733-2032 Outside of North Carolina
(919)715-0319 TDD (Telephone Device for Deaf Caller)
(919)733-0085 Fax

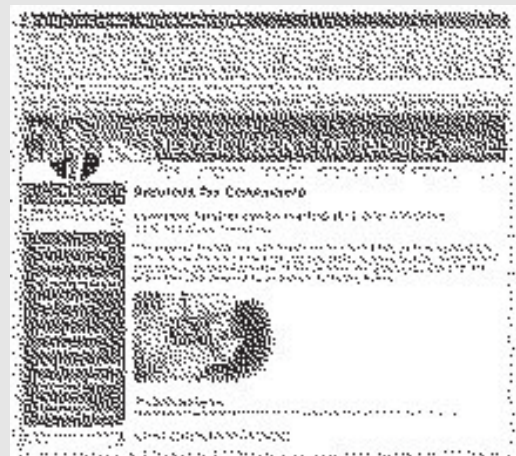
You can find additional information as well as a downloadable copy of our complaint form on the North Carolina Department of Insurance web site at www.ncdoi.com.

The address for the North Carolina Department of Insurance Consumer Services Division is:

Consumer Services Division
North Carolina Department of Insurance
1201 Mail Service Center
Raleigh, NC 27699-1201

Related Publications Available from the NCDOI and its Web Site

HMO Performance Report
Managed Care Plan Consumer Guide
Guide to Appeals and Grievances
A Consumer's Guide to State Continuation
Employer's Guide to HIPAA Rights Regarding Health Insurance
Employees' Guide to HIPAA Rights Regarding Health Insurance
Your HIPAA Rights and Guide to Individual Health Insurance
Getting Off to a Good Start With Medicare
Medicare Changes and Options
Medicare + Choice Comparison Guide
Medicare Supplement Comparison Guide
Guide to Long-Term Care Insurance



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