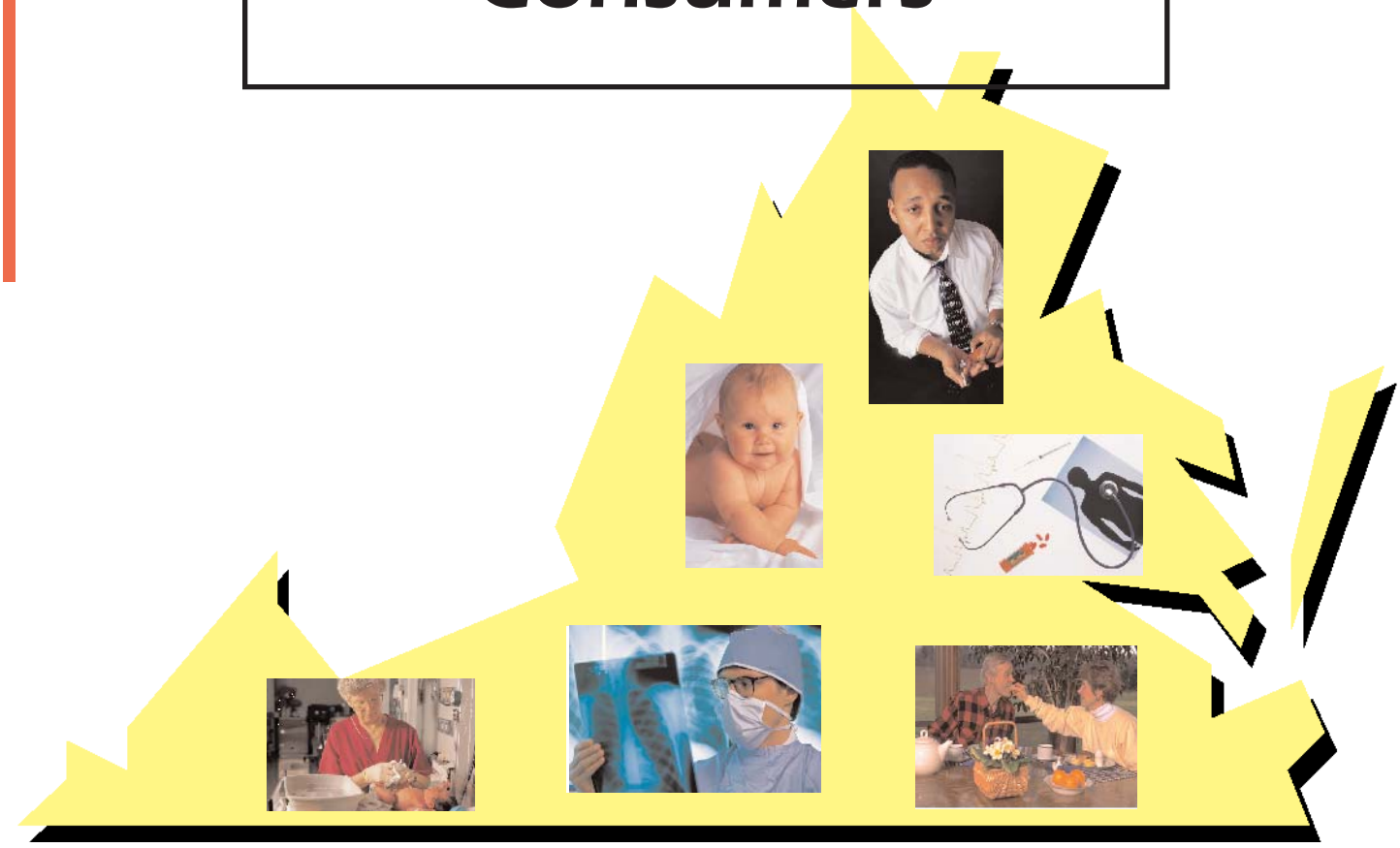
Virginia Health Insurance Guide for Consumers



Prepared by the
Bureau of Insurance
State Corporation Commission
Commonwealth of Virginia

This Consumer's Guide should be used for educational purposes only. It is not intended to be an opinion, legal or otherwise, of the State Corporation Commission on the availability of coverage under a specific insurance policy or contract, nor should it be construed as an endorsement of any product, service, person or organization mentioned in this Guide.

This Guide provides general information about traditional health insurance and managed care health insurance plans. This Guide does not address Medicare supplement (Medigap) Insurance or long-term care insurance, because the State Corporation Commission's Bureau of Insurance has guides and other information available specifically about those types of coverage. If you are interested in information concerning Medicare supplement insurance or long-term care insurance, contact the Bureau of Insurance and we will be pleased to provide this information to you.

The Bureau of Insurance also has many other guides and publications available on a variety of insurance related topics. You may call the Bureau of Insurance or consult the Bureau's web site for more information about other publications available (refer to "Important Information - How to Reach Us" at the front of this Guide for telephone numbers and the web site address).

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Commonwealth of Virginia
State Corporation Commission
Bureau of Insurance
Post Office Box 1157
Richmond, Virginia 23218
Web Site - www.scc.virginia.gov/boi
Email Address - BureauofInsurance@scc.virginia.gov

Jacqueline K. Cunningham

Commissioner of Insurance

State Corporation Commission Bureau of Insurance

P.O. Box 1157
Richmond, VA 23218
Telephone: (804) 371-9741
TDD/Voice: (804) 371-9206
www.scc.virginia.gov/boi

A Message from the Commissioner

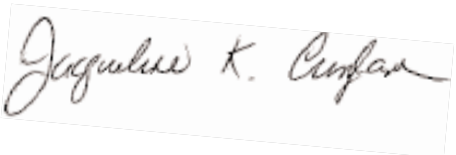
The purpose of the State Corporation Commission's Bureau of Insurance is to serve the people of Virginia in all matters relating to insurance. One of our major concerns is consumer protection and awareness. We strive to make every effort to provide the information you need to make informed decisions when purchasing insurance so that your interests can be safeguarded.

We designed this Consumer's Guide to give you some basic facts about health insurance and managed care health insurance plans. As with our auto, homeowner and life insurance guides, this Guide offers information to familiarize you with the types of health insurance and managed care health insurance plans available, and how these policies and plans could be compatible with your individual needs and circumstances. Use this Guide to help you understand how health insurance can be used to suit your needs and those of your family. By making wise decisions, an informed consumer becomes a protected consumer.

If your questions or problems go beyond the scope of this Guide, my office will provide you with more detailed assistance. To reach the appropriate section within the Bureau of Insurance, refer to the next page in this Guide.

We are here to help you with concerns or problems you have with your health insurance, your managed care health insurance plan, or with any other type of insurance. Please let us know if we can be of service.

Jacqueline K. Cunningham



Commissioner of Insurance

IMPORTANT INFORMATION

(HOW to REACH US)

STATE CORPORATION COMMISSION
BUREAU of INSURANCE

Physical Deliveries/Visits:
Life & Health Division
1300 E. Main Street
Richmond, VA 23219

Mailing address:
Life & Health Division
P. O. Box 1157
Richmond, VA 23218
(Fax) (804) 371-9944

LIFE & HEALTH DIVISION
CONSUMER SERVICES SECTION
(Va. Toll-Free) 1-800-552-7945
(Nationwide Toll-Free) 1-877-310-6560
(In Richmond) (804) 371-9691

TDD USERS ONLY
Telecommunications Device for the Deaf
(804) 371-9206

ASSISTANCE for NON-ENGLISH SPEAKING CONSUMERS
(804) 371-9741
(804) 371-9691
(Toll-Free) 1-877-310-6560

OFFICE of the
MANAGED CARE OMBUDSMAN
(Toll-Free) 1-877-310-6560
(In Richmond) (804) 371-9032

OFFICE of INDEPENDENT EXTERNAL REVIEW
(Toll-Free) 1-877-310-6560
(In Richmond) 371-9913
(Fax) (804) 371-9915

INSURANCE OUTREACH
(Toll-Free) 1-877-310-6560
(In Richmond) (804) 371-9092

Web site
www.scc.virginia.gov/boi

Email Address
BureauofInsurance@scc.virginia.gov

CONTENTS

Health Insurance

Rising health care costs have made it very expensive to be injured or sick. If you do not have a good health care benefit plan to help manage your health care expenses, a serious illness or injury can create major financial burdens.

Health insurance protects us against financial loss stemming from an accident or illness. This Guide describes the various types of policies or plans available in the marketplace, offers tips on choosing the best health insurance policy or health benefit plan for you, provides definitions of common health insurance terms, and suggests what you should do if you have a problem with your health insurance policy or health benefit plan.

This Guide is not a replacement for the detailed information found in your policy, certificate, Evidence of Coverage (EOC), or benefits booklet. Be sure you have a copy of your health benefit plan or health insurance policy and that you take the time to familiarize yourself with your benefits before you have a claim.

If you have questions after reading this Guide, please call the Bureau of Insurance Consumer Services Section at 1-877-310-6560 (in Richmond at (804) 371-9691 between the hours of 8:15 a.m. and 5:00 p.m., Monday through Friday.

Traditional vs. Managed Care Coverage

When selecting or purchasing healthcare coverage, it is important to understand the difference between traditional health insurance and managed care health insurance plans (called "managed care plans" or "MCHIPs" in Virginia).

Traditional insurance plans generally allow you to go to the provider, (physician, hospital, etc.), of your choice, but require that you pay for the services and file (or allow your physician or provider to file) claims for reimbursement. MCHIPs use networks of selected doctors and other providers to provide health care services. In return for using the network of providers, or "staying within the network," you typically pay less for medical care than you would with traditional health insurance. Under a Health Maintenance Organization (HMO), you may be required to receive all non-emergency services within the network.

Under an HMO plan, you must live or work within the plan's service area in order to be eligible for coverage. Under a traditional health insurance plan, you are eligible for coverage regardless of where you live or work.

Under managed care plans, normally, a primary care health professional (PCHP) manages your medical care, and, with some exceptions, you must receive a referral from your PCHP in order to obtain the services of a specialist. Under a traditional health insurance plan, you do not have a PCHP, and you do not need a referral to see a specialist.

Traditional health insurance and managed care plans provide protection through many types of policies and plans and at many prices. Some policies or plans pay most of your healthcare bills or provide most healthcare services for illness or injury. Others will cover only certain illnesses or injuries. Some pay an amount directly related to your healthcare costs. Others pay a set amount for each day that

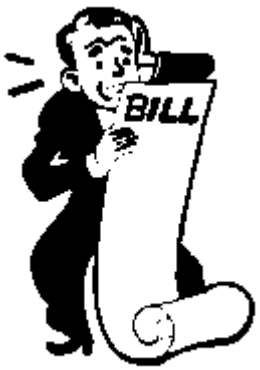
you are in the hospital, without regard to your actual bills. Some plans restrict care to certain providers and require that a PCHP manage all care.

Types of Managed Care Health Insurance Plans (MCHIPs)

Health Maintenance Organizations (HMOs) are the most familiar form of managed care plans. HMO members pay a monthly premium, which gives them access to a wide range of healthcare services. Members pay a fixed dollar amount or copayment for each hospital visit, doctor, or emergency room visit, and for prescription drugs, rather than paying the provider charges in full and obtaining reimbursement for a portion of the charge later. HMOs generally do not require the member to file claims.

When you enroll in an HMO, you must select a PCHP to manage your healthcare. With a few exceptions, you must first consult with your PCHP for healthcare needs. If necessary, your PCHP may refer you to an HMO approved specialist. If you do not get approval from your PCHP before you seek medical care, you may be responsible for payment for those services.

As HMO carriers continue to seek ways to contain costs while responding to consumers' changing needs for healthcare services and benefits, HMO plan designs also continue to change. Some of the newer plan designs may offer more services without PCHP approval, or different forms of cost-sharing, including the requirement for an enrollee to satisfy an annual deductible for certain services.



Preferred Provider Organization (PPO) plans issued by an insurance carrier are plans that provide higher reimbursement if you go to a "preferred" or "participating" provider than if you go to a non-preferred or non-participating provider. Insured individuals choose who will provide their health services, but they pay less in out-of-pocket expenses with a preferred (participating) provider than with a non-preferred (non-participating) provider.

Point of Service (POS) Plans offer HMO enrollees the option of receiving services outside the HMO's network. Inside the network, the plan operates like an HMO. POS plans offer lower out-of-pocket costs to the enrollee using the services of providers inside the network.

In a POS plan, insured members choose, at the point of service, whether to receive care from a healthcare provider within the plan's network or to go out of the network for services. POS plans offer less coverage for healthcare expenses incurred from providers outside the network than for expenses incurred from providers within the network.

In cases of a medical emergency, covered services that you may obtain from providers outside the MCHIP network are subject to cost-sharing that is no greater than what you would pay in-network. This requirement applies to your copayment and coinsurance amount. You should be aware, however, that you may be required to pay any provider charges that are in excess of the allowed amount for the service as determined by your MCHIP. If a deductible applies to out-of-network benefits in general, that deductible may be imposed on out-of-network emergency services. If an out-of-pocket maximum applies to out-of-network benefits in general, that maximum also must apply to out-of-network emergency services.

Types of Traditional Health Insurance Policies

Basic Health Insurance (hospital/surgical) policies provide benefits related to hospitalization costs and associated medical expenses of an insured. Typically, these benefits include hospital room and board; other hospital services, such as x-ray and lab expenses; operating room use; surgical expenses; and in-hospital physician charges.

Hospital/Surgical policies may provide "first-dollar" coverage. This means that there is no deductible for the policyholder to pay, and therefore, no initial out-of-pocket expense. Although there may be little out-of-pocket expense for the policyholder in the event of a short-term hospitalization or routine surgery, lengthy hospitalizations and costly medical care may not be covered by these policies. As a result, unless you have other insurance, you may incur sizable expenses that are difficult to meet.

Major Medical Comprehensive Insurance Plans provide coverage for medical services in and out of the hospital. Major medical plans may also cover the costs of blood transfusions, prescription drugs, and out-of-hospital costs, such as doctor visits.

Major medical policies typically pay a percentage of allowable charges for covered expenses after you pay an annual deductible. You then pay the remaining percentage of allowable charges for covered expenses as coinsurance.

Hospital Confinement Indemnity Insurance provides a predetermined flat benefit amount for each day, week, or month you are hospitalized up to a designated number of days.

Hospital confinement indemnity policies are available directly from insurance companies, by mail, or through insurance agents. As with any product that offers many choices, these policies require care in matching the plan to your needs.

Some policies contain limitations on pre-existing conditions (however, limitations for pre-existing conditions may be reduced in certain circumstances). Others contain an elimination period; this means that benefits will not be paid until you have been hospitalized for a specified number of days. When you apply for the policy, you may be allowed to choose from two or three elimination periods, with different premiums for each. Although you can hold premiums down by choosing a longer elimination period, you should bear in mind that most patients are hospitalized for relatively brief periods of time.

If you do buy a hospital confinement indemnity policy, consider a periodic review and increase of the daily benefits to keep pace with rising health care costs.

Disability Income Insurance Policies provide income for a specific period if you suffer a disability and cannot continue to work. The disability may involve sickness, injury, or a combination of the two.

Employers may offer short-term or long-term disability coverage. Social Security also provides disability protection, but only for those who are severely disabled and unable to work. Most disability income policies coordinate with Social Security benefits and workers' compensation to eliminate duplication of coverage.

When buying a disability income policy, you should find out the insurance carrier's definition of a disability and the requirements that must be met. A carrier may require the insured to provide a written doctor's report before paying for a disability claim. The frequency of this requirement depends on the particular policy.

Examine your disability income policy carefully:

- ❑ Benefits are usually a percentage of your income at the time of purchase, but cost-of-living adjustments may be available.

- ❑ Know how your policy defines "disability." Eligibility for benefits is based on this definition. Is eligibility based on your inability to perform the substantial or major duties of your regular occupation? Or, is eligibility based on your inability to engage in any occupation or employment for which you are qualified because of your education, training, or experience? Or, is there a dual definition?

- ❑ Review the benefit as it relates to the cause of the disability. You want to be insured if disability is caused by both accidental injury or illness.
- ❑ Please be aware that disability income insurance policies include an elimination period (the length of time you must wait after the onset of disability, before benefit payments begin). Benefit payments may actually begin several months after the onset of the disability if it is a long-term disability income policy.
- ❑ Consider disability income insurance that pays benefits to at least age 65. Disability income benefits are designed to replace earned income. A lengthy disability can threaten financial security.

Specified Disease Insurance Policies provide benefits for medical expenses associated with specific diseases named in the policy. For example, cancer policies pay benefits for expenses incurred in connection with treatment of cancer. Benefits are usually limited in amount. Some policies may limit coverage to the first occurrence of the disease. These policies often pay the insured directly for the benefits available under the policy regardless of payments for medical care under other plans.

Short-term or Temporary Health Insurance policies provide coverage for a specified period of time. For example, you might purchase a one-month policy with major medical coverage during a brief period of unemployment.

Limited Benefit Health Policies: Minimum standards were established in Virginia to ensure that individual accident and sickness policies provide a minimum of basic benefits needed for healthcare. An insurance carrier may market an individual accident and sickness policy that does not meet these minimum standards, as long as it discloses that the benefits are limited and describes, in detail, the policy limitations. Contact your agent regarding your policy and its minimum standards.

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There are many consumer guides that explain other types or aspects of health insurance and its benefits. These guides are available from the Bureau of Insurance at no charge. Please call, write or visit our web site to make your request.

Group Coverage vs. Individual Coverage

Health insurance policies and managed care health insurance plans may be obtained in the form of group insurance or individual insurance. The difference between group insurance and individual insurance is in the way coverage is purchased.

Group insurance may be obtained through an employer, a trust, a union, an association, a multiple employer welfare arrangement (MEWA), or other organization, and covers several people or groups under one policy or group agreement.

Individual insurance covers one person or members of one family under one policy or evidence of coverage.

Group Plans

Group health insurance is exactly what its name suggests - one insurance policy or plan covering a group of people. Fulfilling your insurance needs may prove relatively simple if your employer offers a group plan or a choice of plans. The group policyholder may be an association, organization, or union with which you are affiliated, or it may be your employer. Many group plans have provisions for extending coverage to family members.

When you enroll in a group plan, the group (your employer, association, etc.) is the policyholder, and as an employee or group member, you receive a certificate or an evidence of coverage (EOC). The certificate or EOC describes your plan's benefits, limitations and exclusions.

Insurers must offer small employers (employers with 50 or fewer employees) guaranteed-issue group plans known as **Small Employer Group Coverage.** This coverage is available to small business employers regardless of the health claims experience of the employee

group or the health status of an individual employee. Insurance companies and managed care plans that offer coverage to small employers in Virginia must also make available the Essential and the Standard Health Benefit plans, providing state-defined minimum benefits. For more information regarding these plans, contact the Bureau of Insurance.

Many trade and professional associations offer their members insurance. Self-employed men and women often find association membership an attractive route to accessible health insurance.

Note: Often, an insurer issues a group policy to a policyholder (i.e. a trust, association or group) located outside of the Commonwealth of Virginia. Virginia's laws governing benefits may not apply to the out-of-state group policy, even though the Virginians are or may be covered certificateholders under the policy. If the group policy under which you are covered is issued outside of Virginia, and you have an inquiry or complaint about your coverage, you must direct that inquiry or complaint to the insurance department of the state in which the group policy was issued.

What is Covered Under a Group Health Benefit Plan?

A group health benefit plan only covers the expenses outlined in the policy, certificate, or EOC. A number of factors are considered in determining if a service is covered, and the extent of the available coverage. The following factors should be considered before you submit a claim:

- ❑ **Is the service covered under the terms of the policy?**
  The certificate or EOC will describe the covered services and will list exclusions and limitations.
- ❑ **Is the service medically necessary?**
  Routine services or elective procedures that are not medically necessary will generally not be covered.

- **What does the insurer consider to be an "allowable charge" or a "usual, customary and reasonable (UCR) charge" for the service?**
  Many health benefit plans and health insurance policies establish allowable charges for services and procedures. The charges may be representative of fees charged by similarly situated providers rendering the same services in a given locality, region, or area (often referred to as "usual, customary, and reasonable") or they may be based on other criteria established by the insurance carrier. If your plan bases payments on a UCR schedule, or a schedule of allowable charges, you may be responsible for any difference between the UCR or allowable charge and the provider's actual charge. However, in some cases, providers agree to accept the UCR or allowable charge, which means the patient will not be responsible for the additional payment to the provider.

- **Is the condition considered a pre-existing condition?**
  A group health benefit plan may deny benefits for a pre-existing condition, but there are laws in Virginia that specifically define a "pre-existing condition" and limit how long benefits may be excluded because of a pre-existing condition. Also, certain conditions may not be considered pre-existing. In Virginia, any applicable new or renewing plan or policy may not impose limitations on pre-existing conditions for an individual under age 19. Grandfathered individual market health benefit plans or policies may continue to apply pre-existing condition limits or exclusions to these individuals.

- **Did the patient follow any pre-certification or pre-admission requirements prior to obtaining services?**
  Many insurance carriers require pre-admission or pre-certification authorization prior to being admitted for non-emergency services, or receiving certain care. You may be held financially responsible for the cost of the care if you fail to obtain the pre-certification or pre-admission authorization.

Individual Health Insurance Policies

Individual health insurance policies cover one person or members of a family under one policy or evidence of coverage. Individual health insurance coverage is a good option if you are self-employed or lack access to group coverage.

For traditional individual health insurance policies, you may take at least 10 days from the date you receive the policy to decide whether to keep or cancel it. Some policies provide a longer period of time. For a full refund of any premium paid for the policy, you must return the policy to the insurance carrier within the allowed time.

You should carefully consider coverage and costs when purchasing an individual health insurance policy or managed care health insurance plan. Generally, when buying an individual policy or plan, you must provide evidence of insurability before the insurance carrier will agree to insure you or your family. Standards for determining evidence of insurability vary from carrier to carrier.

- ❑ **Can the Bureau of Insurance require an insurer to change my rate?**

  The process by which an insurer or managed care health insurance plan evaluates your eligibility for coverage is referred to as underwriting.

  The Bureau of Insurance does not have the regulatory authority to change an insurer's underwriting decision. However, the Bureau of Insurance will review an insurance carrier's files to ensure that established underwriting guidelines are being administered consistently and appropriately.

Fully Insured Health Benefit Plans vs. Self Funded Health Benefit Plans

Fully insured health benefit plans issued in the Commonwealth of Virginia are regulated by the Bureau of Insurance and are subject to all applicable laws and regulations governing group health benefit plans in Virginia. A fully insured health benefit plan is a plan the employer purchases directly from an insurance carrier, and the insurance carrier assumes the risk to pay all covered health claims.

Self-insured (or self funded) health benefit plans are funded by the employer to pay the health claims of its employees. The employer actually pays the bills for its employees' health care and assumes all associated risks. Sometimes, the employer with a self-insured plan will hire an insurance carrier to handle administrative duties. In this case, the insurance carrier is not assuming any financial risk, but is acting as a third-party administrator, following the directives of the employer. Self-insured health benefit plans are subject to the Federal Employee Retirement and Income Security Act of 1974 (ERISA). The U.S. Department of Labor is the federal government agency that is responsible for handling matters involving most self-insured health benefit plans. You may contact the U.S. Department of Labor at www.dol.gov/ebsa or1-866-444-3272. If your self-insured plan is a non federal governmental plan, the Private Health Insurance Group (PHIG), monitored by the Center for Consumer Information and Insurance Oversight under the U.S. Department of Health and Human Services may be able to assist you. Their contact information is: 1-877-267-2323 ext. 61565 or 1-410-786-1565 or email them at phig@cms.hhs.gov.

Mandated Benefits

Virginia's insurance laws require that health insurance plans offering hospital, medical and surgical, or major medical coverage, including managed care plans: 1) provide certain benefits, known as mandated benefits, in each and every individual or group contract they offer in Virginia; and 2) offer and make available to you, as an individual policyholder, or to your group policyholder if you have group coverage, the option to purchase certain benefits known as mandated offers of coverage. Mandates apply only to Virginia-issued contracts or policies.

For more information on mandated benefits and mandated offers, contact the Bureau of Insurance or visit the Bureau's web site.

Where Can I Obtain Health Insurance Coverage?

Bureau of Insurance Consumer Services Representatives can speak with you by telephone about coverage options that may be available for your particular situation. Consumer Services Representatives are available Monday through Friday, 8:15 a.m. to 5:00 p.m. Eastern Time, toll-free at 1-877-310-6560.

Pre-existing Condition Insurance Plan (PCIP)

The Federal government operates a program called the Pre-existing Condition Insurance Plan (PCIP) in Virginia. The PCIP was created under the Patient Protection and Affordable Care Act (ACA) to help uninsured people with a pre-existing condition obtain affordable health insurance coverage. To find out more about eligibility, benefits and premiums, or to apply for coverage, visit www.pcip.gov. The PCIP call center is open from 8 a.m. to 11 p.m. Eastern Time. You may call toll-free at 1-866-717-5826 (TTY 1-866-561-1604).

Commercial Coverage

Commercial insurance agents and insurance carriers may be found on the internet, or are listed alphabetically and by location in the yellow pages of your telephone directory. The Bureau of Insurance also provides a listing of carriers licensed to write individual health and dental insurance coverage in Virginia. These listings may be obtained by calling the Bureau of Insurance, or visiting the Bureau's web site.

Insurance premiums and policy benefits can vary substantially from carrier to carrier so it usually pays to check with several companies before making a final choice. The Bureau of Insurance has developed a Health Coverage Comparison Form, located in the back of this Guide, to assist you in comparing prospective coverage.

HealthCare.gov

A web portal created by the U.S. Department of Health and Human Services is available to assist persons in gathering information on available health insurance coverage options based on the individual's needs. This tool can be found at www.HealthCare.gov.

Choosing a Health Care Plan

Consider what is most important to you in a health care plan: cost, availability and location of providers, or freedom to see any doctor. If you like the physician you are currently seeing, check to see if he or she is a provider in the plan that you are considering.

What expenses may be related to my health insurance coverage other than my premium?

Become familiar with any amount you will be required to pay when you obtain medical services under your policy or plan. Know your policy or plan deductible, copayment, coinsurance amount, premiums, and any plan limitations, exclusions, or maximums. Review carefully the policy or plan features concerning premium increases.

Deductible – The amount you must pay before your insurer will begin paying its share for services received. An annual deductible may be required before receiving benefits that are payable by your insurer. Sometimes a specific service may carry a deductible.

Copayments – This is a set dollar amount you may be required to pay each time you receive a service. Your coverage documents should indicate whether or not these amounts you pay will count toward your deductible.

Coinsurance – This is the percentage of allowable charges for health care expenses you must pay after you meet any applicable deductible. For example, the insurer might pay 70% of the allowed charges and you will be responsible for 30%. This amount may be required in addition to or instead of a copayment, depending on your policy. Your coverage documents such as your certificate or EOC should indicate whether or not these amounts you pay will count toward your deductible.

Note: Any applicable new coverage you purchase must not apply a deductible, copayment or coinsurance for preventive care services you receive within your plan's participating network of providers, if any. If you join a grandfathered plan, this benefit may not apply. Refer to the Patient Protection and Affordable Care Act section of this Guide for information regarding grandfathered plans.

You are responsible for any costs not covered by your insurer related to any limitations or exclusions stated in your coverage documents. If you visit a health care provider who is not a provider in your insurer's provider network, you may be required to pay all of these costs, or a larger share of the costs. Some health insurers determine a maximum amount they will pay for any service received by an out-of-network provider. You will be responsible for any amount over and above the amount the insurer has determined is the allowable charge. Amounts you must pay over and above the insurer's allowed amount also do not count toward your deductible.

Consider the following features when comparing health care options. While this list of features is not an all-inclusive list, it is intended to provide you with general guidance and important references.

Find out about the insurance carrier. The Bureau of Insurance can tell you whether a carrier is licensed and in good standing to do business in Virginia. However, the Bureau does not rate or recommend particular insurance carriers or managed care health insurance plans.

When selecting an insurance carrier, it is wise to check on a carrier's rating. Several organizations publish insurance carrier ratings. The ratings, including those listed below, may be available in your local library or on the internet. Insurance carriers are rated on a number of elements, such as financial data (including assets and liabilities), management operations, and the carrier's history. You may also wish to review a carrier's stock analysis reports.

Name	Telephone	Web site
A.M. Best Company	1-908-439-2200	www.ambest.com
Moody's Investor Services	1-212-553-1653	www.moodys.com
Standard & Poor's Insurance Rating Services	1-877-772-5436	www.standardandpoors.com
Weiss Ratings, Inc.	1-800-291-8545	www.weissinc.com
Fitch Ratings	1-800-893-4824	www.fitchratings.com

Note: There may be a cost associated with obtaining rating information.

Before purchasing insurance, it is important to verify whether a carrier is a licensed insurer or HMO. You can obtain a listing of licensed insurers authorized to sell accident and sickness insurance, and licensed HMOs from the Bureau of Insurance by telephone or by visiting our web site.

The National Committee for Quality Assurance (NCQA), an independent organization that assesses and reports on health plan quality, can provide information about the quality of care provided by an HMO. The NCQA may be contacted at 1-888-275-7585 or on-line at www.ncqa.org. Be sure to evaluate carefully whether the HMO operates in a service area that is accessible to you and for which you are eligible based on your residence or place of employment.

What provisions might affect my coverage?

Coordination of Benefits - Many health insurance policies and managed care plans provide for coordination of benefits when there is other health insurance coverage available to an insured. Familiarize yourself with how your claims will be paid when you have other health insurance coverage.

Provider Networks - In managed care plans, you may be required to use network providers and facilities, except in an emergency. Find out if plan providers are conveniently located; how you obtain referrals; the circumstances under which you obtain services from a provider outside of the network and the related out-of-pocket expenses; and

the extent to which your plan will cover care obtained outside of the network when you are traveling.

Renewal and Premium Increase - This provision explains when and under what circumstances your insurance carrier may renew your policy or increase your premiums.

Conversion Privileges - This provision allows you to convert coverage to a different insurance plan when you lose eligibility, without a medical examination to prove good health.

What if I Lose My Group Health Insurance Coverage?

There are a number of situations by which you may lose your group health insurance coverage. Generally, when this happens, there are options to continue or convert your group insurance coverage:

COBRA

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), group health benefit plans sponsored by employers with 20 or more employees are required to offer continuation of coverage for you and your dependents for at least 18 months. This period may be extended, depending upon the qualifying event causing the group coverage to end. If you wish to continue your group coverage under COBRA, you must notify your employer within 60 days of receiving notice of your COBRA eligibility. You must also pay the entire premium on a monthly basis, as well as an administrative fee.

WARNING: COBRA is complicated. Your employer's Human Resources office should have a booklet that explains in detail how COBRA works. This booklet may also be obtained from the Bureau of Insurance. COBRA is a federal act and the U.S. Department of Labor (DOL) governs COBRA issues. Contact the Department of Labor at www.dol.gov/ebsa or call 1-866-444-3272 with any questions or concerns.

A web page has been created by the Department of Labor Employee Benefits Security Administration specifically to address questions regarding job loss. That web page can be found at: www.dol.gov/ebsa/publications/joblosstoolkit.html

CONVERSION or CONTINUATION

Group health policies issued under Virginia law include either a conversion provision or a 12-month continuation period. The conversion provision states that a group member who is leaving the group has the right to convert to an individual health insurance policy or plan from group coverage without presenting evidence of insurability.

The group policyholder must provide each employee or other persons covered under the policy written notice of the availability of the option chosen and the procedures as well as timeframes for obtaining conversion or continuation of the group policy. The notice is to be provided within 14 days of the group policyholder's knowledge of the employee's or other person's loss of eligibility under the policy.

The application and payment to extend coverage is made to the group policyholder within 31 days after the issuance of the written notice, but not beyond the 60-day period following the date of the termination of the person's eligibility.

The individual coverage document issued to each person under the group policy will indicate which option is available.

There may be other options available to you as well, depending upon your individual circumstances:

- You may be able to obtain other coverage in accordance with requirements enacted to comply with the Health Insurance Portability and Accountability Act (HIPAA) (a further explanation of HIPAA follows in the next section of this Guide).
- You may consider purchasing a short-term health insurance policy if you are temporarily between jobs. **NOTE:** the purchase of this policy will negate your HIPAA-portability qualifications.
- You may secure health insurance through an association.

READ YOUR COVERAGE DOCUMENT CAREFULLY to evaluate the options available to you.

The Health Insurance Portability and Accountability Act (HIPAA)

A federal law named the Health Insurance Portability and Accountability Act of 1996 (HIPAA) made important changes regarding health insurance in the United States. The Virginia General Assembly passed laws implementing the requirements of HIPAA. These laws provide you with important protections. In some cases, the Virginia laws already met or exceeded these new federal standards prior to the implementation of HIPAA.

HIPAA and the laws enacted in Virginia to implement it may assist you in the following situations:

- Increasing your ability to get health insurance coverage for yourself and your dependents if you start a new job;
- Lessening your chance of losing existing health insurance coverage;
- Helping you maintain continuous health insurance coverage for yourself and your dependents when you change jobs; and
- Helping you buy health insurance coverage if you lose coverage under an employer's group health benefit plan and have no other health insurance coverage available.

HIPAA and Virginia laws enacted to implement HIPAA provide the following specific protections:

- Limit the use of pre-existing condition exclusions;
- Prohibit group health plans from discriminating by denying you coverage or charging you more for coverage based on your or your dependent's past or present health conditions;
- Guarantee certain small employers, and certain individuals who lose job-related coverage, the right to purchase health insurance; and

- Guarantee, in most cases, that employers or individuals who purchase health insurance can renew coverage regardless of any health conditions of individuals covered by the insurance.

HIPAA (and the state laws that implement it) is complex. Because of the complexity of these laws and how they may apply to your situation, we encourage you to call the Bureau of Insurance to discuss the protections available to you under HIPAA and Virginia law.

The Patient Protection and Affordable Care Act (ACA)

The Patient Protection and Affordable Care Act (Affordable Care Act or ACA) became federal law on March 23, 2010 when it was signed by the President of the United States. The ACA implements many significant changes to certain types of health insurance coverage and the ways in which the policies providing these types of health insurance coverage may be purchased, beginning with the law's effective date and extending over the course of several years. These changes are far too numerous to explain in detail in this Guide. Also, in many cases, further regulatory guidance from the federal government is still forthcoming. There are several resources available to consumers who are interested in learning about the ACA and its requirements, www.HealthCare.gov being one, and we strongly encourage readers to consult these resources regularly. This Guide focuses only on provisions of the laws that have been implemented, along with some key terms and concepts.

Immediate Provisions

Several provisions of the ACA became effective on the date of issue for new health benefits plans or health insurance policies issued on or after September 23, 2010, or at renewal of existing health benefit plans or health insurance policies on or after September 23, 2010 (6 months from the effective date of the legislation). These are often referred to as the "immediate provisions." In Virginia, state laws were revised to substantially conform Virginia laws to most of the coverage requirements identified in the immediate provisions. The Bureau has developed an informational document outlining the immediate provisions of the ACA and the corresponding Virginia laws. This document may be accessed via the Bureau's web site, or a copy can be mailed to you upon request. You are encouraged to contact the Bureau with any questions you have about the immediate provisions

and the implications these new laws may have on your personal situation. Additonally, you may visit www.HealthCare.gov to learn more about the immediate provisions along with other components of the ACA.

Explanation of Grandfathered Status

It is important to be able to determine whether your health benefit plan or health insurance policy is grandfathered because grandfathered plans or policies do not have to meet certain provisions of the new laws. If your coverage is grandfathered, your insurer must disclose such status in the plan or policy materials, along with contact information for the appropriate regulatory agency should you have questions or complaints about the grandfathered status.

A grandfathered health benefit plan or health insurance policy refers to coverage that was in effect on or before March 23, 2010 – the date the ACA was enacted. If a group health benefit plan existed on or before March 23, 2010, whether you joined the group initially or at a later date, the group health benefit plan may be grandfathered. If an individual was insured under an individual health insurance policy on or before March 23, 2010, the policy is likely grandfathered. Grandfathered health benefit plans and health insurance policies can lose their grandfathered status if the plan or policy changes or stops covering some of its benefits, if the share you or your employer pays changes by more than a specified amount, or new annual dollar limits are added or decreased. Premium increases do not affect the grandfathered status of your health benefit plan or health insurance policy.

Note: There are certain types of insurance which only provide coverage for certain health conditions, accidental injuries, limited durations, or disability income and are not subject to the requirements of the ACA.

▶ Types of coverage subject to the ACA:

❑ Basic Health Insurance (Hospital/Surgical), Managed Care Health Insurance Plans (HMOs, PPOs, POS), and Major Medical Insurance Plans are required to comply with the provisions of the ACA and corresponding Virginia laws. Certain provisions of the ACA and corresponding Virginia laws do not apply to health benefit plans or health insurance policies that are grandfathered or that have been granted annual limit waivers by the U.S. Department of Health and Human Services.

▶ Types of coverage NOT subject to the ACA:

❑ Hospital confinement indemnity, disability income, specified disease, short-term or temporary health insurance, stand-alone dental and vision plans, and limited benefit health insurance policies **are not** required to comply with the ACA.

As of the date of the printing of this Guide, several key decisions are yet to be made, and further guidance is still to be released, about a number of key initiatives addressed in the ACA. The Bureau intends to update all its resource information regularly and frequently as various requirements of federal and state law are implemented. Readers are encouraged to contact the Bureau and consult the Bureau's web site regularly for updated information.

Filing a Health Insurance Claim

Things to do before you file a claim:

- Review your policy, employee handbook, benefit booklet or EOC carefully to be sure the service in question is covered.
- Follow any rules, including pre-certification requirements and use of network providers, if applicable.
- Find out if your provider submits the claim for you or if you need to do it.

How to submit a claim properly:

- If you need to submit a claim, review the information to be sure it is complete and correct.
- Include your policy number and other identifying information.
- Submit the claim promptly following the accident or illness.
- Send the claim to the right address.
- Keep copies of all documentation for future reference.

Allow reasonable time for the insurance carrier to process the claim.

The carrier should inform you if it needs any additional information to pay the claim.

If your claim is paid:

- If you assigned benefits to the provider, the payment will go directly to the provider. You will pay any deductibles, co-insurance or copayment amounts.

- If you did not assign benefits, the payment will go directly to you, and you will need to pay your providers for the entire amount due them.

If your claim is denied:

- The reason for denial should be stated on your explanation of benefits.

- If you disagree with the reason for denial, review the policy, EOC, employee booklet or benefit booklet for information on appealing the claims decision.

- The insurance carrier should answer any questions you may have.

- If you cannot get the problem resolved by dealing directly with the insurance carrier, the Bureau of Insurance will assist you with claim appeals and complaints.

- For certain denials by your health insurance carrier, you may be entitled to an independent external review as described in the next section.

Receiving Help from the Bureau of Insurance

The Bureau of Insurance assists thousands of consumers each year by responding to inquiries and complaints about services received from their insurance carriers and agents. The Bureau's Life and Health Division provides free professional information and complaint services to consumers who have coverage written in Virginia.

General Questions about Insurance

Consumer Service Representatives can handle your inquiries of a general nature over the telephone. They can be reached Monday through Friday, 8:15 a.m. to 5:00 p.m., toll-free at 1-877-310-6560, or our direct number 1-804-371-9691. If we cannot assist you by telephone, we will advise you to file a written complaint or inquiry with the Bureau of Insurance.

Written inquires of a general nature may be sent via e-mail to BureauofInsurance@scc.virginia.gov. A Bureau representative will respond to your inquiry via e-mail. Please include your name, mailing address and telephone number, in addition to your questions and concerns.

Consumer Services can help you with:

- Clarifying responses to your questions;
- Cutting through red tape;
- Correcting misunderstandings; and
- Investigating your complaint.

Consumer Services cannot:

- Recommend a particular insurance carrier, agent, or product;
- Recommend or rate an insurance carrier;
- Provide legal services that are sometimes required to settle complicated problems;

- Make medical decisions or require an insurer to pay for services it has determined were not "medically necessary;"
- Identify an insurance carrier with whom a particular person may have a policy;
- Dispute an underwriting decision made in accordance with an insurer's underwriting guidelines;
- Resolve a dispute that is a question of fact; or
- Require an insurer to pay a claim for non covered services.

If You Wish to File a Complaint

You are encouraged to work with your agent or other insurance carrier representative to try and resolve a problem before contacting Consumer Services. In many instances, a mistake has been made and is easy to correct upon inquiry. Sending a written letter to the insurance carrier or agent is recommended. Always keep copies of correspondence sent to the carrier concerning the problem. If you e-mail or telephone the carrier or agent, document the date and time of the contact or call; the name of the person(s) with whom you spoke; and what was said during the call.

If communications have stalled, or resolving the issue is slow or unsatisfactory to you, you may file a complaint with the Bureau of Insurance.

A consumer complaint form may be obtained by contacting the Bureau's Consumer Services Section or by visiting the Bureau's web site.

In order for our Bureau Consumer Services staff to review your concerns thoroughly, we ask that you provide as much detail as possible when you submit your complaint. Please provide copies of all supporting documentation with the complete complaint form. Please be sure to keep your original documents for your records.

The Bureau of Insurance also offers assistance to consumers in the internal appeals process with managed care plans via the Office of the Managed Care Ombudsman. The Bureau's Office of Independent External Review administers a process for independent clinical peer review of eligible denials. You should be notified by your health carrier of this opportunity when available.

The Office of the Managed Care Ombudsman

The principal function of the Office of the Managed Care Ombudsman is to help consumers who have health coverage provided by a Managed Care Health Insurance Plan (MCHIP), such as HMOs, PPOs, or POS plan (please refer to pages 3-4). The office was created to promote and protect the interests of persons covered under MCHIPs in Virginia.

The Office of the Managed Care Ombudsman CAN:

- Answer inquiries and questions about MCHIPs and managed care;
- Help individuals understand and pursue their rights of appeal of adverse decisions made by MCHIPs upon receipt of a signed and completed Life & Health Complaint/Appeal Form that may be obtained by contacting the Office of the Managed Care Ombudsman or by visiting the Bureau's web site;
- Answer questions about regulatory requirements affecting MCHIPs and provide information about health benefits mandated by Virginia law as well as provide information about health benefits required under the new federal healthcare reform laws and Virginia's corresponding laws; and
- Develop written information describing different types of MCHIPs and make such information available to consumers, as it becomes available.

The Office of the Managed Care Ombudsman CANNOT:

- Investigate or resolve complaints, but it can refer individuals who have a complaint to the internal review mechanisms at the MCHIP or to the appropriate government agency.

- Require that benefits are paid, but it can assist you in understanding your rights, and it can help you through the appeal process.

The Office of Independent External Review

If you receive an adverse determination made by your health insurance carrier and you have exhausted the internal appeal process with your carrier, or, in some cases, your self-insured ERISA plan, you may request an independent external review of the denial if the denial was based on a determination that the care did not meet requirements for medical necessity; appropriateness; healthcare setting; level of care or effectiveness; or involved an experimental or investigational procedure. All appeals must be filed with the Bureau of Insurance within 120 days of the date you receive notice of your right to an independent external review from your health insurance carrier. The Bureau will randomly select an impartial Independent Review Organization (IRO) to conduct the independent external review. The IRO's decision is binding on the carrier or self-insured ERISA plan (if applicable) and on you except to the extent you have other remedies available under state or federal law.

Qualifications for an Independent External Review

- The patient must be covered by a contract issued in Virginia, or by a self-insured ERISA plan whose plan sponsor's headquarters is located in Virginia and the plan has elected to use Virginia's Independent External Review process.
- You must have exhausted the health insurance carrier's internal appeal process. The process is deemed to be exhausted in the following situations:

1. All available internal appeals have been exhausted.
2. The patient filed an appeal and has not received a response from the carrier on its determination (unless a delay was agreed to) by either 30 days from the date of filing a pre-service appeal, or 60 days from the date of filing a post-service appeal.
3. A request for an expedited internal appeal of an adverse determination has been filed with the health carrier. A simultaneous expedited external review may be requested.
4. The health carrier has agreed to waive the exhaustion requirement.
5. Additional circumstances may allow for the internal appeal process to be deemed exhausted. You may contact the Bureau for additional information or visit our web site.

- The adverse determination for an admission, availability of care, continued stay, or other healthcare service that is a covered benefit has been reviewed by the health insurance carrier or its designated review entity. The determination has been made that the services do not meet the health insurance carrier's requirements for medical necessity, appropriateness, healthcare setting, level of care or effectiveness, or is determined to be experimental or investigational. As a result, the requested service or payment for the service has been denied, reduced or terminated.

- A complete external review request must be received by the Bureau of Insurance within 120 days after the date you received notice of your right to an external review from your health insurance carrier.

Rights and Responsibilities

Know Your Rights

- Insurance carriers are not allowed to unfairly discriminate when it comes to premium rates charged or kinds of coverage;
- Insurance carriers are required to pay claims promptly and fairly;
- Insurance carriers must give the consumer access to certain information that is collected by the carrier.
- When you buy insurance, you have the right to:
  - Receive a copy of the insurance policy, certificate governing your coverage, or evidence of coverage;
  - Receive copies of all forms and applications signed by you or your agent; and
  - Appeal any denied claims.

When buying insurance, you are responsible for:

- Reading and understanding any explanation of benefits forms sent by your insurance carrier;
- Making sure your application is accurately completed, even if the agent or someone else completed it for you;
- Knowing what your policy covers and excludes;
- Paying your premiums, even while involved in a dispute with your carrier; and
- Paying any deductibles, coinsurance, or copayments outlined in your policy, certificate or EOC.

Insurance Rules to Live By

- Know the name of your insurance carrier and policy number.
- Read your policy.
- Be sure your agent is licensed.
- Get a receipt if you pay by cash.
- Read the application before you sign it.

Frequently Asked Questions

GENERAL

I have changed my mind and do not wish to keep the individual health insurance policy that I just received. May I get a refund?
Yes. According to Virginia law, if you are not satisfied with your individual traditional health insurance policy for any reason, you may return it to the insurance carrier within 10 days of the date you received it, and the premium you paid will be promptly refunded. This law does not apply, however, to individual HMO plans.

Does the Bureau of Insurance regulate all health insurance?
Fully insured and individual health insurance plans issued and delivered in Virginia are subject to regulation by the Bureau of Insurance. Most group plans issued to associations or trusts located outside of Virginia, however, are governed by the state in which the policy was issued for delivery, regardless of whether individuals covered under these plans reside in Virginia. Also, self-insured (or self funded) plans are regulated by the federal government, not by the Bureau of Insurance.

PREMIUM RATES

I have just received notice that my health insurance premium is increasing. I have not had any claims. How is my company justified in raising my rate?
Premium rates are calculated based on the pooling of a large number of similar risks. The claim experience of the pool as a whole and not any one individual is used to determine premium rates.

Does the Bureau of Insurance regulate health insurance rates?
The Bureau of Insurance approves premium rates for most individual health insurance policies (HMO products are excluded). In all cases, as it relates to major medical comprehensive plans, insurance carriers must demonstrate thoroughly that at least 60 cents of every premium dollar paid to the insurance carrier will be paid out in medical benefits.

What types of all health insurance premium rates are subject to prior approval in Virginia?

The premium rates associated with individual policies of health insurance issued in Virginia by insurers and health services plans must be submitted to and approved by the Bureau before they can be implemented. This requirement includes the initial rates as well as rate changes.

What requirements are applicable to those types of health insurance products for which prior approval of premium rates is not required?

Under Virginia law, premium rates associated with group accident and sickness insurance contracts and those contracts issued through an association are not subject to prior approval by the Bureau; they are "filed" with the Bureau for informational purposes.

Also under Virginia law, premium rates associated with HMO contracts are not subject to prior approval by the Bureau, and they are also "filed" with the Bureau for informational purposes. However, with respect to HMOs, the Bureau can require a certification that the rates are appropriate and based upon reasonable assumptions. The Bureau also can require other supporting documentation deemed necessary.

How does the Bureau determine whether a premium rate increase for an individual policy of accident and sickness insurance can be approved?

A health insurer requesting a premium rate increase for an individual accident and sickness insurance policy in Virginia must demonstrate that the premium rate is reasonable in relation to the benefits provided under the policy. To make such a demonstration, the insurer must furnish information substantiating that the projected future and lifetime loss ratio applicable to the policy is equal to or greater than the percentage required by Virginia law. A loss ratio represents the amount of a premium dollar that is used for claim payments. The minimum loss ratio requirements under Virginia law range from 45% to 60% depending upon the type of product involved; the average premium applicable to the policy; and the conditions under which the policy may be renewed. The most typical individual policy of accident

and sickness insurance in Virginia must achieve a loss ratio of at least 60%. In simple terms, the insurer must demonstrate that it will pay at least 60 cents in claim payments for every $1.00 it receives in premium payments. While premium rates in Virginia can not be priced to achieve a loss ratio lower than the regulatory standards, they can be priced to achieve a higher loss ratio.

How often can an insurer raise premium rates?

There are no statutory or regulatory requirements in Virginia addressing the frequency under which an insurer may request and implement a rate increase. Your insurance policy may indicate, however, that a rate change may only be implemented at a certain time (generally at policy renewal).

Are insurers prohibited from raising premium rates beyond a certain percentage in any given period of time?

No. Virginia law does not specify a maximum or "cap" beyond which an insurer is prohibited from further raising premium rates. As long as an insurer can demonstrate compliance with the applicable requirements relating to the rates in question, its rate increase request must be approved.

I would like more information about the premium rates applicable to my policy. Can the Bureau of Insurance provide me with specific information about my premium rates?

The Bureau of Insurance maintains records of all premium rate approvals granted to insurers and health services plans operating in Virginia. The Bureau offers two search options on its web site that make it easier to locate information about the premium rates and policy forms that insurers are using in Virginia. One search option provides general information about rate and form filings for all lines of insurance in a concise summarized format, with access to specific file documentation available upon further request. The other search option provides direct access to the premium rates and policy forms associated with most comprehensive major medical accident and sickness and managed care products submitted to the Bureau.

The search options and accompanying user guide can be accessed at: www.scc.virginia.gov/boi/SERFFInquiry.

Additional information can be obtained by contacting the Bureau at (804)371-9110 or by emailing the Bureau at: BOIRRF@scc.virginia.gov.

Should you need additional assistance from us, we encourage you to complete a Premium Inquiry form which can be accessed via our website or by contacting the Bureau to obtain a copy, and then you may return it to us via fax, email or regular mail.

Note: The federal ACA has rules that differ from Virginia's laws regarding unreasonable premium increases and the amount of your premium dollar that must be spent on direct medical care and quality improvements. To learn more about the ACA requirements, see the "Immediate Provisions of Federal Health Care Reform" publication on the Bureau's web site, or contact the Bureau to receive the document by mail.

LOSING COVERAGE

I had a serious health condition that appears to be stabilized; however, I am having difficulty finding an insurance carrier that will accept me for coverage. I am not eligible for guaranteed coverage under HIPAA. What options are available to me?

Each insurance carrier has its own underwriting guidelines. The type of condition and when or how it was treated will factor into how the insurance carrier will respond. Contact several insurance carriers, and then compare options available to you. If none of the options are suitable for you, you may contact Anthem Health Plans of Virginia, Inc. at 1-800-334-7676 or CareFirst BlueCross BlueShield at 1-800-544-8703. You may qualify for an open-enrollment program where you cannot be denied insurance. However, there may be a waiting period for pre-existing conditions. It is important to note that if you are under age 19, you are entitled to an open-enrollment product where there is no waiting period for pre-existing conditions.

Another option for individuals seeking health insurance coverage is the Pre-existing Condition Insurance Plan (PCIP), administered for residents of Virginia by the U.S. Department of Health and Human Services. Further information about this program can be found at www.pcip.gov.

The Healtcare.gov web site provided by the federal government is another source of information that provides health care options based on your personal situation. The web site is www.HealthCare.gov.

Alternative options for health care assistance, including free or low-cost health clinics, can be found on the Virginia Health Care Foundation's web site at www.vhcf.org.

I will be leaving my job in a couple of weeks, and I am worried about my health insurance. Is there any way I can keep my group insurance coverage?

If you are leaving a job, The Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) requires group health plans sponsored by employers with 20 or more employees to offer continuation of coverage for you and your dependents for 18 months or longer, depending on the qualifying event. You would be responsible for the entire premium, both the portion you paid as an employee and the employer's contribution, as well as an administrative fee.

You may also be able to continue the group coverage for an additional 12 months. Or, you may be able to convert your group coverage to an individual coverage. Your group certificate or Evidence of Coverage will indicate the options available to you.

I heard about a law that allows you to take your medical coverage with you when you change jobs. Is this true?

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you do not actually take your exact plan of health benefits with you, but you are credited with the time you were covered under your previous group policy under your new benefit plan. To receive this credit, you must meet the criteria for an "eligible individual." Virginia

law provides for credit towards any pre-existing condition waiting period in your new benefit plan for the amount of time you were covered by your prior group or individual health plan if you do not have greater than a 63-day break in coverage and have had 18 or more months of continuous prior creditable coverage. Also, the new carrier must offer you the insurance coverage without your having to qualify medically for the coverage as long as you are an "eligible individual." For a more detailed explanation concerning HIPAA and the criteria for an "eligible individual," please contact the Bureau of Insurance.

PLAN DESIGN

My insurance carrier pays 80% of charges. My provider charged $4,000 for a medical service, but the insurance carrier paid only $2,800. Why didn't they pay the full 80%?

Carriers often establish allowable charges for certain procedures and services. These charges may be based on a number of factors as determined by the carrier. These factors may include, but are not limited to, geographic location of the provider; complexity of the procedure established by the carrier; and participating provider contracted or negotiated amounts. The carrier will base the percentage it pays on allowable charges, not the billed amount.

Providers can appeal to insurance carriers if a procedure or service was especially difficult, or other circumstances necessitated a charge exceeding the allowable charge. Your policy, certificate, EOC or benefit booklet provides information concerning appeals or requests for reconsideration of payments.

What is a drug formulary?

Many plans or policies establish a list of prescription drugs, which the plan considers medically appropriate and cost effective. The plan will provide coverage for only those prescription drugs named in the list. However, your doctor may present medical evidence to the insurer to obtain an exception that would allow coverage for a prescription drug not routinely covered by the plan.

CONSUMER ASSISTANCE

I am having a problem with my employer's self funded (self-insured) health plan. Can you help?

Self-insured group health plans (or self funded plans) are set up by employers to pay the health claims of its employees. The employer assumes the risk of providing the benefits and paying the claims. A self-insured plan is not subject to the regulatory authority of the Bureau of Insurance. Self-insured plans are subject to the Federal Employee Retirement Income Security Act of 1974 (ERISA).

The U.S. Department of Labor is the federal government agency responsible for handling matters involving self-insured plans. If you cannot receive satisfaction from dealing directly with the plan sponsor (usually the employer) or with the plan administrator, you may contact the U. S. Department of Labor for guidance. The address is:

U. S. Department of Labor
Employee Benefits Security Administration
Benefits Advisor Group
Washington District Office
1335 East West Hwy, Suite 200
Silver Spring, MD 20910
1-866-444-3272
www.dol.gov/ebsa

Self funded non-federal governmental plans do not fall under the responsibility of the U.S. Department of Labor, but under the U.S. Department of Health and Human Services. The agency that may be able to provide assistance for these plans is the Private Health Insurance Group (PHIG). Their contact info is: 1-877-267-2323 ext. 61565 or 1-410-786-1565 or email them at phig@cms.hhs.gov.

What can I do if my doctor says I need a medical procedure and my managed care health insurance plan says it is not medically necessary?

You have the right to request a copy of any utilization review policy and procedures your plan uses to determine medical necessity for a medical condition. You have the right to file an appeal requesting a review of the denial. Consult your doctor and submit any additional important information with your appeal. Your health plan must have a clinical peer reviewer determine on appeal if a treatment is not covered due to medical necessity. If your coverage is provided by a managed care plan, you have the right to seek assistance from the Bureau of Insurance, Office of the Managed Care Ombudsman. Adverse medical determinations you receive from your health plan may be eligible for further consideration through the Independent External Review process explained in the Receving Help from the Bureau of Insurance section of this Guide.

GLOSSARY

Affordable Care Act (ACA)

The abbreviated name given to the Patient Protection and Affordable Care Act of 2010 (public law 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) enacted on March 23, 2010.

Coinsurance

The percentage of allowable charges for health care expenses you must pay after you have met your deductible.

Coordination of Benefits (COB)

Method of integrating benefits payable under more than one health insurance plan so that the insured's benefits from all sources do not exceed 100 % of allowable medical expenses.

Copayment/Copay

A specific charge you pay for a specific medical service. For example, you may pay $25 for an office visit or $30 for a prescription and the health plan covers the rest of the charges for that service.

Cost Sharing

Policy provisions that require individuals to pay, through copayments, deductibles and coinsurance, a portion of their health care expenses.

Deductible

The amount of money you must pay, generally annually, to cover your medical care expenses before your insurance plan starts paying.

Elimination Period

A specified number of days at the beginning of each period of disability (in disability income policies) or hospital confinement (in hospital confinement indemnity policies), during which no benefits are paid.

Evidence of Coverage (EOC)

Document that summarizes the provisions and benefits of a managed care health insurance plan.

Evidence of Insurability

A statement or proof of physical condition or other information affecting a person's eligibility for insurance.

Exclusions

Specific conditions or circumstances for which the policy or plan will not provide benefits.

Explanation of Benefits (EOB)

The statement sent to a participant in a health care plan listing services, amounts paid by the plan, and total amount that may be billed to the patient.

Formulary

List of prescription medications covered by an insurance carrier.

Fully Insured Health Benefit Plan

Employer-purchased insurance coverage from a licensed insurance carrier, wherein the insurance carrier assumes the risk.

Grace Period

Specified time (usually 31 days) following the premium due date during which insurance remains in force and a policyholder may pay the premium without penalty.

Grandfathered Health Benefit Plan or Policy

A group health benefit plan that existed on or before March 23, 2010 or an individual health insurance policy under which an individual was insured on or before March 23, 2010. Grandfathered plans or policies are exempt from many changes required by the ACA and Virginia law. New employees may be added to employment-based group health benefit plans that are grandfathered, and new family members may be added to all grandfathered individual health insurance policies, without removing the grandfathered status.

If the health benefit plan or health insurance policy is considered grandfathered, the plan or policy materials must disclose this in each new plan or policy year.

Group Certificate

The document provided to each member of a group health benefit plan. It describes the benefits provided under the group plan.

Guaranteed Renewable Contract

Contract under which an insured has the right, commonly up to a certain age or for a specified number of years, to continue the policy by the timely payment of premiums. Under guaranteed renewable contracts, the insurer reserves the right to change premium rates by policy class, not just for one or a few members.

Health Maintenance Organization (HMO)

Prepaid managed care health insurance plans in which you pay a premium and the HMO covers your cost of care to see doctors, hospitals and other providers within the HMO's network, at pre-negotiated rates, subject also to your payment of a specified amount as services are delivered. You generally must choose a PCHP who coordinates all of your care and makes referrals to specialists you might need.

Indemnity Plan

Traditional health insurance that usually covers a percentage of the cost of care (often 80%) after the consumer pays an annual deductible. Patients with an indemnity plan can choose any doctor or hospital for their care.

Individual Insurance

A policy that provides protection to an individual and may extend coverage to his or her family sometimes called personal insurance, as to distinguish from group insurance.

Out-of-Network Care

Medical services obtained by managed care health insurance plan members from non-participating or non-preferred providers. In many plans, such care will not be reimbursed unless previous authorization for such care was obtained.

Out-of-Pocket Costs

Health care costs the covered person must pay out of his or her own pocket, including such things as coinsurance, copayments, deductibles, etc. Most plans and policies contain a maximum out-of-pocket limit that is applicable on a policy year or calendar year basis. Please be aware that only those costs the member incurs related to covered benefits count toward any out-of-pocket maximum. The member may have considerable out-of-pocket costs related to non-covered benefits, to include amounts in excess of the allowable charge. In addition, some copayments, coinsurance, and deductibles may not apply to the out-of-pocket maximum.

Pre-Admission or Pre-Certification Authorization

A requirement that the health care plan must approve, in advance, certain hospital admissions or certain procedures.

Pre-existing Condition Exclusion

Generally, a limitation or exclusion of health benefits based on the fact that a physical or mental condition was present before the first day of coverage. HIPAA, the ACA and state laws limit the extent to which a health plan or issuer can apply a pre-existing condition exclusion in certain instances.

Preferred Provider Organization (PPO)

A network of health care providers that have agreed to provide medical services to a health plan's members at discounted costs. The cost to use physicians within the PPO network is generally less than using a non-network provider.

Premium

The amount you pay in exchange for health insurance coverage.

Primary Care Health Professional (PCHP)

The physician (often a physician, internist, or pediatrician) who manages your healthcare. With some exceptions, MCHIPs may require that you must first consult with your PCHP for healthcare needs. A PCHP makes referrals to specialists if necessary.

Provider

Any person or institution that provides medical care.

Rescission

To nullify or make void a policy or coverage. In many cases, when and if a carrier rescinds a policy, premiums are refunded. Current law requires that your coverage can be rescinded only for fraud or intentional misrepresentation of material fact on your application.

Self Funded Health Benefit Plan

A group health benefit plan offered by an employer to employees under which the employer chooses to assume the financial risk of paying health care claims instead of contracting with an insurance carrier to underwrite the risk. This type of plan is usually not evident to the enrollee because the employer generally will contract with an insurance carrier to administer the plan.

Underwriting

Process by which an insurer determines whether or not, and on what basis, it will accept and classify the risks associated with an application for coverage.

LIFE and HEALTH CONSUMER OUTREACH PROGRAMS

The Bureau of Insurance's Life and Health Insurance Consumer Outreach section serves and protects by providing education, information, and assistance to consumers. This mission is accomplished by coordinating all life and health consumer outreach programs, including special programs for senior citizens. The Bureau of Insurance produces and distributes many guides and brochures. A special Outreach program offers help to consumers with their insurance concerns. The Bureau provides speakers for civic or professional group meetings, attendance at health fairs, and participation in seminars. Speakers are available to speak on various topics to your group or organization. Topics include:

Medicare Supplement
Long-Term Care
Managed Care
Health Care Reform
Health Insurance
Life Insurance
HIPAA
Annuities
Assistance for Health Care Providers

Contact the Life and Health
Insurance Consumer Outreach Section at:
P. O. Box 1157
Richmond, VA 23218
Toll-Free 1-877-310-6560
Local (804) 371-9092
Email: L&HOutreach@scc.virginia.gov
Or log onto the Bureau's website at: www.scc.virginia.gov/boi

Virginia Insurance Counseling and Assistance Program (VICAP)

The Virginia Insurance Counseling and Assistance Program (VICAP). VICAP assists older Virginians and others on Medicare to make informed decisions about various types of health insurance. VICAP counselors also assist with complicated medical bills and patients' rights issues.

VICAP Counselors are not permitted to be licensed to sell life and health insurance in Virginia. They are not permitted to recommend a particular insurance carrier or agent. All counseling is confidential. You can reach a VICAP counselor by calling your Area Agency on Aging. Or you may contact VICAP at the Virginia Department for the Aging at its nationwide, Toll-Free number,1-800-552-3402 (Voice TTY).

Health Insurance Comparison Form

If you are in the market for health insurance, these are some factors to consider when comparing health insurance plans. **NOTE**: *Each individual has different insurance needs. These are just some of the factors to consider when comparing health insurance plans.*

I. Cost

		Option 1	Option 2
Premium Amount		$_____Per_____	$_____Per_____
How much is the deductible?	Medical Care	$_____Per_____	$_____Per_____
	Hospital Visits	$_____Per_____	$_____Per_____
	Prescriptions	$_____	$_____
	Total	$_____	$_____
How much is the copay and/or coinsurance?	Primary Office Visit	$_____and/or_____%	$_____and/or_____%
	Specialty Office Visit	$_____and/or_____%	$_____and/or_____%
	Inpatient Hospital **Facility** Per day copay/per admission maxium? **Professional**	$_____and/or_____% $_____/ $_____ $_____and/or_____%	$_____and/or_____% $_____/ $_____ $_____and/or_____%
	Emergency Room	$_____and/or_____%	$_____and/or_____%
Prescription drug costs	Are prescription drugs covered?	❑Yes ❑No	❑Yes ❑No
	Does the plan cover your current prescriptions? (You can find out by calling the carrier or researching online)	❑Yes ❑No	❑Yes ❑No
	How much is the copay or coinsurance per prescription?	**30 day supply** Generic $___and/or__% Brand $____and/or___% **90 day supply** Generic $___and/or__% Brand $____and/or___%	**30 day supply** Generic $___and/or__% Brand $____and/or___% **90 day supply** Generic $___and/or__% Brand $____and/or___%
	What is the yearly limit on my out-of-pocket costs? Does it include the deductible?	❑Yes ❑No	❑Yes ❑No

II. Provider Network Plans

	Option 1	Option 2
Do all of my providers (doctors, specialists, hospitals, pharmacies, etc.) accept this plan? (You can find out by calling the insurer or researching online)	❑Yes ❑No	❑Yes ❑No
Will services received from providers not in the plan's network, other than for emergency care, be covered?	❑Yes ❑No	❑Yes ❑No
May I choose to receive covered services outside any plan network?*	❑Yes ❑No	❑Yes ❑No
Do I need referrals for specialists?	Within the network: ❑Yes ❑No Outside the network: ❑Yes ❑No	Within the network: ❑Yes ❑No Outside the network: ❑Yes ❑No
Do network providers handle claims submission or do I have to pay up front and get the plan to reimburse me?	❑Provider bills ❑Pay up front	❑Provider bills ❑Pay up front

*Be aware that for covered services received outside a plan's provider network, you may be responsible for payment of amounts over and above any copay or coinsurance. You may be responsible for any difference between the provider's actual charge for the service and the health plan's allowed amount for the service. This amount could be substantial.

III. Coverage

	Option 1	Option 2
Does this plan exclude any pre-existing conditions? If I have a pre-existing condition, how long will I have to wait for coverage?	❑Yes ❑No List_____ _____ months	❑Yes ❑No List_____ _____ months
Are there limits on number of visits for types of care?	❑Yes ❑No	❑Yes ❑No
This plan covers these services (covered services): **Note**: Include coverage for any family members. Check for services you and your family use now or plan to use, including prescriptions, maternity, etc.		
This plan does not cover these services (excluded services): **Note**: Include coverage for any family members. Check for services you and your family use now or plan to use, including prescriptions, maternity, etc.		

Note: Each individual has different insurance needs. These are just some of the factors to consider when comparing health insurance plans.

IV. Other Considerations

	Option 1	Option 2
If I travel, does the plan cover care outside of:	My local area? ❑Yes ❑No The country? ❑Yes ❑No	My local area? ❑Yes ❑No The country? ❑Yes ❑No
Does this plan coordinate benefits with other health plans?	❑Yes ❑No	❑Yes ❑No
Is the plan accredited by the National Committee for Quality Assurance (NCQA)?	❑Yes ❑No	❑Yes ❑No
Is the insurance carrier offering a plan authorized to do business in Virginia? (you can call the consumer hotline at 1-800-552-7945 to find out)	❑Yes ❑No	❑Yes ❑No

Note: Each individual has different insurance needs. These are just some of the factors to consider when comparing health insurance plans.

Do you have health insurance related questions?
Call the Bureau of Insurance consumer hotline at:
1-877-310-6560
Or email the Bureau of Insurance at:
BureauofInsurance@scc.virginia.gov

NOTES