A CONSUMERS GUIDE TO GROUP HEALTH INSURANCE IN ARIZONA

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I.

What You Need to Know About Health Insurance

Rising health care costs have made it very expensive to be injured or ill. If you do not have good medical insurance to help pay the bills, a serious injury or illness can create major financial problems. **Having no coverage, too little coverage, or the wrong kind of coverage can be a costly mistake.**

Many types of health insurance are available at various prices. Some policies pay most of your health care bills for any serious injury or illness. Others pay only some of your bills or only for certain injuries or illnesses. Some policies pay an amount directly related to your actual health care costs. Others pay a specific amount for each day that you are in a hospital, without regard to your actual bills.

Even similar types of policies can vary in the details of their coverage. Health insurance should be selected carefully to make sure that you are getting adequate protection for your needs.

This brochure lists most types of health insurance. Your eligibility will vary from company to company, and may be determined by such things as your age, gender, health status and occupation.

II.

Types of Group Health Insurance Policies

- **Major Medical Expense**

This type of policy is usually effective in covering serious illness or injury where costs are high. Expenses you incur both in and out of the hospital, including drugs and doctors' visits, usually are covered. Most major medical plans contain a deductible -- the amount you pay before the insurance company begins paying benefits. After your expenses exceed the deductible amount, benefits are paid as a percentage of actual expenses, often 80 percent.

- **Disability Income Protection**

This coverage provides for weekly or monthly benefit payments while you are disabled after a covered injury or sickness.

The disability payment is usually a set dollar amount not to exceed a certain percentage of your income. Usually the most you can qualify for is approximately 60 percent of your gross earnings.

Be aware that some disability income policies contain an elimination period, measured from the start of each disability. During that time, no benefits are paid. Elimination periods vary, generally from 30 days to six months, depending on the policy. A longer elimination period may provide lower premium payments.

Also, many disability income policies reduce benefits based on other income to which you may be entitled, such as sick leave pay, disability retirement income, and Social Security disability benefits.

- **Accident Only Coverage**

This policy covers losses due to an accident. Benefits vary greatly. Coverage may be provided for death, loss of limb or sight, disability, or hospital and medical care.

- **Specified Disease or Specified Accident**

Some policies cover a specific disease, such as cancer, or a specific kind of accident, such as while traveling away from home. Benefits are not paid for any other sickness or injury. The benefits may be based on your actual medical expenses or payable as a lump sum indemnity.

- **Medicare Supplement**

The federal Medicare program pays most medical expenses for people 65 or older, or for individuals under 65 receiving Social Security disability benefits. However, Medicare does not pay all expenses. As a result, you may consider purchasing a Medicare Supplement policy that helps pay for certain expenses, including deductibles not covered by Medicare.

- **Long-Term Care**

This policy usually pays for skilled, intermediate and custodial care in a nursing home.

It usually pays a fixed amount per day while a person is in a nursing home. Most policies contain elimination periods, during which no benefits are paid. Some policies also cover alternative types of care such as home health care or adult day care. Some even cover home modification expenses.

Normally, these policies pay only for expenses in facilities that are licensed by the state and/or participate in Medicaid and Medicare, and meet the policy's definition of skilled, intermediate or custodial care. For this reason, it is important to find out about the types of nursing homes that are in your area before you buy the policy.

- **Health Maintenance Organizations (HMOs)**

These organizations provide health care services directly to their members, who pay a fixed monthly fee to the HMO. These services include such things as hospital care, surgery and routine office visits. The HMO is an alternative to traditional health insurance because it provides actual services rather than just reimbursement for health care expenses. Enrollees usually pay a small co-payment for care or services they receive.

There are various ways that HMOs can be set up. Some HMOs employ their own physicians, who treat patients at an HMO center. Others contract with individual physicians or groups of physicians. Patients are treated at the physicians' offices or health centers. Usually, HMO members must receive health care treatment at a designated hospital, HMO facility or from physicians who contract with the HMO.

Before you pay a fee to join an HMO, ask questions about how it works and where you would receive care, and talk to people who belong to it. Consider whether you will have to stop seeing a particular physician and choose another.

- **Preferred Provider Organizations (PPOs)**

Under this program, an insurance company enters into contracts with selected hospitals and doctors to furnish services at discounted rates. As a member of a PPO, you might be able to seek care from a doctor or hospital that is not a preferred provider, but you will probably have to pay a higher deductible or co-payment.

- **Point of Service (POS)**

This plan combines the benefits of an HMO and traditional health insurance. Enrollees can use providers in the HMO for a nominal co-payment or seek care outside the HMO network where a deductible and a share of the expenses, often 20 percent to 30 percent, may have to be paid.

III.

Waiting Periods, Preexisting Conditions, Exclusions and Limitations

These provisions limit or exclude the insurance company's obligation to pay benefits. **Policies have a list of exclusions and limitations.** Policies with fewer exclusions may be more expensive than policies with more exclusions. Make sure you understand what will and will not be covered.

- **Waiting Periods**

A waiting period is the amount of time that must pass after the policy takes effect and before coverage begins. If a policy has a waiting period, benefits will not be paid or they might be limited for expenses that arise during a specific number of days after the policy is in effect. Waiting periods are not applicable in some cases if an individual had certain types of prior coverage. Waiting periods may apply only to certain conditions or services.

- **Preexisting Conditions**

Individual policies usually will not pay benefits until a certain time period has elapsed for a health condition you had when you bought the policy. This type of health condition is known as a "preexisting" condition. Exclusions for preexisting conditions are intended to preclude individuals with an illness or injury from waiting to buy a policy until they need treatment that would otherwise be paid for under the policy.

You should know the meaning of any provisions excluding benefits for preexisting conditions. Also, you should know how long the provision will exclude benefits for preexisting conditions. Many claims are denied because of these provisions.

If you are covered by a group policy provided by your employer, the waiting period for preexisting conditions cannot be any longer than 12 months. It may be less or not applicable at all if you have had previous group coverage.

Do not think that because the application asks no questions about your health or medical history or the policy requires no physical examination, the policy will cover conditions that you already have. It probably will not. If the company asks questions about your health history it is important to answer them truthfully.

Under some definitions a condition would be considered "preexisting" even if you did not know that you had the condition before you bought your policy. Also, you need to know how many previous years will be considered for determining a preexisting condition. A group health plan provided through your employer cannot look back any further than six months before your effective date.

- **Other Exclusions**

In addition to preexisting conditions, health insurance policies usually exclude illness or injury resulting from war or military service or those covered under workers' compensation.

IV.

Know Your Rights When Buying Group Health Insurance

COBRA, which gets its name from the Consolidated Omnibus Budget Reconciliation Act of 1986, is a federal program that gives many individuals the right to continue coverage under a group plan. This law applies to insured plans and self-funded, employer-sponsored plans.

HIPAA, the Health Insurance Portability and Accountability Act of 1996, limits insurers' power to deny or delay claims; reduces your chances of losing existing coverage; makes it easier and less risky to switch health plans; and prohibits insurance discrimination based on health problems.

- If you are leaving your job and you had group coverage, you may be able to stay in your plan an extended time (usually 18 months) through COBRA continuation coverage.

- If you are leaving a fully insured group or individual health plan, you may be able to buy a health policy from the company that provided your prior coverage. This is called a conversion policy. The benefits may not be as generous as those under your former plan.

- Under Arizona law, if an individual or group health policy provides family coverage, newborns, adopted children and children placed for adoption are automatically covered under the parents' fully insured health policy for the first 31 days. The insurer may require notification of birth within 31 days to continue coverage beyond the 31-day period.

- If you change jobs or your employer changes health insurance companies you will usually receive credit toward any waiting periods under the new plan.

V.

Renewal Provisions and Changing Of Premium Rates

The renewal provision defines how the policy can be renewed as well as the insurance company's right to revise the policy and the premium rates. This provision can affect the cost of a policy and the coverage. Here are the basic renewal provisions:

- **Noncancelable**

Under this policy, the insurance company cannot change, cancel or refuse to renew the policy as long as premiums are paid on time. The premium rates cannot be changed. However, the policy can provide for scheduled rate increases as you age.

- **Guaranteed Renewable**

Under this policy, you have the right to renew your policy until a specified age.

- **Conditionally Renewable**

This type of policy allows you to renew until a specified age, subject to the insurance company's right to decline renewal under conditions specified in the contract.

- **Term or Nonrenewable**

These policies cannot be renewed, and are often purchased to provide coverage for a short period of time.

VI.

Health Care Appeals

If, after you have purchased a health insurance policy, you disagree with the insurance company regarding a denial of a claim or a request for a medical procedure, you can file a formal appeal. The first step is for the consumer to appeal directly to the insurance company. If the insurer denies a formal appeal, the consumer has 30 days to request an external, independent review. Those appeals are referred to the Arizona Department of Insurance or to an independent medical reviewer approved by the Insurance Department.

An Expedited Medical Review is also available when denial of a treatment or service could cause a negative change in your medical condition. The Insurance Department offers a free brochure that spells out in detail how the Health Care Appeals process works.

VII. Medicare

Medicare is a federal program administered by the Center for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services. Call CMS at (1-800) MEDICARE (1-800-633-4227), or call the State Health Insurance Assistance Program (SHIP) at (800) 432-4040.

If you have questions or complaints regarding specific insurers, contact the Consumer Affairs Division of the Arizona Department of Insurance:

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