INSURANCE FACTS
for Pennsylvania Consumers

A Consumer's Guide to

Health Insurance

1-877-881-6388
Toll-free Automated *Consumer Line*

www.insurance.pa.gov
Pennsylvania Insurance Department Website

Increases in the cost of health care in recent years make the threat of serious illness or injury potentially devastating to the average person or family without health insurance. In order to protect themselves at the lowest possible cost, many consumers are beginning to shop for health care and health insurance the way they usually shop for cars, appliances and other items. This guide can assist you in that process.

There are many different types of policies and health care plans at many different prices. Some pay most of your health care bills for any serious injury or illness. Others pay only part of your bills or only for certain injuries or illnesses. Some pay an amount directly related to your actual health care costs. Others pay a set amount for each day that you are in a hospital, without regard to actual bills.

This guide answers some frequently asked questions about health insurance, explains some of the most common types of health insurance policies and offers tips to consider when purchasing health insurance coverage. Information also is provided about what to do and where to go if you have a question, problem or complaint with your health insurance coverage.

Additional questions can be directed to the Pennsylvania Insurance Department by calling our toll-free auotmated Consumer Line *at* **1-877-881-6388**, *visiting our Web site at* **www.insurance.pa.gov** *or contacting any of our two regional offices listed on the back cover.*

Coinsurance	The share of your covered expenses, usually a percentage, you must pay after the deductible is reached. For example, a policy may require you to pay twenty percent of the cost up to a certain dollar amount.
Conversion of Privileges	Allows the participant or beneficiaries to convert coverage to a different plan of insurance without providing evidence of insurability. The privilege granted by a group policy is to convert to an individual policy upon termination of group coverage.
Coordination of Benefits (COB)	Provisions in group policies that limit the total benefits payable under two or more group policies so that benefits do not exceed the actual amount of covered expenses incurred. COB is particularly important when a husband and wife each have obtained family coverage under separate group policies. Some policies may reduce the amount of benefits payable if benefits are payable under other insurance coverage.
Co-payment	A specified dollar amount a subscriber to a managed care plan must pay for covered health care services. It is paid to the provider at the time the service is rendered.
Deductible	The initial amount of covered expenses a policyholder will have to pay before benefits are paid under the policy. Generally, the higher the deductible, the lower your premium. Remember, the deductible should not be so high that you could not afford to pay it should you become ill. Ask your agent or company representative if the deductible is a flat annual amount or if you must pay a deductible for each treatment, or for each family member. Some major medical policies have what is known as a "variable deductible" which means that the deductible will be the greater of a fixed dollar amount or the total of all health care benefits paid under basic hospital, medical and surgical expense coverage.
Effective Date	The date health insurance protection begins.
Elimination Period	Specified number of days that you must be eligible for coverage or disabled before the policy begins to pay benefits.
Exclusions and Limitations	Conditions or circumstances in which benefits are not payable or may be limited. Some examples of exclusions are suicide or self-inflicted injuries, injuries resulting from war, on-the-job accidents covered by workers' compensation, eye or dental treatment, cosmetic surgery, services for which no charge is made, and services that are not medically necessary. Some policies also may place limitations on or exclude treatment of mental illness or substance abuse.

Pre-existing Condition

An illness or condition which was treated or diagnosed before the policy was issued. Many policies will not pay benefits for pre-existing conditions, or will only cover treatment of them after the policy has been in force for a specified period of time. This varies based on whether the policy is group or individual coverage.

Renewal and Premium Increase Provisions

Determine the conditions under which your policy may be renewed or the premiums increased. Ask what type of renewal provision applies to your policy.

Waiting Period

The amount of time you must wait after buying a policy before coverage begins.

Types of Health Insurance

Health insurance is available through two types of plans: group or individual. **Group plans** are offered through an employer or association; **individual plans** are purchased directly through an insurance company. (For purposes of this brochure, "individual" refers to you and, where applicable, your dependents).

If you work for a company that offers a group insurance plan, or even a choice of plans to its employees, obtaining health insurance may not be a problem. However, if you are not covered by a group plan, or if you want different or additional coverage other than that offered by your employer, you may want to consider buying individual health insurance coverage for yourself or your family, or determine your eligibility for association or government sponsored health insurance.

Employer Sponsored Group Insurance

Employer Sponsored Insurance is group health insurance coverage offered by your employer. The group health insurance coverage purchased by the employer can be through a private insurance company or coverage that is "*self-funded*" or "*self-insured*," meaning that the employer will use its own money to pay for the health care expenses of its employees. It is important to know whether the health insurance coverage under your employer's group policy is purchased through an insurance company or whether it is self-funded. While self-funded plans may provide excellent health coverage, they are regulated by the federal government and are not required to offer the same benefits as private insurance plans that are regulated by state insurance laws.

Individual Insurance

Individual insurance includes health insurance coverage you can purchase on your own directly through an insurance company. Many health insurance companies offer individual health coverage to people who either are self-employed or work for a business that does not offer health insurance.

All Pennsylvania residents can buy individual health insurance through the Blue Cross and Blue Shield plans on a guaranteed issue basis. However, your choice of health plans may be limited and you may face a pre-existing condition exclusion period. However, if you are HIPAA eligible, you would not face a pre-existing exclusion period. (Please see the discussion below on Guaranteed Issue and Eligible Individuals.)

Other insurers that offer individual health insurance coverage can medically underwrite applicants and do not have to offer coverage to everyone who applies. You have limited guaranteed access to individual health insurance in most other states.

Franchise Insurance

Franchise insurance is individual insurance. This type of insurance coverage is optional and the insurance policy is issued to the employee of an employer or a member of an association where the employer or association agrees to collect the policy premiums on behalf of the employee or member and pay them to the insurer. For employees, this option may allow them to purchase coverage through payroll deduction.

Association Sponsored Insurance

Association sponsored insurance includes health insurance coverage that may be offered to you or a member of your family through a fraternal or professional association. Association sponsored insurance usually costs less than individual insurance because, similar to employer sponsored insurance, you may be able to purchase health insurance at a group rate.

Government Sponsored

Government Sponsored insurance includes health insurance coverage that provides medical benefits to senior citizens, disabled persons, and the economically disadvantaged. Examples include Medicare and Medicaid. Government sponsored insurance also may be available to those with conditions related to military service.

Insurance

Fee-for-Service

Fee-for-Service plans often are called traditional or indemnity health insurance. Here, the health insurance company pays all or a portion of the bills after services are received by the insured. Other characteristics of a fee-for-service plan include: 1) no connection between the insurance company and the people who provide health care; 2) no restrictions on the doctors or hospitals you must use to receive health care; 3) a deductible may have to be paid before the policy begins to pay; and 4) co-payments may have to be paid each time you have a claim.

Managed Care plans refer to a variety of health insurance programs such as *Health Maintenance Organization (HMO), Preferred Provider Organization (PPO) and Point of Service (POS).* These programs vary in provider choice, convenience and costs.

On January 1, 1999 the Quality Health Care Accountability and Protection provisions of Act 68 went into effect. Act 68 created new procedures for complaints and grievances against managed care health insurance plans. Act 68 applies to managed care plans including HMOs and POS plans. To obtain a copy of the brochure, Your Rights Under Act 68, *contact the Pennsylvania Insurance Department at* **1-877-881-6388**.

Health Maintenance Organizations (HMOs) are organized systems for health care that provide comprehensive services directly to enrolled members for a fixed, periodic fee. HMOs provide or arrange for health care services through a network or group of health care providers coordinated by the enrollees' primary care physician for such services as routine office visits, diagnostic tests, hospital care, surgical care, emergency care and preventive services. Some HMOs employ the physicians who treat enrolled members at an HMO clinic. Others contract with groups of physicians or individual physicians who maintain their own health center or individual offices where they treat HMO members. Services provided outside the HMO network are not covered except for emergencies or with referrals by the primary care physician and approved by the HMO prior to obtaining services.

Preferred Provider Organization (PPOs) are groups of doctors, hospitals, and other health care providers that have contracts with health insurance companies. The providers agree to serve the company's members and charge negotiated rates. These become the company's preferred providers. Enrollees receive higher levels of coverage (lower deductibles, coinsurance, etc.) when they use preferred providers for medical care.

Point of Service (POS) is a health care plan that allows enrollees to choose whether to receive a specific service from a contracted preferred provider or a non-contracted provider. POS plans are a combination or either an HMO or PPO plan with a traditional indemnity plan. For the maximum level of benefits, the enrollee must consult their primary care physician prior to obtaining

treatment or services.

Available Health Insurance Policies/Coverages

Managed Care

Basic Hospital, Medical and Surgical Insurance

Basic hospital, medical and surgical insurance pays the portion of daily hospital room and board costs specified in the contract. This type of policy also pays for hospital services and supplies such as X-rays, lab tests, medicine and other items up to a stated amount.

Most basic policies have time and dollar limits on benefits. For example, a policy may pay actual costs (the total billed amount for service) up to a fixed amount per day for hospital room and board for a stated number of days. Or, a policy may pay a fixed percentage of all covered hospital costs for a stated number of days. Payments for surgical expenses usually are based on a surgical fee schedule so that a maximum stated amount is paid for a specified operation.

Major Medical

While basic hospital, medical and surgical policies stop paying benefits when certain time limits or dollar limits are reached, *major medical insurance* provides additional protection against the high costs of serious or continuing illnesses and injuries.

Major medical policies usually provide broader coverage than basic policies. They may cover the costs of blood, drugs, and out-of-hospital costs such as visits to the doctor. Benefits are payable for longer periods and major medical policies usually have a large maximum lifetime benefit instead of the smaller dollar and time limits of most basic policies.

Policyholders generally have to pay a yearly deductible before their major medical policies begin to pay benefits. This deductible can be on an individual or a family basis. These policies usually pay a certain percentage, often 80 percent, of covered expenses after the deductible is paid. The policyholder pays the remaining percentage under a co-insurance or co-payment clause. After the stated amount is paid, some policies pay 100 percent of any remaining expenses that are covered by the policy.

The following are considered supplemental policies. Supplemental policies provide coverage beyond, or in addition to, what is provided in your basic policy.

Hospital Indemnity

Hospital indemnity insurance pays a fixed amount specified in your policy for daily, weekly or monthly hospital stays. The benefits paid are not based on your actual expenses and are intended to supplement rather than substitute for other broader forms of coverage.

Disability Insurance

Disability insurance pays a monthly or weekly amount if the policyholder is disabled and cannot work. Some policies pay only in case of an accident, others pay only if the policyholder has an illness and some pay benefits in either case. A disability policy usually includes an elimination period—a specified number of days the policyholder must be disabled before the policy begins to pay benefits. The longer the elimination period, the lower the premium.

A short-term disability policy provides benefits for a specified time, usually 13, 26 or 52 weeks. A long-term policy may provide for benefits to age 65. The longer the benefit period, the higher the premium.

Disability insurance policies will not cover claims that are covered by workers' compensation.

Long-Term Care

Long-term care insurance may cover services ranging from nursing home care to home health care, to providing benefits during an extended period of convalescence. Medicare does not pay benefits for long nursing home stays or other types of long-term care. Other types of health insurance also may exclude such benefits.

Long-term care policies offer either fixed daily benefits or expenses incurred up to the daily benefit selected for skilled nursing care, intermediate care and custodial care for at least one year. Some policies also may offer home health care.

Specified disease insurance pays benefits only for the treatment of a specific disease, such as cancer, stated in the policy. Specified disease policies generally are not available if you previously have been diagnosed or treated for the specified disease. These policies usually have a waiting period before benefits begin and some do not pay for separate treatment or other conditions or

diseases caused by the specified disease.

Specified Disease Accident Insurance

Accident insurance limits payment to a stated amount for specific losses due to an accidental injury under circumstances specified in the policy. Some examples are the loss of an arm, leg, eye or accidental death. This type of policy also may pay some medical costs resulting from an accident. Some common forms of this type of coverage are accidental death, travel accident, specified hazard or school accident insurance.

Credit Accident and Sickness

Credit accident and sickness insurance is a special type of disability policy offered in connection with loans or other credit transactions. Generally it provides a benefit equal to the amount of the monthly loan payment if the insured debtor becomes totally disabled. The benefit is paid directly to the creditor.

You do not, except in unusual circumstances, have to buy credit accident and sickness insurance. If a creditor requires such coverage as security, you do not have to buy the coverage through the creditor. Instead, benefits may be assigned under a policy you already own or you may buy a separate disability policy through another insurance company.

Medicare Supplement

Medicare supplement insurance is designed to provide benefits to help pay what Medicare does not pay. However, these policies may not pay all the expenses that are not covered by Medicare.

Government Sponsored Insurance Programs

Medicare

Medicare and *Medicare managed care plans* are federal programs that provide health insurance benefits for people age 65 and older, those receiving Social Security benefits for disability, and those with end-stage renal disease. Additional information concerning Medicare can be obtained by contacting the Pennsylvania Insurance Department at 1-**877-881-6388**, the U.S. Health Care Financing Administration Regional Office in Philadelphia at **(215) 596-1335** or the Department of Aging's APPRISE program at **1-800-783-7067**.

Medicaid is a joint state and federal program for public assistance to eligible people, regardless of age, whose income and resources are insufficient to pay for health care. More information concerning Medicaid can be obtained by contacting the Pennsylvania Department of Public

Welfare's Recipient Hotline at **1-800-692-7462.**

Medicaid
Children's Health Insurance Program (CHIP)

CHIP provides free or low-cost quality health insurance to uninsured children whose families earn too much to qualify for Medical Assistance, but not enough to purchase health insurance. Children who have not reached their 19th birthday may be eligible for **CHIP** based on the family income. More information about **CHIP** and eligibility requirements can be obtained by contacting the **CHIP** toll free helpline **1-800-986-KIDS.**

adultBasic

adultBasic is administered by the Pennsylvania Insurance Department and offers basic benefits for adults aged 19-64 and are within income guidelines and eligibility requirements. More information about adultBasic can be obtained by calling 1-800-GO-BASIC.

Available coverage for on the job injuries

Workers' Compensation

Workers' compensation provides health care benefits if you are injured or become ill on the job due to workplace exposure. Workers' compensation does not replace your regular health insurance. More information can be obtained by contacting the Bureau of Workers' Compensation at **1-800-482-2383**.

Ways to Maintain Coverage

If you have coverage through an employer's group health plan and then lose the coverage as a result of job termination, you can buy *conversion coverage*. This is an individual policy from the company that insured your employer's group plan. To qualify, you must have been covered under your prior group health plan for at least three months. In addition, when you apply, you cannot be covered under or be eligible for similar benefits through a group health plan or Medicare. You must be notified of your conversion rights and must apply within 31 days of the notification. Surviving spouses, divorced spouses, and dependent children covered under the group health plan also may be eligible to purchase a conversion policy.

Conversion Policies
COBRA Continuation Coverage

A federal law known as the Consolidated Omnibus Budget Reconciliation Act (COBRA) gives a person enrolled in a group policy the right to continue in the group coverage on a temporary basis after the departure from an employer with 20 or more employees. The participant must pay the full group premium, including any part the employer had been paying, plus 2% for administrative expenses. Coverage can be continued for 18 months; 29 months if you become eligible for social security disability during the first 60 days of COBRA continuation; 36 months if you were insured through your spouse's or parent's group coverage and the spouse or parent has died, divorced, or separated. COBRA also applies to dependent children who lose coverage because they reach maximum age limits.

COBRA does not apply if the employer terminates the plan. Also, if the employer goes out of business and cancels the plan or fails to pay the premium, the coverage stops and COBRA does not apply. COBRA only applies when the group policy remains in force. This applies if the employer changes group plans, but not if the plan is completely terminated.

COBRA applies to all employers of 20 or more workers. This includes self-insured employers, but does not apply to plans sponsored by the federal government or certain church related organizations as defined by federal law.

Pre-Existing Conditions

Pre-existing Conditions Recent additions to Pennsylvania law help to assure continued coverage for you and your dependents when you change jobs and obtain health insurance through a group health plan. Insurance companies may impose only one 12-month waiting period for any pre-existing condition treated or diagnosed in the previous six months. Your prior health insurance coverage will be credited toward the pre-existing condition exclusion period as long as you maintained continuous coverage without a break of more than 63 days. Pregnancy is not considered a pre-existing condition. Newborns and adopted children who are covered within 30 days of birth, adoption or placement for adoption are not subject to the 12-month waiting period.

If you have had group health coverage for one year (18 months for late enrollees), and you switch jobs and go to another plan, the new health plan cannot impose another pre-existing condition exclusion period, provided there is no break in your coverage for more than 63 days.

Guaranteed Issue to Eligible Individuals

Guaranteed Issue of Health Insurance to Eligible Individuals. New Pennsylvania law also makes it easier for you to get individual insurance under certain situations, including if you left a job where you had group health insurance, or had another plan for more than 18 months without a break of more than 63 days. Specifically, if you meet certain criteria, you are considered an eligible individual and guaranteed the right to buy individual health coverage from Blue Cross and Blue Shield plans in Pennsylvania without a pre-existing condition exclusion period.

To be an eligible individual, you must:

1) have had 18 months of continuous creditable coverage, (a) during which there was no break of 63 days or more, and (b) at least the last day of which was under a group health plan;

2) have used up any COBRA continuation coverage for which you were eligible;

3) not be eligible for Medicare, Medicaid or a group health plan;

4) not have other health insurance.

You must apply for health insurance for which you are an eligible individual within 63 days of losing your prior coverage.

Health Insurance Tips

Check Agents and Companies

Make sure the agent and company you are dealing with are licensed to sell health insurance by the Pennsylvania Insurance Department.

Make sure any pre-existing conditions are listed on your application, and that all information is correct. False information or misrepresentation of health conditions in your application is against the law and may result in the denial of benefits or cancellation of your policy. If the insurance agent fills out the application for you and makes a mistake, tell him or her to complete another application. If you find a mistake after the application has been forwarded to the company, notify

the company in writing immediately. Do not sign a blank application.

Review Applications Replacing a Policy

If you are replacing an existing policy with a new one, do not cancel your current policy until you are sure your application for the new policy has been approved by the new company and your coverage is in effect. Although a premium may have been paid, coverage usually does not become effective until the application has been approved by the company. Ask your agent when your new coverage will become effective.

If you have an illness that would be considered a pre-existing condition under a new policy, that condition may not be covered for a certain period of time under that policy.

Free Look

Pennsylvania law requires that you have a minimum of ten (10) days to review your policy from the date you receive it. If a copy of the application is included with the policy, check it again for errors. If you decide you don't want the policy, you may return it to the company within the free look period and receive a full refund of any premium paid.

Paying the Premium

Always pay your health insurance premium with a check, money order or bank draft. Make your check out to the insurance company, not to the agent or agency. Whenever you pay a premium in person, always obtain a premium receipt.

Filing Claims

You should furnish your insurance company with written notice of a claim within 20 days or as soon as possible after an accident or illness. You also should notify your agent that you have a claim. Make sure all claim forms are filled out accurately and completely.

Ask your doctor to fill out the proper portion of the form or leave your insurance information with the hospital and ask them to complete the claim form. In some instances you may be asked to assign your benefits to the hospital, doctor or other provider. This means benefits will not be paid to you, but will be paid directly to the provider. Following these instructions will help speed the payment process.

Most companies try to control claim costs by limiting benefits to medically necessary treatment in the least costly setting. Some policies may require you to seek a second opinion before surgery, get pre-admission approval for elective hospitalization or receive certain treatments on an outpatient basis. Ask your insurance agent or a representative of the company to explain the cost

containment measures used by the company you are considering.

Cost Containment
Outline of Coverage

Request an outline of coverage or a brief summary of what is covered under the policy. Make sure you obtain the outline of coverage at the time the product is presented. You may use the outline to compare the coverage with products that may be available from other providers.

Claim Payment

As a policyholder, you should know that when a claim is submitted your provider will check for medical necessity and pay the claim using the usual, customary and reasonable (UCR) method for determining the amount of payment. Medical necessity means the service provided must be appropriate for the patient's condition. This is determined by each provider. UCR is the method used by each provider to determine the amounts payable for each specific service provided. UCR also is determined by each provider.

Medicare Supplement

People eligible for Medicare benefits should shop carefully for a Medicare supplement policy and choose one that provides adequate coverage at an affordable premium. The Pennsylvania Insurance Department offers a consumer guide on Medicare supplement insurance. For more information on Medicare and the types of Medicare supplement coverages available, call the Department's *Consumer Line* at **1-877-881-6388**. Also, the Pennsylvania Department of Aging's APPRISE Program provides free counseling on insurance products for senior citizens. The APPRISE Program's telephone number is **1-800-783-7067.**

Long-Term Care

Before you buy this type of policy, make sure you understand what type of care is covered, what the benefits are, and how long benefits are provided. The Pennsylvania Insurance Department offers several consumer guides on long term care insurance that are available by contacting the Department at **1-877-881-6388.** Also, the Pennsylvania Department of Aging's Apprise Program provides free counseling for senior citizens on insurance products. The Apprise Program's telephone number is **1-800-783-7067**.

Disability Insurance

When buying a disability policy, read the policy's definition of disability—be sure you know what the company considers a disability and what requirements must be met for payment. The amount of weekly or monthly benefits provided may be stated as a percentage of income or as a set dollar amount. The amount of the benefit is limited to a percentage of your income.

Health Insurance Policy Checklist

Select your health insurance coverage carefully to get the protection you need. If you are covered by a group policy or a government program, such as Medicare, make sure you understand how your current coverage will work with any new policy you buy. Contact agents from several companies and write down information on benefits, premiums and other policy factors. Then compare the different policies to decide which will provide the best coverage at the most reasonable price for you. Once you purchase health insurance, read the policy carefully to make certain it meets your needs and that you understand its terms. The following is a suggested list of questions to ask when buying health insurance.

- Are there waiting periods before certain illnesses are covered?

- How much is the deductible? Is the deductible for each treatment or illness, for each family member or is it simply an annual deductible?

- Must I pay a certain percentage of costs (coinsurance) after I have paid the deductible?

- Must I pay a certain flat dollar amount (copayment) for services such as doctor office visits?

- What are the renewal conditions? Under what circumstances can the company increase my premium?

- What is the maximum amount the policy will pay for each illness and for the entire time the policy is in force?

- What types of services does the policy cover? Will it pay for doctors' office visits or house calls?

- What is not covered by the policy?

- What are the limits on:
  - the amount paid for daily hospital room and board?
  - the amount paid for medicine, tests or other hospital expenses?

- the amount paid for specific types of surgery?
- the amount paid for doctors' visits?
- the maximum number of hospital days paid for?
- the maximum number of doctors' visits during a hospital stay?

• How do monetary benefits under the policy compare with actual costs for doctors' visits, hospital care or surgery in my area?
• If you are considering a disability policy:
  - how does the policy define total disability and partial disability?
  - will the policy pay for a partial disability?
  - is there an elimination period before benefits begin, and does it vary depending on whether sickness or an accident is involved?
  - must I be in the hospital to receive benefits?
  - how long do payments continue?
  - is renewability of the policy guaranteed?
  - what is not covered?

When you purchase health insurance, read the policy carefully to make certain it meets your needs and that you understand its terms.

If Your Health Insurance Claim is Denied

If your health insurance claim is denied, you first should review your health insurance policy or employee benefits booklet to determine the appeal rights provided to you under the policy. If you do not have a copy of your health insurance policy or employee benefits booklet, contact the heath insurance company's customer service unit to inquire about the appeal procedures.

You may be required to file a written appeal and to provide information from your doctor supporting your dispute. If you remain dissatisfied after exhausting the appeal mechanism provided by your policy, contact the Pennsylvania Insurance Department to request assistance in determining other remedies or rights you may have.

In order for the Pennsylvania Insurance Department to assist you in an efficient and effective manner, the following information is needed to address your complaint:

1. Name of the health insurance company and/or plan;
2. Identity of the health insurance sponsor (i.e. employer, government or individual);
3. Identification of the specific type of coverage: *(i.e. Fee-for-Service, HMO, PPO*);
4. Type of Policy: *(i.e. Major Medical, Hospital Indemnity, Disability, Long- Term Care)* including policy number or certificate number;
5. Nature of the dispute; and
6. Actions you have taken to resolve the problem.

Harrisburg Regional Office
Room 1321 Strawberry Square
Third and Walnut Streets
Harrisburg, PA 17120
(717) 787-2317
fax (717) 787-8585
TTY/TDD: (717) 783-3898

A Consumer's Guide to Health Insurance

pennsylvania
INSURANCE DEPARTMENT

A consumer service initiative of the
Pennsylvania Insurance Department

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