HEALTH INSURANCE

Illness for non-work related injuries can be financial devastating. Insurance can help protect against disastrous health care expenses and lost wages. If you have a job, your employer may make medical and disability income benefits available to you. You can also purchase these coverages privately or through an insurance agent who is licensed by the State to sell health insurance products.

Types of Health Plans and How They Operate

Medical Expenses Plans— pay expenses incurred for diagnosis and treatment of medical conditions.

Reimbursement and Fixed Allowance Insurance Plans

(Department of Insurance Jurisdiction)

Full freedom-of-choice plans allow you to choose any doctor and hospital. You can also choose the amount of the "deductible" you must pay before the plan pays anything. After the deductible is met, a percentage of all your expenses is usually covered. The difference between the percentage the plan pays and the amount charged is the "co-amount" that you must pay. The policy or employer benefit booklet will spell out the terms and conditions of what is covered and what in not covered. Read this contract BEFORE you need to use the plan and ask your agent or employer to explain anything which is unclear to you.

Preferred Provider Organization (PPO) Plans allow you to choose a doctor or hospital from a list of "preferred" providers in order to receive full benefits. If you go to a doctor or hospital who is not on the list, the plan may cover a smaller percentage or none of your costs. Check with the insurance carrier BEFORE you use the plan to make certain your physician or hospital is a contracting provider. Make certain your doctor refers you to other providers who are on the list, or who the carrier agrees to pay at the "preferred" rate.

Individual Plans are a good alternative if you are not able to get coverage through your employer. A pre-existing condition, such as a past illness, must be covered after one year. However, the insurance company will decide on the basis of your health history if they will issue the coverage.

Multiple Employer welfare Arrangements(MEWA) may be insured or partially –insured plans. They are typically marketed to self-employed individuals or small employers through membership in a trade or other association. The California Insurance Code now requires MEWA's to obtain a "Certificate of Compliance" and to set aside financial reserves to operate. They must comply with the health care reforms effective after July 1993. These plans can only be sold through a licensed life insurance agent.

Disability Income Policies

Replace part of your wages lost because you can not work because of a disabling sickness or injury. Income replacement policies pay weekly or monthly amount when you are unable to perform the duties of your job. The contract defines how much you will be paid, how soon after you are disabled payments begin and when they will cease. There are many different kinds of contracts. Shop carefully through a licensed health insurance agent who is knowledgeable about this type of coverage.

Supplemental Insurance Policies

Are designed to pay **in addition** to your regular medical expenses or income replacement policies and should not be used as a substitute for more than comprehensive coverage. They pay limited benefits such as a daily dollar amount if you are hospitalized (Hospital Income Polices) or expenses incurred to treat a specified "dread disease" such as cancer or a stroke. This coverage may duplicate some of what you are paying for in your comprehensive medical expense plan. Make certain you understand the limitations and exclusions before you buy.

Cancer, hospital indemnity, accident, and medigap contracts are just some examples of supplemental insurance policies.

Pre-Paid Contracts

(*Department of Managed Health Care Jurisdiction*)

Health Maintenance Organizations (HMO) Plans were formed with the idea of controlling cost and providing preventative health care before members get sick. HMOs are comprised of hospitals, doctors and other medical personnel who have joined to provide health care to members in return for a pre-paid monthly charge. You can go to the provider as often a as you need for the same monthly cost and an additional small fee per office visit or prescription. Most other medical services are fully covered. You do not have the option of going to a medical provider who is NOT part of the HMO. Enrollment is usually limited to employer groups, but a few HMOs will take individual members.

Self-Insured Single Employer Plans

(Department of Labor Jurisdiction)

Some large employers and many labor unions provide group health coverage for their employees or members without buying an insurance policy or HMO plan. (Some plans hire insurance companies to do the paperwork). You are self-insured under the Employment Retirement Income Security Act (ERISA) or if it is "insured by" an insurance company. If the plan is self-insured and the employer or the union does not pay a claim, you may have little recourse because these plans are not regulated by the State. Federal labor law governs these plans, but the federal government does not handle claim complaints.

Government Sponsored Medical Expense Programs

Managed Risk Medical Insurance Board (MRMIB)— The California sponsored health care plans for uninsurable individuals. The benefits are limited and there are residency and waiting

periods that must be met before benefits are available. Ask your agent for more information or call 1-800-289-6574 for enrollment forms.

Health Insurance Plan of California (HIPC)—-The State of California sponsored a health insurance pool for small employers (3-50 full-time employees). It guarantees coverage to employees in any one of 20 different health plans offered through insurance companies or HMOs at more favorable rates. Your employers can get more information from an insurance agent or by calling HIPC at 1-800-447-2937.

Medicare— a Federal program which provides medical insurance for people over 65 and for those who are permanently disabled. Contact your local Social Security Office for a copy of the current Medicare handbook.

Medicaid— (Called MediCal in California) is funded jointly by state and federal governments but administered by each state. Medicaid provides medical assistance to low-income families and individual of all ages participating in cash-assistance programs. Medicaid recipients usually do not need private health insurance. Contact your local county Social Services Department for eligibility requirements.

The Health Insurance Portability and Accountability Act

[HIPAA]

An individual who may have difficulty obtaining individual coverage because of pre-existing medical conditions should contact a qualified health insurance agent and ask for information on "HIPAA-ELIGIBLE, guaranteed-issue" individual health plan. An individual may be eligible to purchase an individual health policy without evidence of good health if she/he meets the following requirements:

1. The individual, or covered dependent, has been covered under an employer-sponsored health benefit plan, including COBRA or CalCOBRA continuation coverage, for at least 18 months;

2. The individual terminated employment and must have elected continuation coverage under COBRA/Cal-COBRA;

3. All available COBRA/Cal-COBRA continuation coverage has been exhausted;(If an employer terminates its existing group health plan entirely, no more continuation coverage is "available" through that employer or through a successor employer’s plan, continuation coverage has been exhausted.);

4. The individual submits an application, and a "certificate of Prior Coverage" or an acceptable equivalent, for individual coverage to an insurance carrier or an HMO within 63 days of the termination of the group health benefit plan.

The individual does not purchase any kind of other individual coverage,

including a conversion policy, a short-term interim plan, the Managed

Risk Medical Insurance Plan for uninsurable parties or a medically

underwritten individual policy/HMO.

Questions & Answers

Q. When I apply for insurance, what will they ask?

A. Personal information to determine your eligibility. Companies screen applicants for individual health insurance, so you'll fill out an application and answer questions on your medical history.

If your information is incomplete or inaccurate regarding health history or age, the company may deny benefits or rescind your coverage. Companies frequently ask physicians for medical records and may require you to take additional physical exams or blood tests. However, they cannot ask you for an HIV test, except for disability income and life insurance. People with anything serious in their medical background may be charged a higher price for coverage or may be unable to find individual health insurance at any price.

Q. Can I return my policy?

A. Yes. If you are accepted for **individual** coverage by an insurer, you have a "free look" or review period which varies from 10 to 30 days. If you decide you do not want the policy, return it by certified mail within the required period of time and request a full refund of the premium paid. Employer group plans do not have a "free look" period.

HEALTH INSURANCE TERMS YOU SHOULD KNOW

Assignment of Benefits—When you assign benefits, you sign a paper allowing your hospital or doctor to collect your health insurance benefits directly from your insurance company. Otherwise, you pay for the treatment and the company reimburses you.

Claim—Notification to the insurance company from the insured or health provider (if you have assigned benefits) that a payment is due under provision of the insurance policy.

Co-Payment—The portion charges paid by the patient in addition to any deductible for covered services and supplies.

Deductible—A fixed amount which is deducted from eligible expenses before benefits from the insurance company are payable. You may choose a higher deductible to lower your premium.

ERISA—Employee Retirement Income Security Act (of 1974). Administered by the U.S. Department of Labor, ERISA regulates employer-sponsored pension and insurance plans for employees.

Grace Period—a specified period immediately following premium due date, during which payment can be made to continue the policy in force with out interruption.

Guaranteed Issue—The coverage is available regardless of prior medical history. Small

employers (between 3 and 50 employees) cannot be refused coverage because of the medical history of one or more employees. Some individual plans are available on a Guaranteed Issue Basis, although premiums are higher.

Limitations—Conditions or circumstances for which benefits are not payable or are limited. It is important to read the limitations, exclusions and reductions clause in your policy or certificate of insurance to determine which expenses are not covered.

Medically Necessary—Many insurance policies will pay only for treatment that is deemed "medically necessary " to restore a person's health. For instance, many policies will not cover plastic surgery for cosmetic purposes.

Pre-Existing Conditions—Any illness or health problems you had prior to obtaining insurance. Group health care policies will cover pre-existing conditions after you have been covered for up to 6 months; Individual plans up to 12 months.

Prior Qualifying Coverage—Health plan coverage that was in effect before the effective date of the current or new coverage. Both individual and group plans must credit coverage that was in effect before the start of the current coverage toward the satisfaction of the pre-existing conditions exclusions.

Usual Reasonable and Customary—The charges that a carrier determines normal for a particular medical procedure in a specific geographic area. If charges and higher than what the carrier considers normal, the carrier will not pay the full amount charged and the balance is your responsibility.

Questions or complaints regarding most **HMO**s should be addressed to:

Department of Managed Health Care

320 West 4th Street, Suite 750

Los Angeles, California 90013-1105

(888) 466-2219

The Managed Risk Medical Insurance Board (**MRMIB**)

1000 "G" Street, Suite 450

Sacramento, Ca 95814

(800)289-6574

(916)324-4695

For information about the federal **Employees Retirement Security Act (ERISA)** or **employer**

self-insured plans contact:

U.S. Department of Labor

Pension & Welfare Benefits Administration

200 Constitution avenue, N.W., Room N-5658

Washington, DC 20210

(626) 583-7862 (Southern California)

(415) 744-6700 (Northern California)

Talk to us

Do you have a question, comment or concern?
There are several ways to talk to us:

- Call our Consumer Hotline at **(800) 927-HELP**
- Telecommunication Device for the Deaf dial **(800) 482-4TDD**
- Telephone lines are open from **8:00 AM to 6:00 PM Pacific Time, Monday through Friday,** excluding holidays

- Write: **California Department of Insurance**
  300 South Spring St., South Tower
  Los Angeles, CA 90013

- E-mail us through our Web site at:
  www. insurance.ca.gov

- Visit us in person on the 9th Floor at the address above. **Office Hours: Monday through Friday 8:00 AM to 5:00 PM Pacific Time,** excluding holidays