


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 and/or Long-Term Care Insurance, please 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 website for more information about other publications available, (refer to "Important Information - How to Reach Us" for telephone numbers and the website 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

PO 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 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 educated 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

A handwritten signature of Jacqueline K. Cunningham in black ink, written in a cursive style. The signature is contained within a white rectangular box that has a slight drop shadow.

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

HEALTH INSURANCE CONSUMER SERVICES SECTION

(Va. Toll-free) 1-800-552-7945
(Nationwide Toll-free) 1-877-310-6560
(In Richmond) 371-9691

TDD USERS ONLY

Telecommunications Device for the Deaf
(804) 371-9206

OFFICE OF THE MANAGED CARE OMBUDSMAN

(Toll-Free) 1-877-310-6560
(In Richmond) 371-9032

INDEPENDENT EXTERNAL APPEALS FOR MANAGED CARE HEALTH INSURANCE PLANS (MCHIPS)

(804) 371-9913

INSURANCE OUTREACH

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

WEB SITE

www.scc.virginia.gov/boi




Federal Health Care Reform

Patient Protection and Affordable Care Act (PPACA; Public Law 111-148)

PPACA became federal law on March 23, 2010, when it was signed by the President. Some provisions of this federal law took effect immediately, but most will be phased in over time. A large portion of the law's provisions relating to insurance reforms becomes effective as group health plans and health insurance carriers issue new policies or renew existing policies on or after September 23, 2010 (6 months from the effective date of the legislation).

Some provisions of the federal law will apply to all health care plans and policies. Other provisions will not apply to policies and plans issued or renewed on or after March 23, 2010, if the plans or policies are considered to be grandfathered plans or policies. Grandfathered plans are plans or policies in effect as of March 23, 2010. Certain changes to such an existing plan or policy, however, may cause it to lose its grandfathered status. If you are covered by a grandfathered plan, you should receive a notice indicating such status with your coverage documents at the time your coverage renews. You are encouraged to contact the Bureau of Insurance with any questions you have about these new federal laws, and the implications the new laws may have on your situation.

Please note that certain types of insurance which only provide coverage for certain health conditions are not subject to the requirements of the new federal health care reform laws.



▶ *Which types of traditional health insurance plans **are and are not** subject to the new federal health care reform laws?*

❑ Basic Health Insurance (Hospital/Surgical), Major Medical Insurance Plans, and Comprehensive Policies as described on pages 4 and 5 of the Guide are subject to the new federal health care reform laws. They **must comply** with the prohibition on lifetime dollar limits and restricted annual dollar limits on essential health benefits and other federal health care reform laws discussed in this flyer.

❑ Hospital Confinement Indemnity, Disability Income Insurance Policies, Specified Disease Insurance Policies, Short-term or Temporary Health Insurance, and Limited Benefit Health Policies as described on pages 5-8 of the Guide **are not** required to comply with the new federal health care reforms discussed in this flyer.


You will need to be aware of the following changes to the attached Virginia Health Insurance Guide for Consumers, hereafter referred to as the Guide, that have been brought about by federal health care reform:

▶ Preventive Care Services

Pages 1-2 and 4-8 of the Guide mention coverage provided for healthcare services and the bills pertaining to these services. You should be aware that newly effective health care plans and policies or non-grandfathered health plans/policies renewed on or after 9/23/10, must provide coverage for preventive services, as outlined by the federal government, without cost-sharing.

▶ Lifetime and Annual Dollar Limits

Pages 1-2 and 4-8 of the Guide discuss coverage provided for healthcare services and the bills pertaining to these services. For all health care plans and policies issued or renewed on or after 9/23/10, no lifetime dollar limits can be placed on health care coverage for essential health benefits as defined by the federal government.




For plans issued or renewed on or after 9/23/10, the annual dollar limit for essential health benefits in non-grandfathered plans may be no less than \$750,000; for plans years beginning 9/23/11, the annual dollar limit for essential health benefits in non-grandfathered plans must be no less than \$1.25 million; and for plan years beginning 9/23/12 – 12/31/13, no less than \$2 million. After this date, it is planned that health care coverage will be offered through Exchanges which will be required to provide coverage for essential health benefits with no annual dollar limits. Grandfathered individual market plans are not subject to the annual dollar limit restriction.

► Patient Protections

Coverage for Emergency Services – Pages 3 and 14 of the Guide indicate that PPO and POS plans provide less coverage for health care expenses provided outside the network than for expenses incurred within the network. This is still the case under the new federal health care reform. However, in cases of a medical emergency, covered services you may obtain outside the network would be subject to cost-sharing that is no greater than what you would pay in-network, for all new or non-grandfathered plans renewing on or after 9/23/10. This requirement applies to your copayment, coinsurance and deductible amounts. You should be aware though, that even under the new federal health care reform you may be required to pay any provider charges that are in excess of the determined allowed amount for the service.

Page 10 describes the manner in which companies determine allowable charges and usual, customary and reasonable (UCR) charges.



For the plans and policies subject to the new federal law as described in the paragraph above, the allowable charge for emergency services is determined by the greater of: (1) the amount or median of amounts negotiated with participating providers for the emergency service; (2) the plan's UCR rate or other rate calculation usually used by the plan for the emergency service, excluding in-network copayment or coinsurance; or (3) Medicare rates for the emergency service, excluding any in-network copayment or coinsurance.

Primary Care Providers – Pages 2, 4, 31, 34, and 37 of the Guide discuss primary care physicians. The new federal health care reform law will require all new or non-grandfathered plans that renew on or after 9/23/10 to allow a participating obstetrician or gynecologist to act as a primary care provider for obstetrical or gynecological care.

► Pre-existing Condition Exclusions

Pages 10, 18, 26, 29, and 36 of the Guide discuss the possibility of benefits being denied for a pre-existing condition. The new federal health care reform laws require that as of 9/23/10, any new or renewing plan may not impose limitations on pre-existing conditions for an individual under age 19. Grandfathered individual market plans may continue to apply pre-existing condition limits or exclusions to these individuals.

Page 18 of the Guide discusses limits imposed on the use of pre-existing condition exclusions under HIPAA and Virginia laws. The new federal health care reform laws limit these exclusions further as described above.



► Appeals Process

Internal Appeals – Page 19 of the Guide states that your explanation of benefits should include the reason for denial if a claim is denied. For plans or policies that are new or renewing on or after 9/23/10, and are not grandfathered, the new federal health care reform law requires that the notice of adverse benefit determination includes the diagnosis and treatment codes, along with the code meanings, as well as a description of the plan's standard used to deny the claim.

External Appeals – Pages 23 and 24 of the Guide discuss the independent external appeals process administered by the Bureau of Insurance. This particular process described is only made available to otherwise eligible persons covered under an MCHIP policy written in Virginia who have received a final or expedited denial on an issue involving experimental/investigational services or a determination that the requested services are not medical necessary. A new process will become effective 7/1/11.

Individuals covered by non-grandfathered group health plans and policies issued by health care insurers not subject to the process administered by the Bureau of Insurance will need to comply with a process prescribed by the new federal health care reform as plans/policies are issued or renewed on or after 9/23/10. The process will require that you are informed of the independent external appeal process available to you.

► Web Portal

Page 26 of the Guide provides information for persons trying to obtain health insurance. A new web portal has been created by the U.S. Department of Health and Human Services to assist persons in obtaining health insurance, and can be found at <http://www.healthcare.gov>, or by accessing the Bureau of Insurance's website at <http://www.scc.virginia.gov/boi>, clicking the "Federal Health Care Reform" box and clicking the link to "U.S. Department of Health and Human Services website on Federal Health Care Reform."



▶ Temporary High Risk Pool Program

Page 26 of the Guide indicates that there is no risk pool in Virginia. The new federal health care reform laws have created a temporary high risk pool in Virginia operated by the U.S. Department of Health and Human Services. Further information about this program can be found at the link on our website mentioned in the paragraph above, or at <http://www.healthcare.gov>.

▶ Rescissions


Page 28 of the Guide discusses situations in which your insurance policy may be rescinded. For plans and policy years beginning or renewing on or after 9/23/10, insurers may only rescind coverage in the instance of fraud or intentional misrepresentation of material fact as stated in your coverage documents.

Important Note: The Bureau of Insurance prepared this information to assist Virginia consumers in understanding the new federal health care reform legislation and how it may impact them. This information is not intended to be an opinion, legal or otherwise, on the new federal health care reform legislation, nor should it be construed as a position of the Bureau of Insurance or the Virginia State Corporation Commission on the new federal health care reform legislation or any of its provisions.

The following general revisions apply to the attached guide as well:

▶ The State Corporation Commission, Bureau of Insurance's new web site is: <http://www.scc.virginia.gov/boi>. You may refer to this website for additional current contact information.

▶ The State Corporation Commission, Bureau of Insurance's new Email address is: BureauofInsurance@scc.virginia.gov



▶ Pages 12 and 30 of the Guide indicate that the U.S. Department of Labor (DOL) is the federal government agency that is responsible for handling matters involving self-insured plans. The DOL is responsible for handling matters involving self-insured non-governmental or non-Church-related plans. The U.S. Department of Health and Human Services (HHS) can assist individuals covered by governmental or Church-related self-funded plans.


▶ Pages 14 and 26 of the Guide discuss how you can visit the Bureau's website to obtain a listing of authorized insurers and HMOs licensed by the Bureau of Insurance. The directions for finding this information should state: click on "Consumer" and "Want Information About Regulated Companies?"

▶ Page 16 of the Guide refers to a website designed to help understand rights and responsibilities with respect to public sector COBRA continuation coverage. The website can now be found at: http://www.cms.gov/COBRAContinuationofCov/01_Overview.asp#TopOfPage

▶ Page 16 of the Guide also refers to HMO plans offering a conversion option, but not a continuation option. New HMO rules became effective 1/1/06, requiring the group policyholder to elect either a conversion or continuation option for the enrollees of the group. Effective 1/1/11, Virginia rules provide for a revised continuation process for HMO members.

▶ Page 21 of the Guide states that complaints may be submitted electronically. This is no longer the case, but check back as this may be implemented again at some point in the future.

▶ Page 22 of the Guide indicates that the Office of the Managed Care Ombudsman can help individuals understand and pursue their appeal rights upon the Office's receipt of a signed inquiry form or letter from the consumer requesting assistance.



As a point of clarification, the Office will respond to every letter our office receives. However, in order to formally assist a consumer in the appeals process by contacting the MCHIP, we must receive a signed and completed Life & Health Complaint/Appeal Form that can be obtained by contacting the Office in any of the ways described in the Guide.

▶ Page 22 of the Guide indicates that the Office of the Managed Care Ombudsman can provide information about health benefits mandated by Virginia law. We can also provide information about health benefits required under the new federal health care reform laws.

▶ Page 24 of the Guide displays a toll-free telephone number for the Bureau of Insurance's External Appeals office that is no longer valid. For questions relating to submitting an external appeal please contact the Office of the Managed Care Ombudsman at: [\(877\) 310-6560](tel:877-310-6560).

▶ Pages 35 and 36 of the Guide define "Maximum Out-of-Pocket Costs" and "Out-of-Pocket Costs." Please be aware that these costs only consider those expenses the member incurs from costs related to covered benefits. The member may have considerable out-of-pocket costs related to non-covered benefits, to include amounts in excess of the allowable charge.

▶ Page 36 of the Guide defines "Out-of-Network Care." Preauthorization for non-emergency out-of-network care is a requirement for HMO members. However, many PPO plans and some POS plans do allow care to be obtained out-of-network without preauthorization. The MCHIP member should be aware that in addition to increased cost-sharing for out-of-network care, except in some emergency situations as describe in this flyer, the member will also be responsible for payment of charges billed by the healthcare provider in excess of the plan's allowable charges. These amounts can be significant.



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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 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 policy or plan for you, provides definitions of common health insurance terms, and suggests what you should do if you have a problem with your health policy or 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 plan 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 toll-free at 1-800-552-7945 (in Richmond at 371-9691) between the hours of 8:15 a.m. and 5:00 p.m., Monday through Friday.

Traditional Versus Managed Care Coverage

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

Traditional Insurance plans generally allow you to go to the provider, (physician, hospital, etc.), of your choosing, but require that you pay

for the services and file (or allow your physician or provider to file) claims for reimbursement. Managed Care Health Insurance Plans use networks of selected doctors and other providers to provide health 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.


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 health care 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 primary care provider (a PCP) manage all care.



Types of Managed Care Health Insurance Plans

Health Maintenance Organizations (HMOs) are the most familiar form of managed care plans. HMO members pay a fixed dollar amount, usually monthly, which gives them access to a wide range of healthcare services. Members pay a predetermined fee or co-payment for each hospital visit, doctor, or emergency room visit, and for prescription drugs, rather than paying the provider in full and obtaining a portion of the reimbursement later. HMOs generally eliminate the need to file claims.

When you enroll in an HMO, you must select a primary care physician (PCP) to manage your healthcare. With a few exceptions, you must first consult with your PCP for healthcare needs. If necessary, your PCP may refer you to an HMO approved specialist. If you do not get



approval from your PCP 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 PCP approval, and/or different forms of cost-sharing, including the requirement for an enrollee to pay an annual deductible for certain services rather than a copayment for each specific service.


Preferred Provider Organization (PPO) plans issued by an insurance company are plans that provide higher reimbursement if you go to a "preferred" or "participating" provider that provides services to health plan members for discounted fees. 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 health care expenses provided outside the network than for expenses incurred within the network. Visits outside the network normally require the payment of deductibles and coinsurance.

What's the Difference Between Managed Care and Traditional Health Insurance?

There are a number of significant differences between managed care plans and traditional health insurance policies. You should consider



these differences when deciding what type of plan best suits your needs.

Under Managed Care plans, your choice of providers may be limited to those within the network, or your out-of-pocket costs will be lower when you obtain services from providers within the network. Under a traditional health insurance policy, you may select your own providers.

Under some Managed Care plans, the provider receives a pre-established fee regardless of the amount of service performed. A provider may receive a flat fee for each patient in the plan, or he or she may receive a negotiated fee for each service performed. Under traditional health insurance plans, the provider bills you each time you receive care or treatment.

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

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

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 room and board and other hospital services such as x-ray and lab expenses and operating room use.

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 are usually not covered by these policies. As a result, unless you have other insurance, you may incur sizable expenses that are difficult to meet.



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

Many companies offer coverage that combine Basic and Major Medical Plans into one policy. These policies are often called **Comprehensive** policies. Major Medical and Comprehensive policies typically contain lifetime limits on benefits to be paid under the policy. It is important to make sure a lifetime amount is adequate to cover losses in the event of catastrophic illness or injury.

Hospital confinement indemnity insurance provides a predetermined flat benefit amount for each day, week, or month an insured is 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 after 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, with fixed benefit dollars, consider a periodic review and increase of the daily benefits to keep pace with rising health care costs.

Disability income insurance policies provide replacement 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 and/or long-term disability coverage. Social Security also provides disability protection, but only for those that 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 company's definition of a disability and the requirements that must be met. An insurance company paying for a disability claim may require the policyholder to provide a written doctor's report. 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.

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- ❑ Know how your policy defines "disability." Eligibility for benefits is based on this definition. Is eligibility based on the premise that you are unable 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 accident, illness or injury.
 - ❑ 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 or more after the onset of the disability.
 - ❑ 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 that lasts only for a specified period of time. For example, you might



purchase a one-month policy with major medical coverage for a brief period of unemployment.

Limited Benefit Health Policies: Minimum standards were established in Virginia to insure that individual accident and sickness policies provide a minimum of basic benefits needed for health care. A company 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 limitations. Contact your agent regarding your policy and minimum standards.

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

Group Coverage Versus 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 all 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. Group plans cover several people or groups under one policy. The group policyholder may be an association, business, or union with which you are affiliated, or it may be your employer.

Many group plans include provisions to include 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).

Insurers must offer Small Employers, (employers of two to fifty 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 Health Insurance Plans that offer coverage to Small Employers in Virginia must also make available the Essential and the Standard Health Benefit plans.

Many trade and professional associations offer their members insurance. Self-employed men and women often find **association** membership an attractive route to 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. This means that Virginia's laws governing benefits may not apply to the out-of-state group policy, even though the insurance is sold to Virginians. 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 Plan?

A group plan will only cover 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 company consider to be an "allowable charge" or a "usual, customary and reasonable (UCR) charge" for the service?**
Many policies and plans 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 company. 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 difference.
- Is the condition considered a pre-existing condition?**
A group health 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



withheld because of a pre-existing condition. Also, certain conditions may not be considered pre-existing.

Did the patient follow any pre-certification or pre-admission requirements prior to obtaining services?

Many insurers 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 Plans


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

For traditional health insurance individual plans, you may take at least 10 days from the date you receive the policy to decide whether to keep or cancel it. Some policies or plans provide a longer period of time. For a full refund, you must return the policy to the company 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 company will agree to insure you or your family. Standards for determining evidence of insurability vary from company to company.

The process by which an insurer or managed care organization 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 insurer's files to ensure that established underwriting guidelines are being administered consistently and appropriately.

Fully Insured Group Plans Versus Self-Insured Group Plans

Fully insured 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 plans in Virginia. A "fully insured plan" is a plan the employer purchases directly from an insurance company, and the insurance company assumes the risk to pay all covered health claims.

Self-insured (or self-funded) 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 company to handle administrative duties. In this case, the insurance company is not assuming any financial risk, but is acting as a third-party administrator, following the directives of the employer. Self-insured plans are subject to the Federal Employee Retirement Act of 1974 (ERISA). The U.S. Department of Labor is the federal government agency that is responsible for handling matters involving self-insured plans.

Mandated Benefits

Virginia's insurance laws require that many health insurance plans, including Managed Care Health Insurance 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 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 or visit the Bureau's website.

Choosing a Health Care Plan

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


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



Name	Telephone	Web Site
A.M. Best Company	1-908-439-2200	www.ambest.com
Moody's Investor Services	1-212-553-0377	www.moody.com
Standard & Poor's Insurance Rating Services	1-212-438-2400	www.standardandpoors.com
The Street.com Ratings	1-800-289-9222	www.thestreet.com
Fitch Ratings	1-800-893-4824	www.fitchibca.com

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

Before purchasing insurance, it is important to verify whether a company is an authorized insurer or managed care health insurance



plan in Virginia. You can obtain a listing of authorized insurers and licensed HMOs from the Bureau of Insurance by telephone, or visit our web site, click on “Consumers” and “Want Information About An Insurance Company?”

The Virginia Department of Health also offers a listing of licensed Managed Care Health Insurance Plans.

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 can 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 are my out-of-pocket costs? 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, co-payment, coinsurance amount, premiums, and any plan limitations or maximums. Review carefully the policy or plan features concerning premium increases.

What provisions might affect my coverage?

Coordination of Benefits - Many health insurance policies and managed care plans coordinate benefits with other plans when other coverage is involved. Familiarize yourself with how your claims will be paid when you have other health insurance coverage or another managed care health insurance plan.

Provider Networks - In managed care plans, with some exceptions, you are required to use network providers and facilities. 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 any associated fees; 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 company can 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 that may result in losing group health insurance or managed care 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 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 governs COBRA issues. Contact the Department of Labor at www.dol.gov or call 1-866-487-2365 (TTY 1-877-889-5627).

The Centers for Medicare & Medicaid Services or "CMS", formerly known as the Health Care Financing Administration or "HCFA", has created a website for COBRA continuation of coverage as it applies to group health plans sponsored by state and local government employers (title XXII of the Public Health Service Act; 42 U.S.C. 300bb-1 through 300bb-8). The website is designed to assist qualified beneficiaries, state and local government employers and group health plan administrators in understanding their rights and responsibilities with respect to public sector COBRA continuation coverage. The website may be directly accessed at www.cms.hhs.gov/hipaa/hipaa1/cobra.

CONVERSION or CONTINUATION

Traditional group health insurance policies issued under Virginia law include either a conversion provision or a 90-day continuation period. (HMO plans must offer the conversion option, but do not have to offer a continuation option). The conversion provision states that an insured group member who is leaving the group has the right to convert to an individual health insurance policy or plan from the group insurer without presenting evidence of insurability. The conversion application for the policy has to be made to the insurer within 31 days after termination.

The continuation provision requires application for the extended coverage to be made to the group policyholder prior to termination.

The certificate of insurance 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 below).
- 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 CERTIFICATE or EOC CAREFULLY to evaluate the options available to you.

The Health Insurance Portability and Accountability Act (HIPAA)

A federal law called 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 coverage for yourself and your dependents if you start a new job;
- Lessening your chance of losing existing health care coverage;
- Helping you maintain continuous health 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 plan and have no other health 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.

Making 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 company to process the claim. The company should inform you if it needs any additional information to complete 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 other cost-sharing 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 review of the claims decision.
- The company should answer any questions you may have.
- If you cannot get the problem resolved by dealing directly with the company, the Bureau of Insurance will assist you with claims and complaints.

Receiving Help from The Bureau of Insurance

The Bureau of Insurance responds to thousands of individual consumer inquiries and complaints each year. The Consumer Services



Section provides free professional information and complaint services to individuals covered under policies and plans issued in Virginia.

General Questions about Insurance

Staff in the Consumer Services Section is ready to assist you when you are unable to find the answer to a general question. The Consumer Services Representatives specialize in areas of senior issues and complaints, managed care issues and commercial insurers. You may reach the Consumer Services Section Monday through Friday, 8:15 a.m. to 5:00 p.m., toll-free within Virginia at 1-800-552-7945 or in Richmond at 371-9691. If your question cannot be answered by telephone, you will be advised to file a written inquiry with the Bureau.

Written inquiries of a general nature may be sent via e-mail, to BureauofInsurance@scc.virginia.gov, or by regular mail. A Consumer Services Representative will promptly respond to your inquiry. Please include your name, current mailing address and telephone number along with 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 company, agent, or product; or
- ♦ Provide legal services or legal advice.

If You Wish to File a Complaint

You are encouraged to work with your agent or other company representative to resolve a dispute. Many times, if a mistake has been

made, it will be corrected upon inquiry. Sending a written letter to the company or agent is recommended. Always keep copies of correspondence sent to the company concerning the dispute. If you decide to e-mail or telephone the company or agent, document the date and time of the contact or call; the name of the person(s) you talked with at the company; and, what was said in the conversation.



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

A Consumer Complaint Form may be obtained by contacting the Bureau of Insurance's Consumer Services Section, or by visiting the Bureau's website. Click on "Consumers" and follow the appropriate links.

Provide the requested information on the complaint form as completely and accurately as possible. Explain how you tried to resolve the issue and what you think the company or agent should do to resolve the matter. Attach copies of all correspondence, e-mails, and telephone notes, as well as a copy of your insurance policy, certificate, or EOC. Letters written on your behalf by medical and legal professionals, and sales literature should also be included.

The Bureau of Insurance also offers assistance to consumers enrolled in managed care plans via The Office of the Managed Care Ombudsman and through the Bureau's Independent External Appeals for Managed Care Health Insurance Plans (MCHIPs).

The Office of the Managed Care Ombudsman

The principal function of the Office of the Managed Care Ombudsman is to help Virginia consumers who have health insurance provided by a Managed Care Health Insurance Plan (MCHIP). 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 inquiry form or letter from the consumer requesting assistance;
- Answer questions about regulatory requirements affecting MCHIPs and provide information about health benefits mandated by Virginia law; and
- Develop written information describing different types of MCHIPs and make such information available to consumers, as it is 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.

**To contact the Office of the
Managed Care Ombudsman:**

P. O. Box 1157
Richmond, VA 23218
Telephone Toll free (877) 310-6560
Or locally (804) 371-9032
Or log onto the Bureau's website, click on
"Consumer"
and click on the link to
"Office of the Managed Care Ombudsman"



Independent External Appeals for Managed Care Health Insurance Plans

After you have exhausted all internal appeals regarding a decision made by your MCHIP, you may file for an external appeal. If your appeal is accepted, the Bureau will ask an independent healthcare review organization that is not affiliated with your MCHIP to conduct a review of your appeal. You, your treating physician, and your MCHIP will be asked to give the review organization all medical information pertinent to your appeal.

The review organization will make a written recommendation to the Commissioner of Insurance who will review the recommendation to ensure that it is not arbitrary or capricious. The Commissioner will then issue a written ruling that will uphold, reverse, or modify the decision made by your plan. That ruling is binding and cannot be appealed.

Qualifications to Appeal a Decision Made by Your MCHIP

- The patient must be covered by a contract issued in Virginia by a MCHIP.
- After exhausting all internal appeals, unless an expedited review has been requested, patients who have been denied coverage because their insurance plan determines the care was not medically necessary or involved experimental or investigative procedures, can file for an external review. All appeals must be filed within 30 days of the final decision of the patient's insurance plan to deny coverage.
- Patients must be covered by an eligible insurance plan, which disqualifies self-insured (or self-funded) ERISA plans, Medicare, and Medicaid. Also, persons covered by federal employee health plans are not eligible to file appeals for external review with the Bureau.

- To be eligible for appeal, the patient's claim must exceed \$300. There is a \$50 filing fee with any appeal. This fee may be waived based upon financial hardship.

To contact the
Bureau of Insurance
External Appeals for
Managed Care Health Insurance Plans:

P. O. Box 1157
Richmond, VA 23218
(Toll-free) 1-800-640-0886
(Local) 804-371-9913
Or log onto the Bureau's website, click on
"Consumer"
and click on the link to
"Independent External Appeals"

Rights and Responsibilities

Know Your Rights

- ⇒ Insurance companies cannot unfairly discriminate concerning rates and coverage;
- ⇒ Claims must be paid promptly and fairly;
- ⇒ Consumers have a right to access certain information collected by insurance companies if coverage is refused, coverage is terminated, coverage differs from what was originally applied for, or premiums are higher than what was quoted you at the time of application;
- ⇒ 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;
 - ✓ Appeal any denied claims.



When buying insurance, you are responsible for:

- ⇒ Reading and understanding any explanation of benefits forms sent by your insurance company;
- ⇒ 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 company; and
- ⇒ Paying any deductibles, coinsurance, or co-payments, outlined in your policy, certificate or EOC.

Insurance Rules to Live By

- ⇒ Know the name of your insurance company 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 Health Insurance

Where can I obtain health insurance?


Insurance agents and companies 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 health insurance and licensed HMOs in Virginia. These listings may be obtained by calling the Bureau of Insurance, or visiting the Bureau's website. Click on "Consumer" and "Want Information About a Company?" Insurance premiums can vary substantially from company to company so it usually pays to check with several companies before making a final choice.

I had a serious health condition that appears to be stabilized; however, I am having difficulty finding an insurance company 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/how it was treated will factor into how the insurance company will respond. Contact several insurance companies, then compare options available to you. If none of the options suit you, you may contact Anthem Health Plans of Virginia, Inc. (formerly TRIGON) at 1-800-334-7676 or Carefirst Blue Cross Blue Shield 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. There is no risk pool in Virginia. Therefore, the Open Enrollment product may be the only way for you to secure insurance if you can not get it anywhere else.

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 company 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.

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

Companies often establish allowable charges for certain procedures and services. These charges may be based on a "usual, customary and reasonable" (UCR) schedule, or they may be based on other criteria established by the company. It appears that your company paid 80% of the allowable or UCR charge established by the company for your medical procedure.


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

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, is used to determine premium rates.

Does the Virginia Bureau of Insurance regulate all health insurance?

Group 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.

Does the Bureau of Insurance regulate health insurance rates?

The Bureau of Insurance approves premium rates for individual health insurance policies. In all cases, rates must be applied fairly and reasonably.

My insurance company has rescinded my health insurance policy. What does this mean?

The insurer has voided coverage. Recision usually occurs as a result of incomplete or inaccurate information submitted on the application, or an omission of information that is pertinent to the underwriting of the policy.


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 will allow coverage for a prescription drug not routinely covered by the plan.

Group Health Insurance

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 90 days. Or, you may be able to convert your group coverage to an individual coverage. Your group certificate or EOC will indicate the options available to you.

Why are premiums on a conversion policy so expensive?


Conversion is made without evidence of insurability and, therefore must cover those who would otherwise be uninsurable. Because the claims experience for these types of policies is generally much higher, substantial premiums are often required to cover the risk.

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 preexisting 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. Also, the new carrier must offer you the insurance coverage without your having to medically qualify 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.

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
Frances Perkins Building
200 Constitution Avenue, NW
Washington, DC 20210
1-866-487-2365
www.dol.gov

Managed Care Health Insurance Plans

How do I select a managed care health insurance plan (e.g., HMO, PPO)?

Consider what is most important to you in a health 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. If you or a dependent has special medical needs, check that the plan you are considering has adequate medical services and providers for that specialty.

In completing my application for insurance, I noticed that I needed to choose a primary care physician. What does that mean?

Your primary care physician (PCP) is responsible for managing your health care needs. Many managed care plans require their members to receive care from the PCP or obtain a referral from the PCP to receive care from a specialist.



May I use any provider that I choose under the plan?

If you are covered under an HMO, in most cases you will need to receive all services from your PCP or other participating plan providers. Generally, if you are covered under a PPO or POS, you will be able to choose any provider. However, you will be required to pay a larger portion of the bill if you use a non-participating (or non-preferred) provider, and you may be required to have some services preauthorized by the insurance company. Your member handbook or EOC should explain the requirements specific to your plan.

What can I do if I want a different primary care physician (PCP)?

Follow the plan's procedures for changing primary care providers. Consult your member handbook or EOC, or your employer may be able to assist you.

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?

If you are a participant in a Managed Care Health Insurance Plan (MCHIP), 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 reconsideration. Consult your doctor and submit any additional important information with your appeal. Your insurance company must have a medical doctor determine if a treatment is not covered due to medical necessity. You have the right to seek assistance from the Bureau of Insurance, Office of the Managed Care Ombudsman, and your situation may be eligible for further consideration through the Independent External Appeals process (see page 23).



GLOSSARY

Coinsurance

The percentage of health care allowable charges 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 percent of allowable medical expenses.

Copayment

A specific charge you pay for a specific medical service. For example, you may pay \$10 for an office visit or \$5 for a prescription and the health plan covers the rest of the medical charges.

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 policy or HMO plan starts paying.

Eligible Expenses

Expenses defined in the health plan as being eligible for coverage. This could involve specified health services, fees or "usual, customary and reasonable charges."

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.



Enrollee

An individual who is enrolled in an MCHIP.

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 and/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 policy or managed care plan listing services, amounts paid by the plan, and total amount billed to the patient.

Fee-For-Service

A payment system for health care where the provider is paid for each service rendered rather than a pre-negotiated amount for each patient.

Formulary

List of prescription medications covered by an insurance company.

Fully Insured Plan

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

Gatekeeper

Role of the primary care physician or PCP in HMOs and other forms of MCHIPs. The Gatekeeper coordinates care and makes referrals to specialists.



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.

Grievance Procedure

A procedure which allows a member of a health plan or a provider of benefits to express complaints, protest a decision, and seek remedies.

Group Certificate

The document provided to each member of a group 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, 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.

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 PCP who coordinates all of your care and makes referrals to any 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 a policyholder and may extend coverage to his or her family; sometimes called personal insurance, as distinct from group insurance.

Lifetime Maximum

The total amount of benefits that a health care plan will pay over a policyholder's lifetime.

Maximum Out-of-Pocket Costs

The most a member will pay considering copayments, coinsurance, deductibles, etc., usually on a calendar year or policy year basis.

Medicaid

A joint state and federal public assistance program that pays for health care services for low income or disabled persons.

Medicare

A federally administered health insurance program that covers the cost of hospitalization, medical care, and some related services for most people over age 65, people receiving Social Security Disability Insurance payments, and people with End Stage Renal Disease (ESRD).

Medicare Supplement Insurance

Insurance coverage sold on an individual or group basis which helps to fill the gaps in the protection provided by the Medicare program. This insurance is also called "Medigap program."

Multiple Employer Welfare Arrangement (MEWA)

An arrangement by which two or more employers form a coalition to offer a health plan to their employees.



Noncancelable

A health insurance policy that the insured has a right to continue in force by payment of premiums, as set forth in the contract, for a period of time as set forth in the contract. During that period of time, the insurer may not make any change in any provision of the contract, including the premium.

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.

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 and some state laws limit the extent to which a health plan or issuer can apply a preexisting 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 Physician (PCP)

Under many MCHIPs, the physician (often a physician, internist, or pediatrician) who manages your healthcare. With some exceptions, you must first consult with your PCP for healthcare needs. A PCP makes referrals to specialists if necessary.

Provider

Any person or institution that provides medical care.

Referral


The process under which an HMO member receives authorization (generally from his or her PCP) to receive or obtain care from a specialist or hospital.

Rescind

To nullify or make void a policy or coverage. In many cases, when and if a company rescinds a policy, premiums are refunded.

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. Consumer Outreach is offered through many different means. The most popular are 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:

Senior Issues such as Medicare Supplement and Long-Term Care
Ethics & Fairness in Carrier Business Practices
Health Insurance
Life Insurance
HIPAA
Small Employer Insurance
Annuities
Agent Licensing
Homeowners Insurance
Commercial Insurance
Automobile Insurance

**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**

**Or log onto the Bureau's website, click on "Consumer"
and click on "Want a Speaker to Address Your Group?"**



Virginia Insurance Counseling and Assistance Program (VICAP)

Another resource to assist you with your health insurance needs is 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 company 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 Center for Elder Rights in the Virginia Department for the Aging at its nationwide, toll-free number, 1-800-552-3402 (Voice TTY).

