Health Insurance

a guide for consumers

STATE OF FLORIDA
Florida Department of Financial Services

Contents

Consumer **HELPLINE**

1-877-693-5236

or visit our Web site at:
www.MyFloridaCFO.com

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NOTE:

Most insurance rates and forms in Florida are regulated by the Office of Insurance Regulation (OIR). Other financial services are regulated by the Office of Financial Regulation (OFR). Although both are administratively housed within the Department of Financial Services (DFS), they are separate entities that report to the Florida Cabinet. Because DFS handles consumer-related matters, consumers should remember that DFS is their point of contact for all problems and questions.

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Health Insurance

Nobody plans on getting sick or injured. But life is full of unexpected events that force us to seek medical care. These include everything from a common cold to a more prolonged illness or injury. When these situations arise, your best financial defense is to have adequate health insurance.

Health insurance can help protect your assets and pay medical expenses, but selecting the policy to best meet your needs can be challenging. This guide explains the various types of policies that are available, offers tips on choosing a policy and provides definitions for the numerous health insurance terms you may encounter. If you have any questions after reading this guide, please call the Florida Department of Financial Services (DFS) Consumer Helpline toll-free at 1-877-MY-FL-CFO (1-877-693-5236).

TRADITIONAL VERSUS MANAGED CARE COVERAGE

Your first health insurance choice may be to decide between traditional health insurance and a managed care option. With traditional health insurance, you – the policyholder – select a health care provider, such as a doctor or hospital. You may have to pay for services when rendered and then submit the bill to the insurance company for reimbursement of the portion it agreed to pay under the policy terms. Frequently, the provider will submit the bill directly to the insurer and await payment.

The managed care system combines the delivery and financing of health care services. This limits your choice of doctors and hospitals. In return for this limited choice, however, you usually pay less for medical care (i.e., doctor visits, prescriptions, surgery and other covered benefits) than you would with traditional health insurance. The managed care network controls health care services.

Types Of Managed Care

Health Maintenance Organizations (HMOs)

HMO members pay a monthly fixed dollar amount (similar to an insurance premium), which gives them access to a wide range of health care services. In many cases, members also pay a predetermined amount, or copayment, for each doctor or emergency room visit and for prescription drugs, rather than paying the provider in full and obtaining a portion of the reimbursement later. Recent legislative and regulatory changes have provided HMOs with the opportunity to offer plans with deductibles and coinsurance similar to PPOs (discussed below). HMO members often have little or no paperwork to complete due to the elimination of reimbursement. They must use the HMO's network of providers, which may include the doctors, pharmacies and hospitals under contract with that particular HMO.

You may obtain the free publication Health Maintenance Organizations: A Guide for Consumers by calling the Consumer Helpline toll-free at 1-877-MY-FL-CFO (1-877-693-5236), or by downloading it from the DFS Web site at www.MyFloridaCFO.com.

Exclusive Provider Organizations (EPOs)

In an EPO arrangement, an insurance company contracts with hospitals or specific providers. Insured members must use the contracted hospitals or providers to receive benefits from these plans.

Preferred Provider Organizations (PPOs)

A PPO offers another kind of provider network to meet the health care needs of consumers. A traditional insurance carrier provides the health benefits. An insurer contracts with a group of health care providers to control the cost of providing benefits to consumers. These providers charge lower-than-usual fees because they require prompt payment and serve a greater number of patients. Consumers usually choose who will provide their health services, but pay less in coinsurance with a preferred provider than with a non-preferred provider.

Point-of-Service Plans

These plans may be called by a variety of names and have various features. They combine some aspects of traditional medical expense insurance plans and other aspects of HMOs and PPOs. In a POS plan, insured members may choose, at the point of service, whether to receive care from a physician within the plan's network or to go out of the network for services. The POS plan provides less coverage for health care expenses provided outside the network than for expenses incurred within the network. Also, the POS plan will usually require you to pay deductibles and coinsurance costs for medical care received out of network.

Types Of Traditional Care

Basic medical insurance (hospital/medical/surgical)

Hospital insurance usually pays a portion of your room and board. It may also pay some expenses for other hospital services, such as operating room use, laboratory tests and X-rays. Medical/surgical insurance helps pay for surgical and related costs (either in the hospital or doctor's office), and may pay for anesthesiology. It may also pay doctor fees for medical visits when you receive hospital care other than surgery. Payments for surgical expenses are usually fixed amounts based on a surgical fee schedule. Insurance companies use fee schedules to determine the average cost of a procedure according to usual, customary and reasonable charges.

- Usual refers to the fee a doctor normally charges for a procedure.
- Customary involves the range of usual fees charged by doctors of the same specialty in a given geographic area for a specific procedure.
- Reasonable applies to a fee that differs from the "usual or customary" charges because of unusual circumstances. The procedure may involve medical complications that require additional time, skill and expertise. This provision limits the amount the insurance company will pay under your policy. If possible, check what your insurer will pay prior to the delivery of medical services subject to a usual, customary or reasonable rate.

Basic medical insurance policies offer consumers differing benefits for room and board, physician, surgical and miscellaneous expenses. You should carefully check to see if policies offer equal benefits when comparing premium rates.

Major medical insurance

These policies provide protection against the high costs of hospitalization, injuries and serious or ongoing illnesses. Other possible coverages include the cost of blood transfusions, drugs and out-of-hospital costs, such as doctor visits. Most group health policies fall under the category of major medical policies. This category also includes the basic and standard plans issued under small group health access coverage (see "Group Plans").

Major medical policies cost extra and provide more benefits than basic policies. A major medical policy normally pays 80 percent of covered expenses, after you pay the deductible. Insurance companies use fee schedules to determine the average cost of a procedure; however, this cost may differ from the actual charge you receive. Many PPO plans stipulate that the provider may not charge for the actual cost in excess of the usual and customary amount.

Maximum out-of-pocket limits restrict the amount of coinsurance you pay. Not all policies include such limits, but those that do pay 100 percent of remaining covered expenses after you pay a stated amount of coinsurance.

TYPES OF MAJOR MEDICAL COVERAGE

Group Plans

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. You will receive a certificate that acts as your policy when you obtain insurance through a group plan. Most group policies are suitable for the average person and may include provisions to cover family members.

Businesses with one to 50 employees have access to guaranteed-issue group plans, often referred to as small group health coverage. Guaranteed-issue coverage for a one-life group (a self-employed individual with no eligible employees) is only available during the month of August each year, with the policy being effective on October 1. These plans are available to small-business employers regardless of the health claims experience of an employee group or the health status of an employee. Insurance companies and HMOs that offer small group coverage must offer employers the option of purchasing a basic or standard plan. Most insurers or HMOs offer other health-benefit plans in addition to the basic and standard plans.

For more information on small group basic and standard plans and the Small Group Health Access Act, you may request a free copy of the guide Small-Business Owners' Insurance by calling the Consumer Helpline toll-free at 1-877-MY-FL-CFO (1-877-693-5236), or you may download it from the DFS Web site at www.MyFloridaCFO.com.

Individual Plans

Individual plans cover one person or all members of a family under one policy. Usually, people buy individual plans because they lack access to employer-based group policies or want to supplement these policies. Others use individual health policies during periods of unemployment when they lack coverage under group policies, or because they want to supplement Medicare benefits. If you buy an individual policy, you may take 10 days from the date you receive the policy to decide whether to keep or cancel it. For a full refund, you must return the policy to the company within the allowed time. If you reject the policy, you should return it by registered or certified mail. This may help you avoid a potential dispute with a particular insurer.

Out-of-State Association-Based Coverage

An insurance company that markets health coverage to members of an association must be licensed by the state of Florida to sell such coverage to members who are state residents. However, if the association is located in a state other than Florida, the coverage offered to members will likely be governed by the laws of that state–not Florida. This means that many of the Florida consumer protection laws will not apply to this coverage–most notably rate approval requirements. While this "out-of-state association" type of coverage may appear affordable in the beginning, the absence of laws protecting the consumer from renewal rate abuses may become more apparent in future years.

This would become an issue should you develop a chronic health condition and are unable to medically qualify again for a more affordable policy. The decision to purchase out-of-state association coverage must be carefully considered in light of personal circumstances, with an emphasis on how long one anticipates needing the coverage and other options for coverage should it become unaffordable. In general, the longer one will need the coverage, the more important it becomes to consider coverage that is governed by all of Florida's consumer protections laws–not just some of them.

The forms and the rates charged are not approved in Florida. When your coverage terminates, you are eligible for a guaranteed-issue conversion policy. Your coverage document should contain information about this conversion option.

Consumer Alert

By statute, applications for medical coverage not governed by Florida law must contain a disclosure statement in contrasting color near the signature block declaring what state governs the coverage and the ramifications of not purchasing coverage governed by Florida's consumer protections. Furthermore, certificates issued under a policy approved by another state must contain the following statement, generally found on the front page: "The benefits of the policy providing your coverage are governed primarily by the laws of a state other than Florida." These disclosures should prompt you to ask further questions about the laws governing this coverage and the resulting suitability of this coverage for your needs.

In Addition to Major Medical Plans, There Are Self-Employed Plans.

Traditional health insurance and managed-care plans form major parts of the American health care system. However, employers may select an alternative to cover health expenses and meet employees' needs. This is known as a single-employer plan.

Single-employer plans

These plans fall under the guidelines of the federal Employee Retirement Income Security Act (ERISA). Employers establish these plans to provide health care and/or other employment benefits to employees, their families and dependents. An insurance carrier may fully insure a plan of this type or the employer may opt for self-insurance.

Employers participating in a self-insured plan assume the financial risks involved, rather than transferring this risk to an insurance carrier. The employer pays for claims filed by employees covered by the plan. Your employer might hire an insurance company to administer the plan, but this company does not take responsibility for paying claims. DFS does not regulate self-insured, single-employer plans. In addition, the Florida Guaranty Fund, which pays losses to policyholders when certain insurance companies become insolvent, does not cover such plans.

An insurance company's name or logo may appear on the forms and paperwork you receive from your single-employer, but this should not fool you. Many of these plans hire an insurance company to handle paperwork. The insurance company acts as a third-party administrator, but does not assume any legal obligation to pay claims.

You should determine whether your coverage comes from a self-insured plan. An insurance company may appear to underwrite a plan without actually doing so. You should also check the history of the group offering the plan, and talk to current members to see if they have experienced any trouble getting claims paid.

Facts to Consider

Group and individual health insurance plans usually offer coverage for family members. Family policies generally pay benefits for your spouse and your dependent children up to the age specified in the policy. However, your insurance company cannot terminate coverage for dependent children who lack other means of support due to mental or physical handicaps. Both group and individual plans may include several kinds of coverage, such as "hospital," "medical/surgical" and "major medical."

Supplemental Health Insurance

These policies provide coverage beyond, or in addition to, what your basic policy provides. You should use these policies as supplements, rather than substitutes, for basic medical insurance. Some policies include elimination periods, which means companies will pay benefits only after you stay in the hospital for a specified number of days.

Hospital confinement indemnity insurance

These policies pay a fixed amount or indemnity for each day, week or month you stay in a hospital. Such policies pay a flat amount for benefits.

Disability income insurance

These policies pay a weekly or monthly income for a specific period if you suffer a disability and cannot continue or obtain work. The disability may involve sickness, injury or a combination of the two. Most disability insurance plans coordinate with Social Security benefits and workers' compensation to eliminate duplication of coverage.

You may select a disability policy that includes an elimination period, or length of time that you must wait after a covered illness begins, before receiving benefits. The longer the elimination period, the lower your premium. Premiums may also vary depending upon your occupation (and the risks involved) and your age. For example, a high-rise construction worker would likely pay higher premiums than a florist.

When buying a disability policy, you should find out the company's definition of a disability and the requirements that must be met. Individual and group disability income policies must provide coverage for a policyholder or eligible dependent who becomes disabled. This coverage applies during the first 12 months of the disability, but only if the person can no longer perform material and substantial duties of his or her occupation. After the first 12 months, the company may base the continuance of benefits on the person's ability to perform any work for which he or she is reasonably trained.

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 upon the particular policy. For example, a given insurer may require such medical updates every month. In addition, the insurer may monitor certain public activities by policyholders who file claims. Insurers may do so to fight fraud and keep insurance costs down.

Accident insurance

These policies cover death, disability, hospital and medical care resulting from an accident. A common variation called "accidental death insurance" can pay additional benefits for death due to motor vehicle or at-home accidents.

Limited benefit insurance

These policies cover certain expenses from specifically named illnesses, injuries or circumstances. For example, cancer policies pay benefits for the actual treatment of cancer. Some also pay benefits for conditions or diseases caused or aggravated by cancer or its treatment.

Long-term care insurance

Long-term care encompasses a wide range of medical, personal and social services. A person may need this care if they suffer from prolonged illnesses, disabilities or cognitive impairment. Private insurance companies offer individual or group long-term care insurance policies that provide benefits for a variety of services not covered by your regular health insurance, or by Medicare or Medicare supplement insurance.

Home health care policy

This type of policy covers services prescribed by a physician and from a Medicare-certified or state-licensed home health care service. The care must help with activities of daily living or the supervision or protection of a patient with cognitive impairment (such as Alzheimer's disease or senility). Some policies offering nursing home coverage automatically offer home health care as well. Some companies offer home health care as an option or rider to a long-term care policy. A few companies offer policies covering only home health care. You may obtain more information about policy options from your agent.

Nursing home care policy

This limited-benefit insurance policy offers an alternative for some people and covers either one level or several levels of care. In Florida, the levels of care include custodial, intermediate and skilled (defined in the Glossary). Cognitive impairment or the inability to perform one or more of the activities of daily living will activate the benefit.

You may obtain the free guide Long-Term Care and Other Options for Seniors by calling the Consumer Helpline toll-free at 1-877-MY-FL-CFO (1-877-693-5236), or by downloading it from the DFS Web site at www.MyFloridaCFO.com.

For definitions of deductible, coinsurance and copayment, see the Glossary in the back of this guide.

HEALTH SAVINGS ACCOUNTS

Health Savings Accounts (HSAs) are new tax-free savings plans that Floridians can take advantage of to pay for qualified medical expenses. This program allows consumers to deposit pre-tax dollars into their HSA up to the level of their deductible. HSAs must be used in conjunction with a high-deductible health plan. To qualify, the health plan must have a minimum deductible of $1,000 (up to $2,650) for an individual policy and $2,000 (up to $5,150) for a family policy. The insurance premium is paid for outside of the HSA. For a list of companies offering qualifying insurance policies, please call the Department or visit our Web site at www.MyFloridaCFO.com. For more information on HSAs, please visit www.ustreas.gov/offices/public-affairs/hsa, or call the Internal Revenue Service at (202) 622-6080.

COBRA

The Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) allows retiring employees, or those who lose coverage due to quitting a job or reduced work hours, to continue group coverage for a limited period of time. This also applies to their dependents who lose coverage because of divorce or legal separation; death of the covered employee; the covered employee qualifying for Medicare; or a loss of dependent status under the health plan's provisions. COBRA applies only to employers with 20 or more employees.

If you qualify for COBRA benefits, your health-plan administrator must give you a notice stating your right to choose to continue benefits provided by the plan. You then have 60 days to accept coverage or lose all rights to the benefits. Once you select COBRA coverage, you may have to pay 100 percent of the total insurance cost, plus a 2 percent processing fee. To obtain a free publication that explains COBRA in more detail, call the Employee Benefits Security Administration at 1-866-444-3272.

Mini-COBRA

Florida's mini-COBRA law provides similar continuation of coverage protection for employees who work for employers with fewer than 20 employees.

Note: Under Florida's mini-COBRA law, the employee must notify the insurer within 63 days of losing group eligibility that he or she is eligible to continue coverage.

Qualifying For COBRA And Mini-COBRA

Continuation of coverage runs from a minimum of 18 months to a maximum of 36 months, depending upon the individual situation. The coverage may continue for an additional 11 months for an insured's disability that occurs during a qualifying event such as termination (except for gross misconduct) or a reduction in work hours for the employee; however, it cannot exceed the limit of 36 months. Other qualifying events may include:

- A beneficiary loses coverage due to the employee's death;
- A divorce or legal separation of the employee and a spouse;
- The employee's qualification for Medicare; and
- A dependent child's loss of status under the health plan's provisions.

In addition, Florida law gives you the option of converting your policy to an individual plan if you leave the group. If you terminate employment, get divorced or reach age 25 and no longer qualify under a parent's group plan, you may convert your group policy to an individual policy. A conversion policy usually costs more than a group policy. It may provide fewer benefits, but you don't need a physical exam to qualify for coverage.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Federal provisions referred to as the Health Insurance Portability and Accountability Act, and various Florida laws implementing this act, govern many important health insurance continuation situations. Whenever you have a question concerning your health care coverage circumstances when your coverage is terminated, you lose health care benefits when your employment or COBRA ends, or your coverage changes because of a change in carriers or a change in your job, you may find yourself in a situation where HIPAA protections apply.

If you have any questions regarding your health insurance, you may call the Consumer Helpline toll-free at 1-877-MY-FL-CFO (1-877-693-5236) to discuss your options under HIPAA and state law.

Portability

One of the most important HIPAA protections involves credit for prior coverage, often referred to as portability. HIPAA requires that time spent under previous coverage reduces any waiting period for a pre-existing condition under a new group plan you join. The law also limits these waiting periods to 12 months for a new employee joining the plan or 18 months if an employee decides to join the plan at a later date. (However, a pregnant woman who changes jobs and joins a new plan with two to 50 employees does not have to fulfill a waiting period before the health plan must pay for health care services associated with the pregnancy.)

Your insurance company will issue a "certificate of previous coverage," which is your proof of prior coverage and is required to be issued to you when your coverage terminates. This certificate will include a statement of how long you and any dependents were insured. It will also explain to your new employer or company the range of benefits and coverage you had under that plan or policy.

You may have had health plan benefits for the most recent 12 months from either a group plan or an individual insurance policy. In either case, your previous coverage will generally reduce any waiting period for a pre-existing condition if you apply for a new group plan within 63 days.

Please note: The waiting period a new employee experiences before they are eligible for benefits is not included in the calculation of the 63 days.

"Guaranteed-Issue" Individual Health Insurance Policies

Normally, people seeking individual medical coverage submit to medical underwriting to determine if they are sufficiently healthy to qualify for coverage. However, under certain circumstances, individuals may qualify for guaranteed-issue health policies by virtue of HIPAA and state law, meaning that the coverage must be issued regardless of the applicant's health status.

Who Qualifies For A "Guaranteed-Issue" Policy?

There are important requirements that determine whether you qualify for a guaranteed-issue, individual health insurance policy:

- You previously held membership under an employer group health, governmental or church plan, and no longer qualify for that plan or any other group plan;
- You exhausted any available COBRA or similar continuation of coverage periods;

- You have had 18 months of coverage with no "break in coverage" for a period greater than 63 days in which you lacked group or COBRA insurance; or

- You were issued individual medical coverage in Florida because your insurer withdrew from your area and you lost coverage, or you moved to another county in Florida where your current medical plan is no longer applicable.

What do I qualify for?

If your prior group coverage was an insured medical plan governed by Florida law, you qualify for a choice of plans that "convert" you to individual coverage, called a "conversion" plan.

If your prior group coverage was through a self-insured group plan, or from an employer group insurance plan governed by the laws of another state, or you lost your individual coverage as mentioned above, then you are entitled to apply to receive a guaranteed-issue individual plan from any carrier marketing to individuals in the state. Such a carrier must offer you the two most popular products it is currently offering.

An exception applies when the administrator of a self-insured group health plan offers a conversion option that complies with Florida law. In this case, you will not qualify for any other guaranteed-issue plan except for a choice between the conversion options above.

Guaranteed-issue individual policies include the following protections:

Credit for prior coverage

If you have 18 months of previous coverage without a break of 63 days or greater, you will not have a pre-existing condition waiting period for your individual policy to begin. Your previous coverage acts as a "credit" against the longest of such periods (24 months) that an insurer may require for a guaranteed-issue policy. Any previous coverage of your spouse or dependents also acts as a credit.

Coverage for a pre-existing condition

The policy may not completely exclude coverage for pre-existing conditions for you, your spouse or dependents by issuing a rider to the policy.

Coverage for a newborn or newly adopted child

If your child was born or adopted within the last 18 months, the child does not have to meet a "prior coverage" requirement. The child qualifies for benefits as soon as the policy begins.

DFS is ready to help you understand your HIPAA or health care continuation questions. If you or your insurance agent has a question, call the Consumer Helpline toll-free at 1-877-MY-FL-CFO (1-877-693-5236). You may also call the Helpline to find out if a company sells individual health insurance in Florida.

THINGS TO CONSIDER WHEN COMPARING HEALTH CARE OPTIONS

Choosing a health care plan is an important decision. A health care plan provides financial protection from the costs of an unforeseen event or condition. You should make sure that the company that you are purchasing coverage from, as well as the agent, are licensed. Your financial needs and your ability to absorb routine costs will affect the type of policy you purchase. Purchasing a policy that provides for first dollar protection is very expensive. You need to evaluate your financial needs and decide what level of costs you are able to handle and for what level of costs you need to purchase financial protection. The greater the cost sharing between you and the company, the lower the premium cost will be to you. If you purchase coverage at a lower premium, but the policy will not pay costs until a certain dollar value is reached, you need to be able to meet this cost responsibility. Consider the following features when comparing health care options.

What Will You Pay Out-Of-Pocket?

Premium — This is the monthly or annual amount you pay for your insurance policy.

Maximum out-of-pocket — This is a provision that limits the amount you pay out-of-pocket for covered claims.

UCR (usual, customary and reasonable) — This is the amount of a claim that the policy will reimburse based on an average range of fees for given procedures, geographic areas, etc. Often, the provision will limit the amount the company will pay, so be aware of UCR provisions. This is an important feature that should be considered. Two otherwise identical policies could provide substantial reimbursement differences based on how the company defines UCR. This is not consistent between carriers.

You will also be responsible for the deductible, coinsurance and/or copayment. For definitions, see the Glossary in the back of this guide.

What Provisions Might Affect Your Coverage?

Coordination of benefits — With this provision, you will not receive more benefits than your actual hospital and medical expenses, even though you may obtain another policy. A husband and wife with family coverage under separate group policies can't collect for the same claim twice, even if they paid two premiums.

Renewal and premium increases — This provision determines the cases when 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 exam to prove good health.

QUESTIONS AND ANSWERS ABOUT PREMIUMS

Why Do Companies Raise Premiums?

Insurance companies often raise premiums when the cost of claims they must pay increases.

Medical-cost inflation, a major factor that contributes to premium increases, measures the increased cost of a particular procedure each year.

Medical utilization, or the number of times doctors perform a procedure each year, also causes premium increases.

Cost shifting occurs when hospitals raise their rates for services to offset the cost of caring for nonpaying or indigent patients. In addition, new technologies, tests and medical malpractice claims can contribute to cost shifting and increase the cost of health insurance.

What Do Your Premiums Pay For?

Premiums help pay policyholders' claims and other expenses, such as agent commissions, premium taxes and administrative expenses.

How Do Insurance Companies Determine Premiums?

An insurance company considers many factors when setting premiums, such as:

- medical-care costs,
- coverage,
- age of the policyholder (both current age and the age at which the policy was issued),
- gender,
- lifestyle habits (such as smoking),
- geographic area and
- riders purchased.

One example from the last category, called a waiver-of-premium rider, would require you to pay higher monthly premiums if selected. In return, the company would pay your premium if you became sick and couldn't pay it.

Consumer Alert

A recent legislative change provides that companies offer up to a 10 percent annual premium rebate for participation in wellness programs. You should inquire about this rebate with your company.

Also, a Florida law rewards individuals who find improper charges on their health care bills. The law attempts to help contain the ever increasing costs of insurance and health care. You should carefully review the charges when you receive a bill from your hospital, doctor or other health care provider. You should verify that your bill covers only procedures you actually received. This will also help you to watch out for "double billing," or being charged twice for the same procedure. If you see a mistake, you should notify your insurance company in writing. You may receive 20 percent of the reduction amount, up to $500, for an incorrect bill that merits a reduction.

RENEWABLE CONDITIONS AND PREMIUM INCREASES

Conditions for renewals and premium increases vary from policy to policy; ask your insurance agent or company representative about the conditions of the policy under consideration. You should also know these key terms:

Conditionally renewable
Under this condition, an insurance company may renew a policy until the policyholder reaches a certain age. The company may decline renewal or increase premiums under specified contract conditions. For example, a company may decline the renewal of your policy because of a career change. Most companies decline renewals for reasons other than a policyholder's failing health.

Guaranteed renewable
This means a company must renew a policy for a specific period. Companies must raise premiums consistently for all insureds in the same class.

Noncancelable
Under this condition, an insurance company can't cancel your policy or increase your premium if you pay on time.

Optionally renewable
This means an insurance company may cancel a policy at the end of the contract period for any reason, and increase premiums at any time.

Short term, nonrenewable
This means that you can't renew your policy at the end of the policy term. Premiums remain constant for the policy period, which usually lasts a few months.

Under Florida law, your company must give you a 45-day notice, in writing, of cancellation, nonrenewal or premium change; HMOs must provide notice within 30 days. However, your company must only provide a 10-day notice, in writing, for a cancellation due to your failure to pay premiums.

- Take your application for coverage seriously, and answer the health questions thoroughly– an insurance company may refuse to pay your claim or cancel your policy due to an incorrect or incomplete application.

- Watch out for "telemarketing fraud," or high-pressure schemes in which a telephone caller may try to sell you unnecessary or unwanted insurance. Such a caller may use deceptive tactics, such as asking you to pay premiums in cash for a "last chance" offer. Ask for written policy information and thoroughly research the insurance agent and company credentials. If you suspect this type of crime has occurred, you may call our Fraud Hotline toll-free at 1-800-378-0445, or the Florida Department of Agriculture and Consumer Services at 1-800-HELP-FLA (1-800-435-7352). For a nominal fee, the Department of Agriculture and Consumer Services can add you to a list that telemarketers are forbidden to call. You can also register with the National Do Not Call Registry by visiting www.donotcall.gov or by calling 1-888-382-1222.

- Contact your policy administrator if you want to convert from group to individual coverage because of divorce, age restrictions, etc.

- Your company must notify you in writing at least 45 days before canceling or not renewing your contract, or changing your premiums. HMOs must provide notice in 30 days. You may contact the Consumer Helpline toll-free at 1-877-MY-FL-CFO (1-877-693-5236) if you don't receive such notification.

- You are entitled to a "free look" period of 10 days when you purchase an individual health insurance policy. You should return the policy by registered or certified mail within the allowed time if you decide not to keep it.

- You are entitled to a "grace period," which is a specified time frame when you can submit an overdue payment and still maintain coverage under your policy.

- Ask your agent if the coverage involves an out-of-state policy; if so, you should make sure it contains all the coverage you need before you buy it. Read everything carefully. If your document says it is a "certificate," you may have an out-of-state policy.

- Before buying additional policies, it pays to understand how your current coverage will work with another policy. Do not overinsure–you cannot collect on the same claim twice.

- Maintain continuous coverage by not canceling your old policy until you are certain that your new company has accepted your application. Some companies do not begin coverage until they approve your application and notify you.

- Pay your premiums, even if a dispute arises with your company. Otherwise, it may cancel your policy for nonpayment of premiums.

What About Coverage For "Alternative" Therapies

Due to increasing consumer interest, some health insurance companies and health maintenance organizations now offer coverage for "alternative" medicine and therapies, such as herbal supplements, acupuncture, massage, etc. In some cases, alternative treatments cost less than conventional approaches. However, widespread coverage for alternative medicines will probably not occur until medical experts can conduct long-term studies and additional research. The existing coverage generally involves limited reimbursement and other restrictions.

FILING CLAIMS

Florida law standardizes the claim forms used for health insurance. Many doctors and hospitals keep claim forms on hand and will file them for you. The following guidelines can help speed up the claims process.

- Inform your insurance company about a claim in writing within 20 days of the accident or illness. You must file your claim within 90 days.
- Contact your agent if you need help filing your claim. You should fill out all claim forms accurately and completely; attach copies of bills when requested, and keep your originals. Have your doctor and hospital representative complete (and sign, if necessary) their sections of the form right away.
- Keep copies of everything you send the company or the company sends to you, including a record of the date you filed the claim.

Please note: Your company should pay a claim promptly after it receives a completed claim form. The company should also provide an explanation for a partial payment or a rejected claim.

For more information, contact your insurance company or HMO representative, or your employer's human resources office. You should also seek competent medical advice from your doctor and other health care professionals.

HOW TO SELECT AN INSURANCE COMPANY

When selecting an insurance company, it is wise to know that company's rating. Several organizations publish insurance company ratings, available in your local library and on the Internet. These organizations include: A.M. Best Company, Standard & Poor's, Weiss Ratings Inc., Moody's Investors Service and Duff & Phelps. Companies are rated on a number of elements, such as financial data (including assets and liabilities), management operations and the company's history.

Before buying insurance, verify whether a company is licensed to sell insurance in Florida by calling the DFS Consumer Helpline toll-free at 1-877-MY-FL-CFO (1-877-693-5236). Be sure to have the full, legal name of the insurance company when you call. You can also go to www.MyFloridaCFO.com and click on the "Verify Before You Buy" button at the bottom of the page to search for licensing information.

HOW TO SELECT AN INSURANCE AGENT

When selecting an agent, choose one who is licensed to sell insurance in Florida. Some agents have professional insurance designations such as the following:

CEBS - Certified Employee Benefits Specialist
CFP - Certified Financial Planner
ChFC - Chartered Financial Consultant
CIC - Certified Insurance Counselor
CLU - Chartered Life Underwriter
CPCU - Chartered Property and Casualty Underwriter
LUTCF - Life Underwriting Training Council Fellow
RHU - Registered Health Underwriter

Make sure you select an agent with whom you feel comfortable and who will be available to answer your questions. Remember: An agent may represent more than one company. To verify whether an agent is licensed, call the Consumer Helpline toll-free at 1-877-MY-FL-CFO (1-877-693-5236). You can also go to www.MyFloridaCFO.com and click on the "Verify Before You Buy" button at the bottom of the page to search for licensing information.

MEDICAL PRIVACY AND THE MEDICAL INFORMATION BUREAU

The Medical Information Bureau (MIB) is a data bank of medical and nonmedical information on nearly 15 million Americans, collected from the MIB's 800 insurance company members.

The companies send the MIB information you have written on applications, enrollment forms, and requests for upgrading coverage for health, life or disability insurance. The MIB also records information from medical exams, blood and lab tests, and hospital reports, when such information is legally obtainable.

If you have been denied life or disability insurance and wonder why, your file at the MIB may be the answer. You have the right to make sure the information in your MIB file is correct. Call the MIB at (866) 692-6901 and ask for a copy of your records, or access its Web site at www.mib.com.

When you buy insurance, you have certain rights and responsibilities.

Your Rights

You have the right to receive a copy of the insurance policy or certificate governing your coverage.

You have the right to receive copies of all forms and applications signed by you or the agent.

You have the right to appeal any denied claims.

Your Responsibilities

You are responsible for reading and understanding your insurance policy.

You are responsible for reading and understanding any "explanation of benefits" forms sent by your insurance company. These forms usually state: "This is not a bill." However, you should still closely study them to make sure you actually received the medical services that your insurance company was billed for.

You are responsible for reporting suspected fraud to DFS. If you suspect a crime has occurred, call our Fraud Hotline toll-free at 1-800-378-0445.

You are responsible for making sure your application is accurate. This includes information on pre-existing conditions. If you make a fraudulent or unintentional misstatement on your application, the company may cancel your policy or refuse to pay a claim.

You are responsible for knowing what your policy covers and excludes.

You are responsible for paying your premiums, even while involved in a dispute with your company.

You are responsible for paying the deductibles outlined in your policy.

You are responsible for verifying licenses of an insurance agent and company by calling the Consumer Helpline toll-free at 1-877-MY-FL-CFO (1-877-693-5236).

Remember, a business card is not a license!

INSURANCE DISCRIMINATION AGAINST VICTIMS OF ABUSE

Florida law prevents insurance companies from discriminating against victims of domestic violence or abuse. If you are denied insurance, if your rates are raised, or if the insurer refuses to pay a claim, demand in writing that the insurer explain in writing why it took this action. If you believe you have been discriminated against, call the Florida Domestic Violence Hotline at 1-800 500-1119 or the Battered Women's Justice Project at 1-800-903-0111. You can also file a complaint through the DFS Consumer Helpline toll-free at 1 877-MY-FL-CFO (1-877-693-5236), or go to the Department's Web site at www.MyFloridaCFO.com.

SENIORS: NEED HELP WITH YOUR INSURANCE QUESTIONS?

The Florida Department of Elder Affairs has developed a program to help seniors with their Medicare and health insurance questions.

SHINE (Serving Health Insurance Needs of Elders) trains senior volunteers to assist other seniors with their questions about Medicare, Medicare supplement, long-term care and other health insurance issues. The Florida Department of Financial Services serves as SHINE's technical advisor and recommends the program to consumers. To find out if a SHINE program operates in your community, please contact the Elder Helpline toll-free at 1-800-96-ELDER (1-800-963-5337) or the Florida Department of Elder Affairs at (850) 414-2000.

INSURANCE FRAUD COSTS US ALL!

Insurance fraud costs each Florida family an additional $1,500 per year* in increased premiums. In fact, it can inflate your premiums by as much as 30 percent, according to the National Insurance Crime Bureau. This includes the money you pay for life, auto, health, homeowners and other types of insurance. You can protect your personal and family pocketbook by learning about the many different types of insurance scams. Some common examples include:

Fictional visit — A health care provider bills the federal Medicare program for unnecessary, unauthorized or fictional visits to a patient's home.

Rogue agent commits "stacking" — An insurance agent commits "stacking" by deliberately selling unnecessary health insurance to a consumer that duplicates existing coverage.

Applicant fraud — An applicant deliberately withholds information about a pre-existing condition in hopes of obtaining health insurance.

Unauthorized referral — A laboratory bills a health insurer for a patient's tests using information stolen from a referring physician. Actually, the physician has never seen the patient.

Deceptive billing — A senior sells insurance information to a health care provider, who bills Medicare for services never rendered. In some cases, such providers bill for as many as 800 phony services for one senior in a three-month period.

Many other types of insurance fraud exist. If you suspect such a crime has occurred, call the DFS Fraud Hotline toll-free at 1-800-378-0445.

*Source: The Coalition Against Insurance Fraud

GLOSSARY

Application
This document is a signed statement of facts that an insurer uses to determine whether to issue coverage. The application includes your name, age, address, and may include questions about your medical history. It becomes part of your health insurance contract.

Assignment
An assignment is a document signed by a policyholder authorizing a company to pay benefits directly to a hospital, doctor or other health care provider.

Coinsurance
This is the cost that a policyholder must pay out-of-pocket. Coinsurance usually involves a percentage of what a procedure costs. Many policies require the buyer to pay 20 percent up to a certain dollar amount.

Conversion Policy
A conversion policy is an individual policy or certificate issued when a person no longer qualifies as a certificate holder under group coverage or as a dependent under a group certificate or individual policy.

Copayment
This is a specified dollar amount a subscriber must pay for covered health care services. The subscriber pays this amount to the provider at the time of service.

Cost Shifting
This practice, used by hospitals, increases the cost of hospital services to offset the cost of caring for nonpaying or indigent patients.

Customary Charge
This is the range of usual fees charged by doctors of the same specialty in a given geographic area for a specific procedure.

Deductible
This is the amount you must pay out-of-pocket before an insurance company pays its share. Usually, the higher the deductible, the lower the premium.

Effective Date
This is the date on which health insurance protection begins.

Elimination Period
This is the length of time a policyholder has to wait after a covered illness begins before receiving benefits.

Exclusions
These are certain conditions (or life events) specified in a health policy for which there is no coverage.

Free Look Period
This is a 10-day period after you receive a health policy which allows you time to decide whether to keep it. This applies only to individual health policies.

Grace Period
This is a specified period in which a policyholder may submit an overdue payment and still retain coverage.

Guaranteed-Issue Policy
This type of policy is one that an insurance company must issue to you under certain circumstances, regardless of any health conditions you suffer from.

Insolvency
This is the inability of a company to meet financial obligations or debts.

Medical-Cost Inflation
This is an increase in insurance premium due to a rise in the cost of medical care. It

measures the additional cost of medical services from one year to the next. It does not consider the number of times doctors perform the procedure in a year.

Medical Utilization

This is the frequency of a policyholder's use of medical services in a given year resulting in an insurance claim. This term also refers to the number of times doctors perform a procedure in a year.

Medically Necessary

This is a medical procedure or treatment necessary to maintain or resume good health. Many insurance policies will only pay for medically necessary treatments.

Pre-Existing Condition

This is an illness, diagnosed or treated before buying a health insurance policy, that existed during the six-month period immediately preceding the policy's effective date. A policy usually will not cover a pre-existing condition until some time after the policyholder purchases the coverage.

Reasonable Charge

This is a fee that differs from usual or customary charges because of unusual circumstances involving medical complications that require additional time, skill and expertise.

Rider

This is an attachment to an insurance policy that specifies conditions or benefits the policy covers in addition to the original contract benefits.

Small Business

This is a business that has one to 50 employees.

Stop-Loss Limit

This is a provision that limits the amount of coinsurance a policyholder must pay.

Surgical Schedule

This is a list of cash allowances payable for various kinds of surgery. The severity of an operation determines the maximum amount payable.

Usual Charge

This is the fee a doctor most frequently charges patients for a procedure.

Waiting Period

This is the time between the date a policy becomes effective and the date benefit payments begin.

Levels of Nursing Care

There are various degrees of nursing care. The three levels often referred to in Medicare, Medicare supplement and other insurance policies include the following:

Skilled Nursing Care –This level of care provides daily (around-the-clock) nursing and rehabilitative care performed by or under the supervision of a registered nurse or a doctor.

Intermediate Care –This level of care provides less than 24-hour daily nursing and rehabilitative care performed by or under the supervision of skilled medical personnel. Care must be supervised by a registered nurse or a doctor.

Custodial Care –This lower level of care does not require a nurse to administer it. It may be provided in a nursing home or a private home, but must be recommended by a doctor. This care includes help with activities of daily living. A Medicare supplement policy provides limited nursing care coverage, as it supplements Medicare payments for skilled nursing care, but not intermediate or custodial care.

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