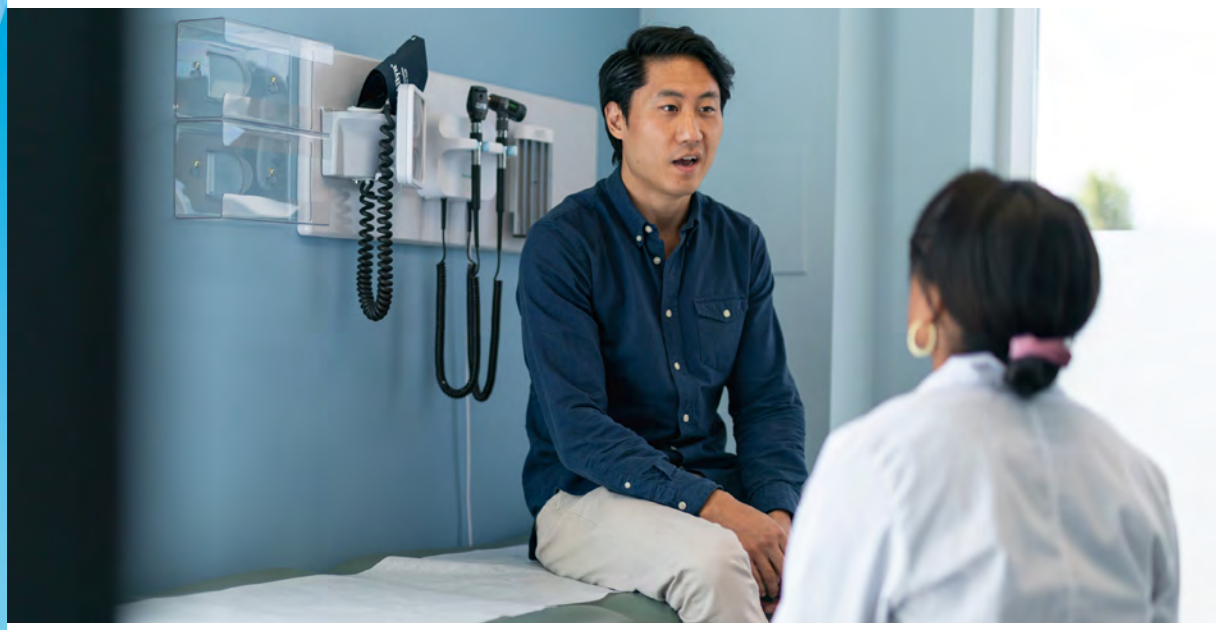
Department of Insurance

HEALTH Insurance Guide

This Guide:

Describes how to find and use health insurance
Explains how to appeal a decision by your health plan



Mike DeWine ,Governor | Jon Husted, Lt. Governor | Judith L. French, Director

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Disclaimer Notice:

The information included in this publication is meant to serve as a guide and is not a substitute for legal or professional advice. Please be certain to check with a professional if you have questions. May change without notice.

The Basics of Health Insurance

This guide was created to help individuals, families, self-employed people, and small business owners understand some of the basics of health insurance.

If you have health coverage, keep it. Unless the policy owner (you or your employer) stops paying premiums, the health plan cannot cancel your coverage even if you get sick. The law allows you to keep coverage through life-changing events (divorce, changing jobs, job loss, etc.) though the coverage and/or premiums may change depending on the situation.

Not having health insurance can be a dangerous decision. If you're not covered and have an accident or develop a serious illness, it can be financially devastating.

What is Health Insurance?

Health insurance is a general term used to describe many kinds of insurance coverage. For most people, the term "health insurance" means comprehensive health insurance.

This is the broadest kind of health insurance and covers most of the cost of keeping you healthy and getting you healthy if you become ill. Comprehensive health insurance includes doctor visits, hospital care, tests, certain therapies, and sometimes prescription drugs. Medicare and Medicaid provide such comprehensive coverage to eligible people.

Types of Comprehensive Health Insurance Plans

Comprehensive health insurance plans can be offered by employers or on an individual basis through a variety of insurance companies. Coverage can be in the form of managed care or traditional health insurance.

Managed Care

Managed care is a type of health delivery system that includes participating providers who contract with the health plan.

The providers manage the care of their patients. Types of managed care plans include HMOs (called health insuring companies (HICs) in Ohio), PPOs, and POS plans.

Some managed care plans require you to have a Primary Care Physician (PCP). If so, you must rely on your PCP anytime you need a service.

When appropriate, the PCP will refer you to a specialist within the plan's network. The plan may allow you direct access to the specialist depending on the seriousness of your condition or if you require specialized care over a long period of time.

Point-of-Service (POS)

A POS plan, also known as an open-ended HMO, is a blend of HMO and PPO coverage. You may use doctors in the HMO network or you may choose other doctors. You pay a higher cost if you use doctors outside the network.

Preferred Provider Organization (PPO)

Preferred Provider Organization is a plan that contracts with independent providers at a discount for services. The enrollees may go outside the network, but would pay a greater percentage of the cost of coverage than within the network.

Traditional Health Insurance

Under traditional major medical insurance, you are covered to use any hospital or doctor.

Traditional insurance plans normally require you to pay a monthly premium, an annual deductible and coinsurance for each service.

Coverage Provided by Employers

Most Ohioans get health insurance coverage through their employers. It is important to understand, however, that employers offer insurance voluntarily — no law requires it.

The employer may offer insurance that covers only you, or may offer coverage to you and your dependents. Plan coverage details may be based on whether you are part of a large or small employer group.

Some large employers self-insure the health benefit plans that cover employees. If your employer is self-insured, it means the employer, not an insurance company, is responsible for payment of your covered health care services.

These plans may be administered by the employer itself or the employer may contract with an outside administrator (often a health insurance company) to process claims.

The best way to know if your plan is self-insured is to ask your employer's Human Resources department.

Many self-insured plans are not subject to state insurance laws. The U.S. Department of Labor regulates most aspects of self-insured health plans under the Employees Retirement Income Security Act (ERISA).

Health Savings Account (HSA) with a High-Deductible Health Plan

Employers may offer Health Savings Accounts to employees. HSAs are savings funds that allow you to pay some health care costs with tax-free dollars. HSAs let you pay for current medical expenses and save for future qualified medical and retiree health expenses on a tax-free basis.

In order to use a health savings account you must also have a high-deductible health plan to use with it. Under a high-deductible health plan, you pay a lower premium and accept greater risk.

Professional Organization Plans and Association Plans

Sometimes associations such as local chambers of commerce and professional organizations offer group health plans. You may also qualify for health insurance through a religious or fraternal organization.

Coverage Individuals Can Buy Directly

If you cannot get health insurance through your employer (or your spouse's / partner's employer) or are self-employed or not employed, you may be able to buy health insurance coverage for yourself and your family. This is called individual coverage.

There are different avenues for buying individual coverage: through the individual private market, (temporary) COBRA or state continuation, (permanent) coverage, HIPAA-eligible, or state-sponsored insurance (Medicaid).

If you change jobs or leave group coverage, you should know your rights to continue or convert the old coverage. Although the coverage can be costly, you are allowed by law to keep your family covered.

An insurance agent can help you find appropriate insurance in the private insurance market, or you can call the Ohio Department of Insurance at 800-686-1526 with questions about your options.

Public Health Insurance Plans

Depending on your situation, you may qualify for a government health insurance program, such as Medicaid or Medicare. If you can't afford health insurance, the Ohio Department of Job & Family Services — the agency that administers Medicaid — may be able to help. You can contact Medicaid by calling 800-324-8680.

Other Helpful Numbers:

US Department of Labor
866-487-2365 dol.gov

Ohio Department of Health
614-466-3543 odh.ohio.gov

Ohio Department of Medicaid
800-324-8680 jfs.ohio.gov

Medicare.gov
800-633-4227 medicare.gov

Ohio Public Health Department
614-221-5994 aohc.net

Ohio Family Coverage Coalition
800-634-4442 uhcanohio.org

Types of Non-Comprehensive Health Insurance Plans

Short-Term Health Insurance

Short-term insurance will generally provide coverage for no longer than one year. Because you cannot carry eligibility from prior coverage to a short-term health policy, no short-term health policy covers pre-existing conditions. College alumni associations may offer this option to recent graduates.

Student Group Coverage

Many colleges and universities offer health insurance to enrolled students and may offer coverage for an extended period of time after graduation.

Disability Insurance

Disability insurance is sometimes called supplemental income insurance. It pays a fixed amount for a specified period of time when you can't work because of an accident or illness. Coverage may be short-term or long-term. Your employer may offer this coverage or you can purchase it on your own.

Benefits and eligibility requirements can vary greatly, depending on such things as how the plan defines disability, waiting periods, length of hospitalization and exclusions.

Cancer Insurance

Cancer insurance provides benefits only if you get cancer. Like all insurance products, the policy will not be offered to you if cancer was diagnosed before you applied for the coverage.

Dental Insurance

Some companies provide dental insurance to their employees and plans are available for individuals as well. Plans normally have a network of dentists they prefer you to use. You may still get benefits if you use a dentist who is not in the plan's network, but your coinsurance will be lower by choosing an in-network dentist.

Vision Insurance

Employers may offer vision coverage; plans may also be purchased by individuals. Vision insurance is a wellness benefit that helps pay your costs for eye exams, corrective lenses and other vision services. Some plans require you to use a provider network.

Long-Term Care (LTC) Insurance

Insurance that pays for care given in a skilled nursing facility, adult care facility or at home. Covers chronic medical conditions and helps with activities of daily living.

Other Options

Health Discount Cards

Coverage through a discount card is not health insurance. Such cards simply discount the cost for medical services when received from certain doctors and other providers. Health discount cards can save you money but they do not offer the protections carried by actual health insurance.

If health insurance is not available to you — for whatever reason — a discount plan may help lower your medical costs. Always read the membership agreement and use the plan wisely. The Ohio Department of Insurance has limited authority over these plans.

Possible Additional Benefits in Ohio Plans

Prescription Drug Coverage

Ohio law does not require health plans to cover prescription drugs. Plans that do provide this coverage can exclude a specific drug or a specific class of drugs (example: birth control pills). If your health plan covers prescriptions, it may have a formulary — a list of the drugs it will pay for.

It may be possible for you to get a drug that's not on the plan formulary if your doctor certifies the formulary drug will not treat your condition effectively or that it could cause a bad reaction.

Mental Health Coverage

All health plans in Ohio must provide coverage for the diagnosis and treatment of biologically-based mental illness. Care must be provided on the same terms and conditions as that of all other physical disorders, except in limited circumstances.

A plan must also provide prescription drug coverage for biologically-based mental illness if prescription drugs are covered for physical illness. Benefits must have the same copays, deductibles and cost sharing requirements for physical illnesses.

Employers and insurers may negotiate rates of reimbursement and may establish provider networks to deliver mental health services to their insureds.

Well-Child Coverage

HMOs cover well-child care for all children. Traditional plans that offer family coverage must help pay for certain routine benefits for children, such as complete physical exams, developmental assessments, anticipatory guidance, lab tests and immunizations from birth through age eight. Plans are not required to pay more than $500 in benefits the first year, and no more than $150 each year from age one through age eight. As of age nine, this coverage is not required.

Mentally Impaired or Handicapped Child Coverage

Group policies for family members normally stop covering children who have reached the range of 26 years old. But if your child is mentally or physically impaired the coverage must be continued for as long as the child must depend on you for maintenance and support.

Domestic Partner Coverage

Ohio law does not require health insurance plans or private employers to provide coverage for domestic partners and their families. The law also does not prohibit such coverage, therefore check your policy for more information about whether this coverage is available.

Hospitalization and Emergency Care

Except in emergency situations, most health policies require you or your doctor to tell the plan before you check into a hospital.

Insurance companies call this procedure pre-certification, and they use it to determine whether your hospitalization is medically necessary. Your policy or benefits booklet should explain the procedure to follow and list a phone number you or your doctor can call. The company may also require notification before you have outpatient elective surgery, visit a specialist or have expensive tests such as a Computed Axial Tomography (CAT) scan or Magnetic Resonance Imaging (MRI).

Please note: pre-certification determines medical necessity, but does not guarantee payment, even if surgery has been performed.

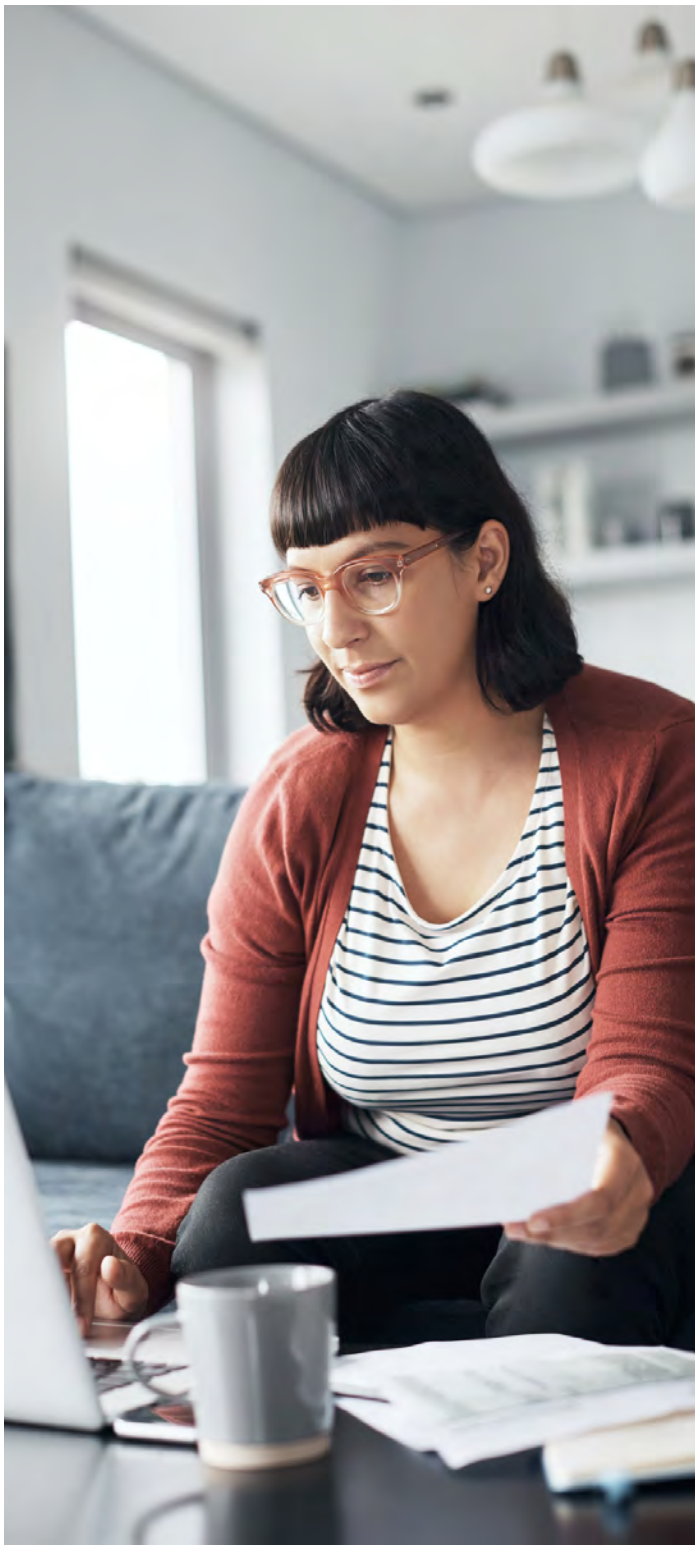
The insurance company could still deny payment based on factors the plan might not confirm during pre-certification, such as:

- Whether you are being treated for a pre-existing condition that your new policy does not cover
- Discrepancies between information provided by your doctor during pre-certification and your actual medical records
- Whether the patient was insured when services were performed (maybe you did not pay last month's premium or your child was the patient but is not included under the policy)

The plan's pre-certification notice should make it clear what has and has not been approved.

If you don't agree with the company's decision you may have the right to appeal.

Pre-certification is never required in an emergency. Ohio law defines medical emergencies based on the actions a prudent layperson (someone with little or no medical knowledge or background) would take in such situations.



Choosing a Plan / Understanding Your Plan

Before you choose a health plan or to understand the plan you have, check the policy's details. Know how the plan defines the terms shown on this page to have an idea of your possible out-of-pocket costs.

Coinsurance

The amount you pay for a covered service or treatment after the health plan's deductible has been met. Coinsurance is usually based on a percentage.

For example, you might pay 20 percent of hospital charges. If you use network providers, you are responsible for 20 percent of the eligible charges. Network providers have agreed not to bill for anything over the approved amount.

However, if you use non-network providers, the plan would pay its share up to the approved amount only (this may be called "usual, customary, reasonable" or UCR). You are responsible for your coinsurance percentage plus the difference between the approved amount and the billed amount. The difference can be significant.

Copayment

A flat fee you pay for a covered health care service or treatment. Certain types of plans, including HMOs and some PPOs, require a copayment for each office visit to a doctor and often a larger copayment for emergency care.

Creditable Coverage

Written proof of coverage from your former employer or health insurer which you use to get new insurance. Proof of creditable coverage guarantees that any waiting period the new plan normally imposes before covering pre-existing conditions will be eliminated or reduced. This is important when you change jobs (or insurance plans) and need pre-existing conditions to be covered right away.

Deductible

The amount you pay for medical bills before your plan begins to pay. Normally, a larger deductible means a less expensive policy.

Explanation of Benefits (EOB)

A statement from your health insurer that shows amounts it has paid and amounts it has not paid for a claim. If you want to challenge the company's payments, it's important to make sure you get all the EOBs that apply to the claim and keep them organized.

Out-of-Pocket Maximum

The amount of coinsurance/copayments you must pay yourself before your health plan starts paying 100 percent of your covered medical bills. This amount may or may not include the deductible and likely does not include penalties and many out-of-network charges.

Premium

The amount you pay to the insurance company in exchange for providing coverage for a specified period of time under a contract. Premiums are usually paid for a one-month period but can be scheduled for annual or quarterly payment.

Getting Individual Health Insurance

If you can't get health insurance through an employer or a government-sponsored program such as Medicare or Medicaid, you may be able to buy or access coverage for yourself and your family through individual coverage.

My job doesn't offer a health plan. I've looked for coverage and no private company will cover me. What can I do?

Open Enrollment

Ohio insurance companies must hold open enrollment every year. The coverage is guaranteed issue. This means the company cannot deny you coverage. However, the company is not required to take additional enrollees once they have met their quota. Professional associations: You may qualify to join a professional, fraternal or civic association that offers health insurance to its members. Check in your city or county for such possibilities.

Government-Sponsored

Medicare provides health insurance to people age 65 or older, and people under age 65 who have certain disabilities. Medicaid is health insurance for people with limited income and resources. You may qualify for one program or both.

Where can I find information on open enrollment? Is this a good option?

Visit the Ohio Department of Insurance website or call the department's Consumer Services Division: 800-686-1526.

If you're eligible, health insurance through open enrollment is guaranteed issue so you cannot be turned down. In general, people who apply through open enrollment have pre-existing conditions. The premiums are more expensive than health policies that are medically underwritten.

I'm looking for part-time work. Will I have health insurance?

No employer is required to offer health insurance. However, you should be offered the same health benefits as any other employee if:

- Insurance is offered by the employer, and
- The group is between two and 50 people and your normal work week is 25 hours or more

I'm getting a divorce/separating from my partner* and do not currently have a job with insurance coverage. What are my health insurance options?

If your ex-spouse has employer group health insurance and you are enrolled in that plan, you may have the right to continue group coverage through COBRA.

Another option: you could convert the group coverage to an individual policy offered by the same insurance company that fully insures your ex-spouse's / ex-partner's group.

* Neither same-sex or different-sex domestic partners are eligible for COBRA.

I have never had health insurance and I would like to purchase it. What are my options?

You can purchase insurance through:

- Your employer, if health insurance coverage is offered to employees and their families
- A private carrier for an individual policy on your own
- Professional associations

I just found out I'm pregnant. Can I get health insurance?

Generally, insurance companies regard pregnancy as a pre-existing condition.

Therefore, if you apply for individual coverage after becoming pregnant — and the policy is subject to medical underwriting — your application will likely be rejected.

If you have an employer plan that includes maternity benefits, your pregnancy cannot be considered a pre-existing condition.

If you're eligible, open enrollment may also be an option.

I'm 50 years old and have been diagnosed with a disability. My employer does not provide health insurance. Can I qualify for Medicare?

In addition to people who are age 65 and older, Medicare covers people with certain disabilities who are not yet age 65. To find out if you are eligible:

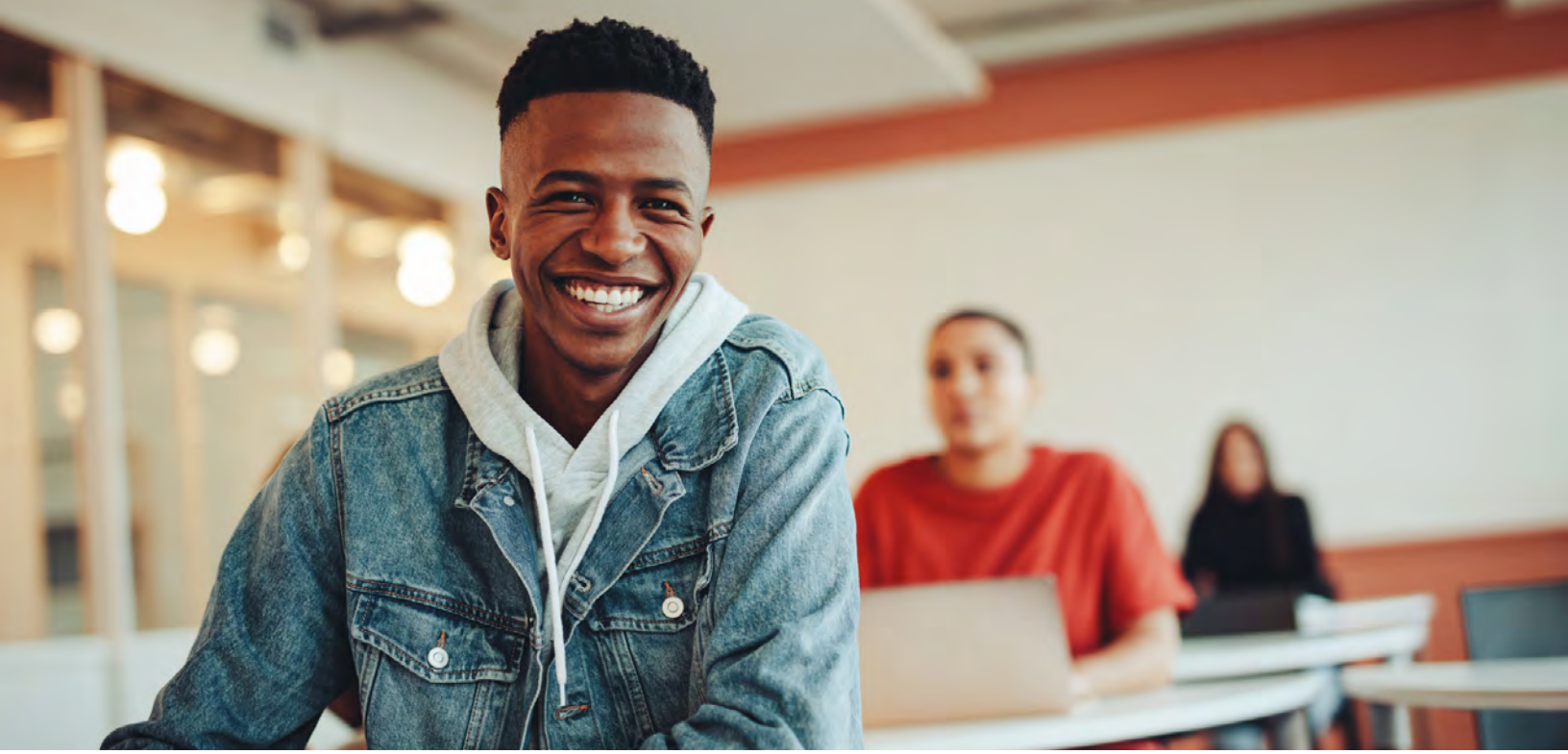
- Call Medicare at 800-633-4227 or visit medicare.gov
- For further assistance, call OSHIIP at the Ohio Department of Insurance: 800-686-1578

I've checked out the premiums and I truly cannot afford health insurance right now. What else can I do?

You may want to consider applying for financial assistance. One possible option is Ohio's Medicaid program.

Medicaid provides basic health care services for people with limited incomes and children or disabilities. The Ohio Department of Job & Family Services administers Medicaid. Call your local county Department of Job & Family Services or call the Ohio Medicaid hotline to apply: 800-324-8680.

Visit the Ohio Department of Insurance website at insurance.ohio.gov or call the department's Consumer Services Division at 800-686-1526 if you have any health insurance questions.



Young Adults

I just landed my first job and the employer is offering coverage, but the premium is expensive. Should I accept it?

One of the best and least expensive ways to get and keep health coverage is through an employer. Not every company makes health insurance available to its workers.

State and federal law can protect you from losing health insurance once you have it. If you get sick, change jobs or lose your job, you can stay fully covered in a health plan. Your coverage cannot be cancelled unless you stop paying premiums or commit fraud.

For a more affordable option, ask if your employer offers a flexible spending plan, such as a Health Savings Account (HSA). You combine the account with a high-deductible health plan, and fund the HSA with pre-tax dollars you can use to pay smaller medical expenses. The high-deductible plan covers large health costs.

I don't have a lot of extra cash and I'm healthy. Wouldn't it be a waste of money for me to buy health insurance?

Now may be the best time for you to buy, for the following reasons:

- If admitted to a hospital because of an accident or illness, you will be responsible for the entire bill for your care unless you already have health insurance
- If you develop a condition that's chronic (long-lasting), insurance may not cover the condition unless you have owned the policy for some period of time
- Once you have health insurance, the law protects you from losing coverage due to illness and no company can cancel you unless you stop paying your premium or commit fraud

I'm graduating from college this year. Can I keep the coverage I've had all along?

If you've been covered under your parents' health insurance policy while you were in college and reach the limiting age of the plan, you may qualify for extending that coverage if:

Eligibility - Federal

- Child can be married or unmarried
- A child of the covered employee defined by the plan
- Have not yet reached their 26th birthday
- Not have their own employer coverage available if the parent is covered under a group health plan that was in existence on March 23, 2010
- No other eligibility requirements are permitted

Such plans may extend coverage under the Consolidated Omnibus Budget Reconciliation Act — called COBRA — or conversion.

Other options:

- Interim coverage may be offered by the college to graduates — check with the school
- Catastrophic health coverage in the form of a short-term policy
- A health discount card

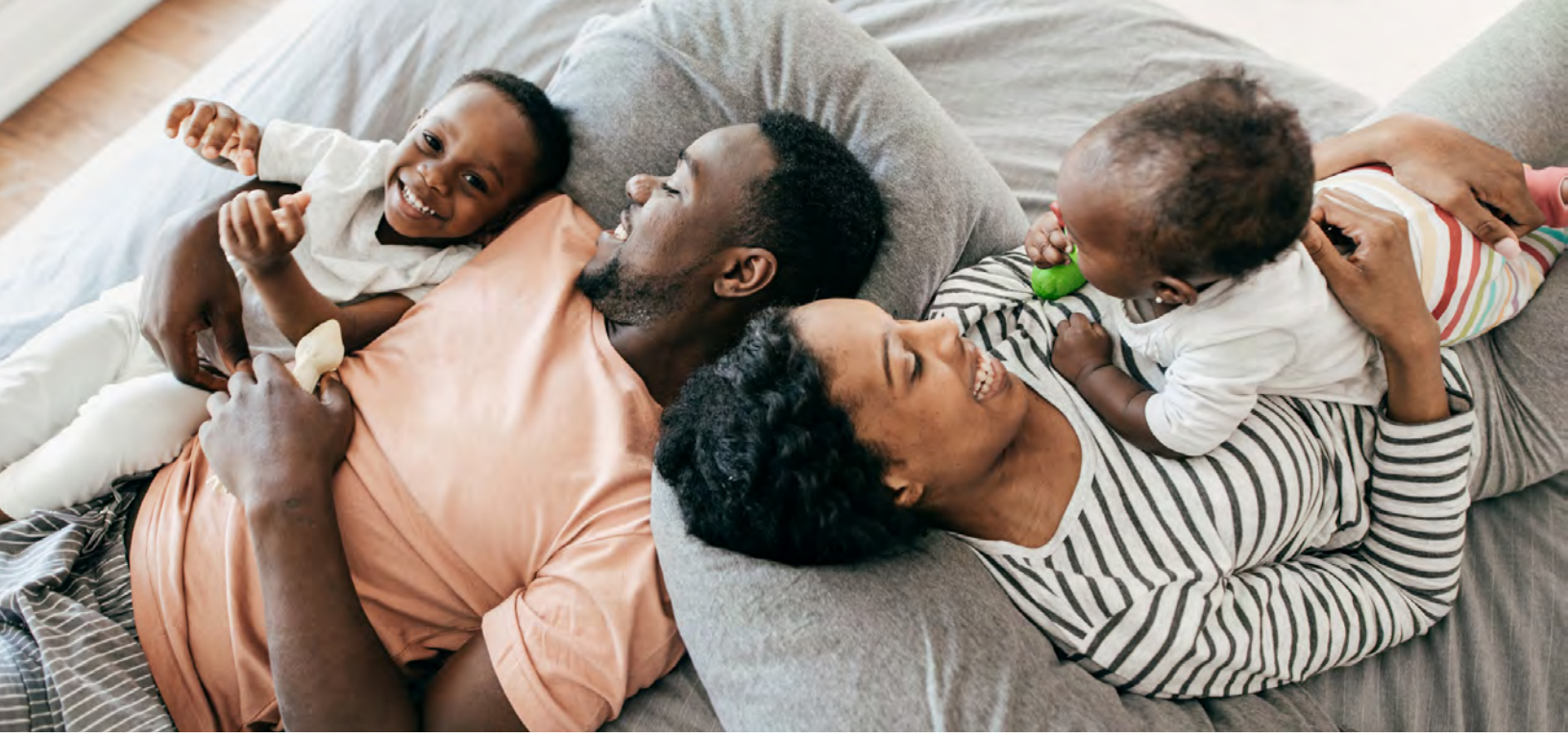
Eligibility - State

- Child must be unmarried, an Ohio resident OR a full-time student at an accredited public or private institution of higher education
- Natural child, stepchild, or adopted child of the insured
- Have not yet reached their 28th birthday
- Not employed by an employer that offers any health benefits
- Not eligible for coverage under Medicaid or Medicare
- Covered by a fully insured or public employee benefit plan

I've checked out the premiums and I truly cannot afford health insurance right now. What else can I do?

You may want to consider applying for financial assistance. One possible option is Ohio's Medicaid program. Medicaid provides basic health care services for people with limited incomes.

The Ohio Department of Job & Family Services administers Medicaid. Apply at your local county Department of Job & Family Services or call the Ohio Medicaid hotline for information: 800-324-8680.



Families

Our baby is due next month. How will my health insurance cover the charges for delivery and after?

Review your coverage to find out how your health plan handles the costs. Consider all the costs that might apply to your situation: prenatal vitamins, prenatal and neonatal screenings and tests, emergency procedures, delivery and pediatric care.

My partner recently gave birth to our baby daughter. Will my employer-sponsored health plan cover both my partner and daughter?

Ohio law does not require nor prohibit the coverage of domestic partners (same-sex or different-sex) and their families by health plans or private employers. However, a child may not be denied enrollment because the child was born out of wedlock. Check with your Human Resources office for details on your coverage.

My son is two weeks old. He's covered automatically under my health plan from work, right?

Yes, the child is covered for the first 31 days, but you must let the plan know about the new baby. Consult with the employer or health insurance provider regarding the notification requirements before your child is born. If you adopt, ask your employer or health plan in advance about requirements for getting the coverage.

We both work and have two separate health plans with family coverage. Which plan covers the children?

Ohio's Coordination of Benefits (COB) rules can allow you to use both health plans to pay your children's claims.

One plan will be the children's primary insurance and pay first. The other plan will be secondary and pay part or all of the remaining amount. Ohio's COB rules cover most situations when there are two health plans.

Make sure to follow all requirements (such as using network providers) for either plan; if you don't, the state's COB rules will not help and both plans could deny your claim.

How long will my plan cover the children?

Check with the plan. Coverage may last to age 26 or 28 depending on state or federal law.

In the case of a child with a developmental disability, the child continues to be an eligible dependent under your insurance policy regardless of age. Medicare may be an option for children with developmental disabilities.

My dependent children are full-time students. Are they still covered under my plan?

Usually, if the dependent child meets the qualifications on page 12. If your child attends an out-of-state college and your plan requires you to use a network, you may need to find your child a separate health plan for coverage other than emergency care. Ask the plan if it has a network your student can use in the other state. If not, look for coverage by working through the school or an insurance company authorized in that state.

I've heard of a program called SCHIP. Can my kids qualify?

SCHIP stands for the State Children's Health Insurance Program, a federal and state initiative to provide financial assistance to families who do not qualify for Medicaid.

For more information, please visit the Ohio Department of Job & Family Services at jfs.ohio.gov or call 800-324-8680.

My agent talked with me about disability insurance. Is it a good idea to buy a policy?

That's a decision only you can make. If a working parent becomes disabled and the family loses income it may be difficult to manage. Weigh the cost you'd have to pay for disability insurance against the protection it provides.

If you are married and both spouses work and contribute to the household income, consider disability insurance for both. Think about having only one salary coming in and plan accordingly.

My family is maturing. Are there good reasons to adjust my coverage?

If you have employer-sponsored coverage, you may want to consider annually whether to alter elections or eliminate certain types of coverage that you may no longer need.

Ask your employer about making changes to your coverage. Some group policies will not permit you to make any adjustments.

If you have young children, you may want preventive care benefits that include providing shots and "well visits" for the kids.

If you've decided not to have more children, you may no longer want a policy that covers pregnancy-related services.

Plans offered through health discount cards may be an option, but they are not health insurance. Used properly, discount cards will save you money when you receive health services from certain doctors, dentists and other providers. Carefully research any discount card you consider. Discount cards cost less to have than insurance, but they provide only a discount on services; they do not pay for services. Having a discount card does not qualify as creditable coverage.

Know your rights on keeping health insurance and if you lose your job, change jobs or decide to start your own business, know the available options to keep your family covered.

You may want to consider whether long-term care insurance makes sense for you. You may want a certified financial planner to help you weigh your options regarding long-term care insurance

What if I retire or get laid off before I turn age 65? Will I be eligible for Medicare?

Medicare covers people who have paid into the system for a specific period of time. Others may purchase coverage. You must be at least age 65 to qualify or be under age 65 with certain disabilities. People who retire or lose employer coverage before age 65 should consider buying a health plan to cover the period of time before they qualify for Medicare.

If you are planning to retire early, talk with your employer's human resources staff. Find out if you are eligible for health insurance in the employer plan under one of the methods established by law to help you stay covered.

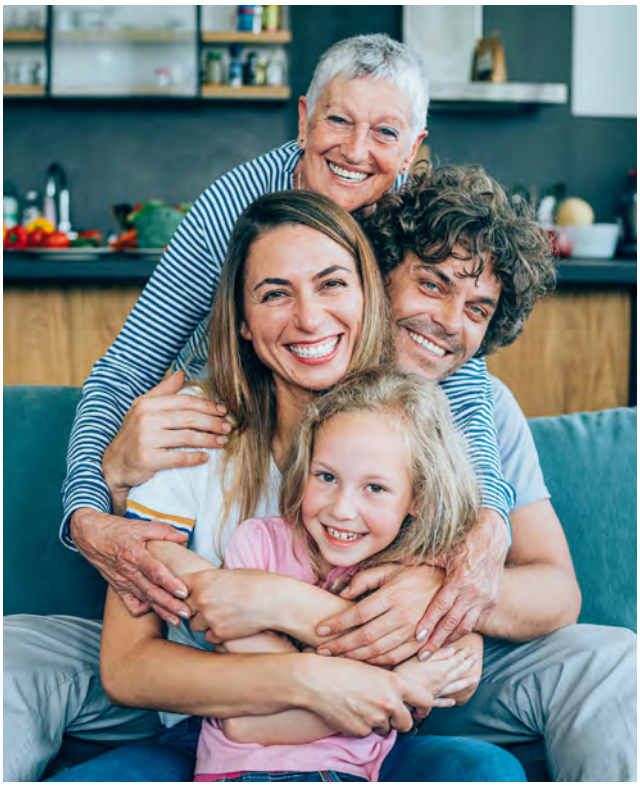
Your premium will be more expensive than when you worked. In addition, the employer can renegotiate its group health insurance contract at any time, which can cause changes to your premium or terminate the coverage. However, you are more likely to get a better rate in the employer plan than if you have individual coverage.

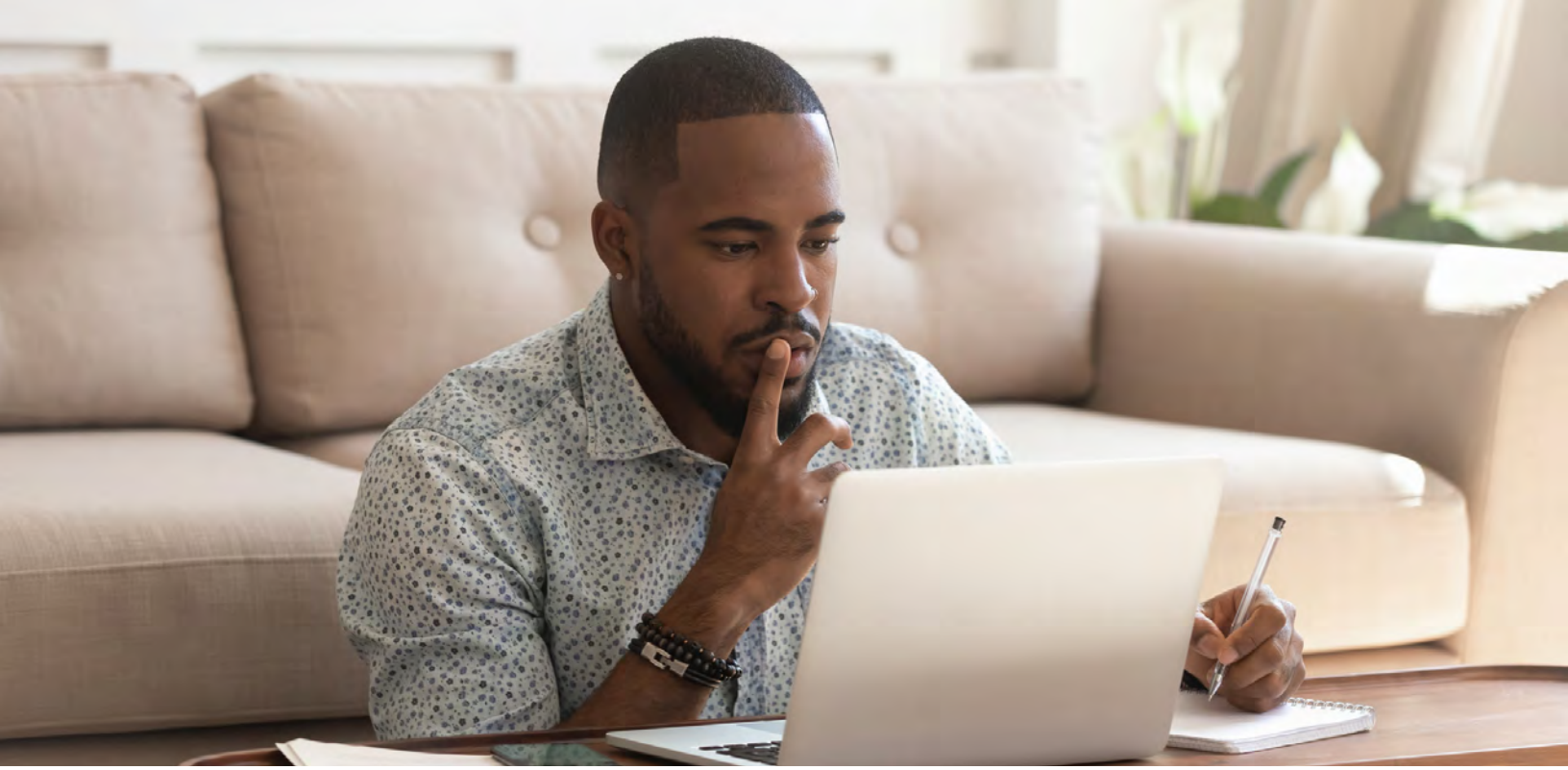
If your COBRA benefits run out and you're still not yet eligible for Medicare, you may want to consider a conversion policy.

We've priced available plans and our family truly cannot afford health insurance right now. What else can we do?

You may want to consider applying for financial assistance. One possible option is Ohio's Medicaid program.

Medicaid provides basic health care services for people with limited incomes and children or disabilities. The Ohio Department of Job & Family Services administers Medicaid. Apply at your local county Department of Job & Family Services or call the Ohio Medicaid hotline for information: 800-324-8680.





Job Change/Job Loss

I'm leaving a job with employer group coverage for a new job that also provides group coverage. What are my rights?

You have rights under the Health Insurance Portability and Accountability Act (HIPAA). HIPAA reduces or eliminates the period you would otherwise have to wait for the new plan to cover pre-existing conditions.

HIPAA applies if you have an employer health plan, leave for a new job and the new employer offers health insurance.

Any plan your new employer offers:

- Must include all family members who meet the new plan's eligibility requirements
- Cannot reject you or charge you higher premiums because of a family member's health problems
- May offer a special enrollment period if you add a new dependent due to marriage, birth, adoption or loss of other coverage. Any family member can join during a special enrollment period without having to wait for coverage of pre-existing conditions
- May cost you more than the old plan

If the new plan is through a traditional health insurance company:

- Enroll within 63 days after your previous coverage ends in order to use your creditable coverage. By applying creditable coverage, you reduce any period of time the plan requires before it covers your pre-existing conditions
- If you (or a family member) are pregnant when you switch jobs, the new plan will cover the pregnancy only if the new plan includes maternity coverage
- The new plan may have a waiting period before you can enroll. Talk with the new employer about specifics

If the new plan is through an HMO:

- The plan may have an "affiliation period" which could delay your coverage for a maximum of 90 days after you submit the enrollment form
- No pre-existing condition waiting period is allowed. All benefits must be covered the day coverage goes into effect
- Maternity must be covered if the plan is full service

I'm leaving a job with employer group insurance for a job that does not offer a health plan (or to become self-employed). — OR — I've been laid off from a job with employer group insurance. What are my options?

Generally, you will be able to choose from two options,

1. Continuation of the group benefits: Temporary coverage that lasts no less than 12 months
2. Conversion to an individual policy/purchasing your own individual policy: Permanent coverage that lasts as long as you pay premiums or do not commit fraud.

Continuation of group coverage/COBRA

You have the right to temporarily continue group coverage/COBRA if you lose a job with employer-sponsored health insurance. The number of employees at the job you left will determine how it may work.

Ohio's continuation law

If your employer has two to 20 workers, you can continue under the ex-employer's group coverage for twelve months, if you:

- Were covered for three months prior to termination
- Were involuntarily terminated, and the termination was not based on gross misconduct
- Pay the plan's full cost
- Are not eligible for Medicare
- Apply within 31 days of losing group coverage

Federal continuation law: COBRA

If you leave a company with 20 or more employees, you can temporarily continue the ex-employer's group coverage under a federal law known as the Consolidated Omnibus Budget Reconciliation Act (COBRA).

COBRA does not apply to plans sponsored by the federal government and some church-related organizations.

The employer must notify you of your rights under COBRA within 30 days after you leave the group. Once you're notified, you have an additional 60 days to apply for coverage.

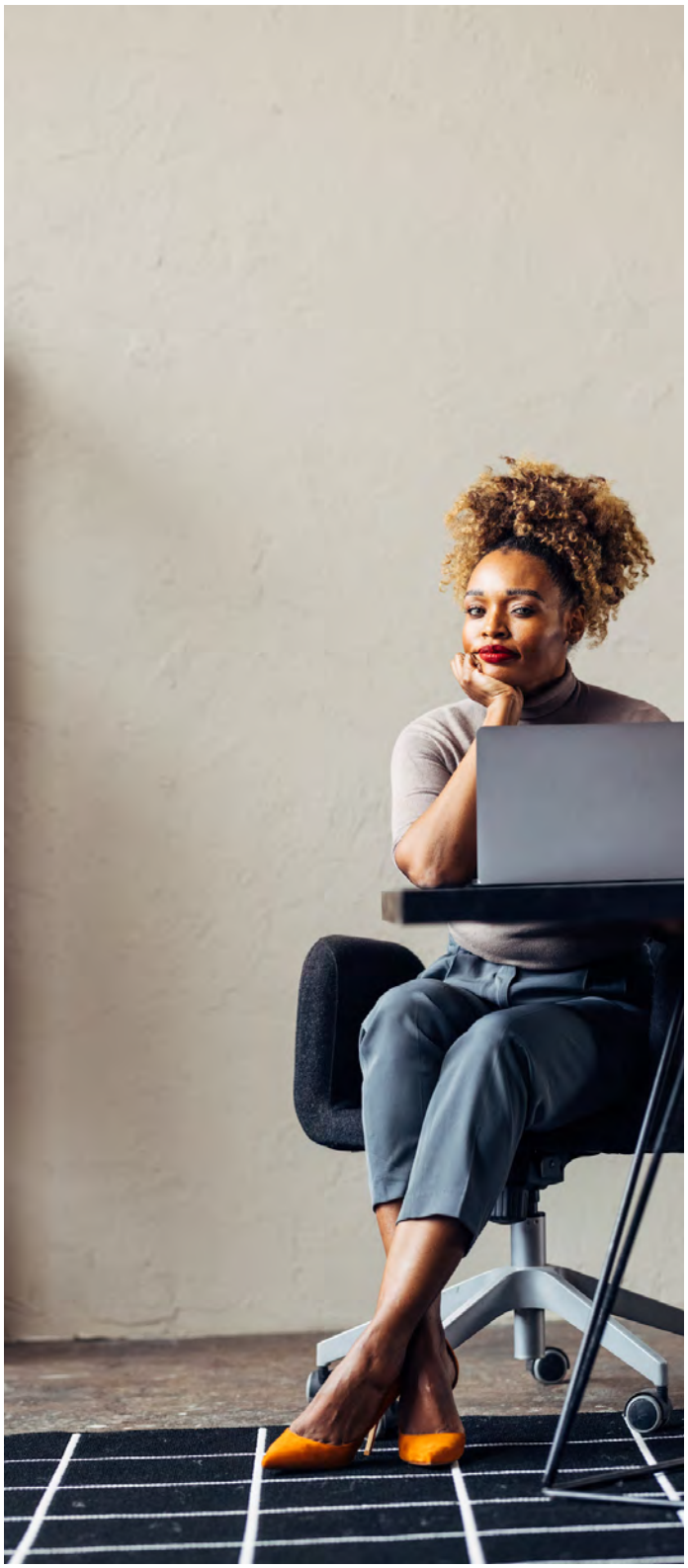
You will be responsible for the full premium plus two percent for administrative fees.

Coverage under COBRA is temporary and ends after:

- 18 months, in most cases
- 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 job or parent's job and that individual becomes eligible for Medicare, dies, or you lose your dependent status
- The employer goes out of business or stops offering an employee group plan
- You fail to pay the premium

Once COBRA ends you can apply within 31 days to convert (see below) to an individual policy provided by the group's insurer under Ohio's Basic or Standard plan, unless the employer is self-insured.

Ask the human resources office for a booklet on COBRA. Or contact the U.S. Department of Labor, Employee Benefits Security Administration at 866-444-3272.



Conversion to an individual policy/Purchasing your own individual policy:

If you lose a job with employer-sponsored health insurance, you may be eligible for permanent individual coverage that will last as long as you continue to pay premiums.

HIPAA, the same federal law that allows you to maintain coverage when you change jobs, also established two full-service individual health plans available to people with pre-existing conditions losing employer group insurance. These plans are called Basic and Standard.

When you have pre-existing conditions and you move from employer group coverage to an individual plan, it helps to know if you are a federally eligible individual (or FEI) under HIPAA. In general, a person with FEI status has had no lapse in health coverage. Depending on your FEI status, coverage under the Basic or Standard plans may be immediate. The period of time before the new plan covers pre-existing conditions may also be reduced.

You cannot be turned down for coverage due to your health, but a plan can reject you if it has already reached its annual enrollment limit.

You qualify as an FEI only if you meet all of the following conditions:

- Have had 18 months of creditable coverage
- Were most recently covered by an employer group
- Were not terminated from your group plan due to premium nonpayment or fraud
- Obtained coverage by midnight of the 63rd day after your previous coverage ended
- Are not eligible for Medicare, Medicaid or other group coverage
- Have exhausted all continuation of benefit options (e.g., COBRA)
- Do not have any other health insurance

Creditable coverage is proof that you were covered under your old plan. It reduces — or eliminates — the period of time a new plan can make you wait before it pays for your or your covered family member's pre-existing conditions. You get credit for how long you were with the old plan; the new plan must reduce your pre-existing condition waiting period by an equal amount of time. You prove creditable coverage through a certificate from your ex-employer or its health plan.

You have creditable coverage if you were under any plan listed here:

- A group health insurance plan
- Medicare or Medicaid
- TRICARE
- Indian Health Medical Program
- A state health risk pool
- A health plan under chapter 89 of title 5, US
- A public health plan
- A health plan under section 5(e) of the Peace Corps Act
- A state children's health insurance program (SCHIP)

Conversion to an individual plan from the employer's insurance company

Through HIPAA, Ohio has two individual health plans called Basic and Standard. You can convert your coverage to any Basic or Standard plan offered by the employer's insurance company, unless the employer is self-insured.

You must have had continuous coverage for one year prior to conversion. If you apply within 31 days of leaving the group, you cannot be turned down for coverage due to your health. The new plan may cost more and may not have the same benefits. You can keep the policy as long as you pay premiums.

You have conversion rights if you have FEI status and:

- You leave the employer
- You are a covered family member of an insured who has died
- You reach the age limit for coverage under your parent's group
- You divorce or separate from the insured

Purchasing an individual plan from any health insurer

The rules for buying your own policy from the individual health insurance market depend on whether you are a federally eligible individual, (FEI).

If you qualify as an FEI:

- No insurance company offering individual coverage can reject your application for the Basic or Standard plan because of your health status
- Pre-existing conditions cannot be excluded
- Conversion is an option. Your former employer's insurance company must accept your application to convert your group coverage to an individual plan. However, any other insurer can reject your application if the plan has reached its open enrollment limit

If you do not qualify as an FEI:

- Open enrollment may be an option. Ohio insurers must hold open enrollment to give individuals who do not qualify for FEI status an opportunity to purchase health insurance
- You cannot be rejected due to poor health, but the policy may be underwritten
- However, any insurer can reject your application if the plan has reached its open enrollment limit

I'm leaving a company that self-insured. What are my rights and options to secure health insurance?

Your options will generally include temporary continuation of the group benefits, or purchasing individual coverage on your own. Contact the U.S. Department of Labor with questions: 866-487-2365.

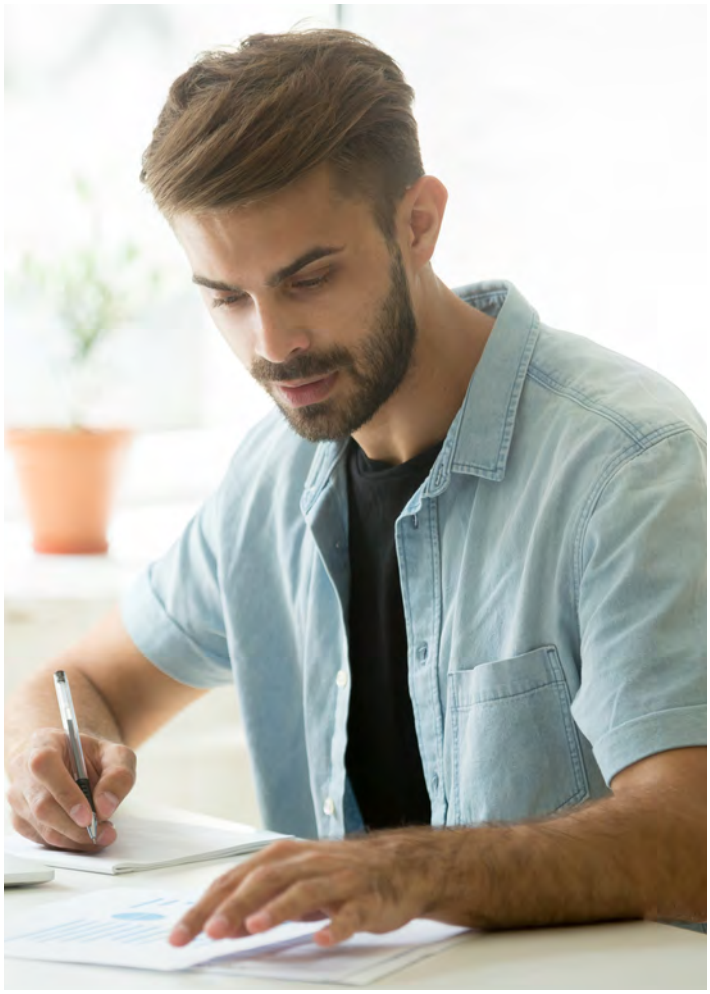
I have been fired and no longer have health insurance. What are my options?

You are eligible for COBRA. Unless, you have been fired because of gross misconduct in which case continuation of group health insurance coverage is not an option. See "Purchasing an individual plan from any health insurer" for details about your options for individual coverage.

I've checked out the premiums and I truly cannot afford health insurance right now. What else can I do?

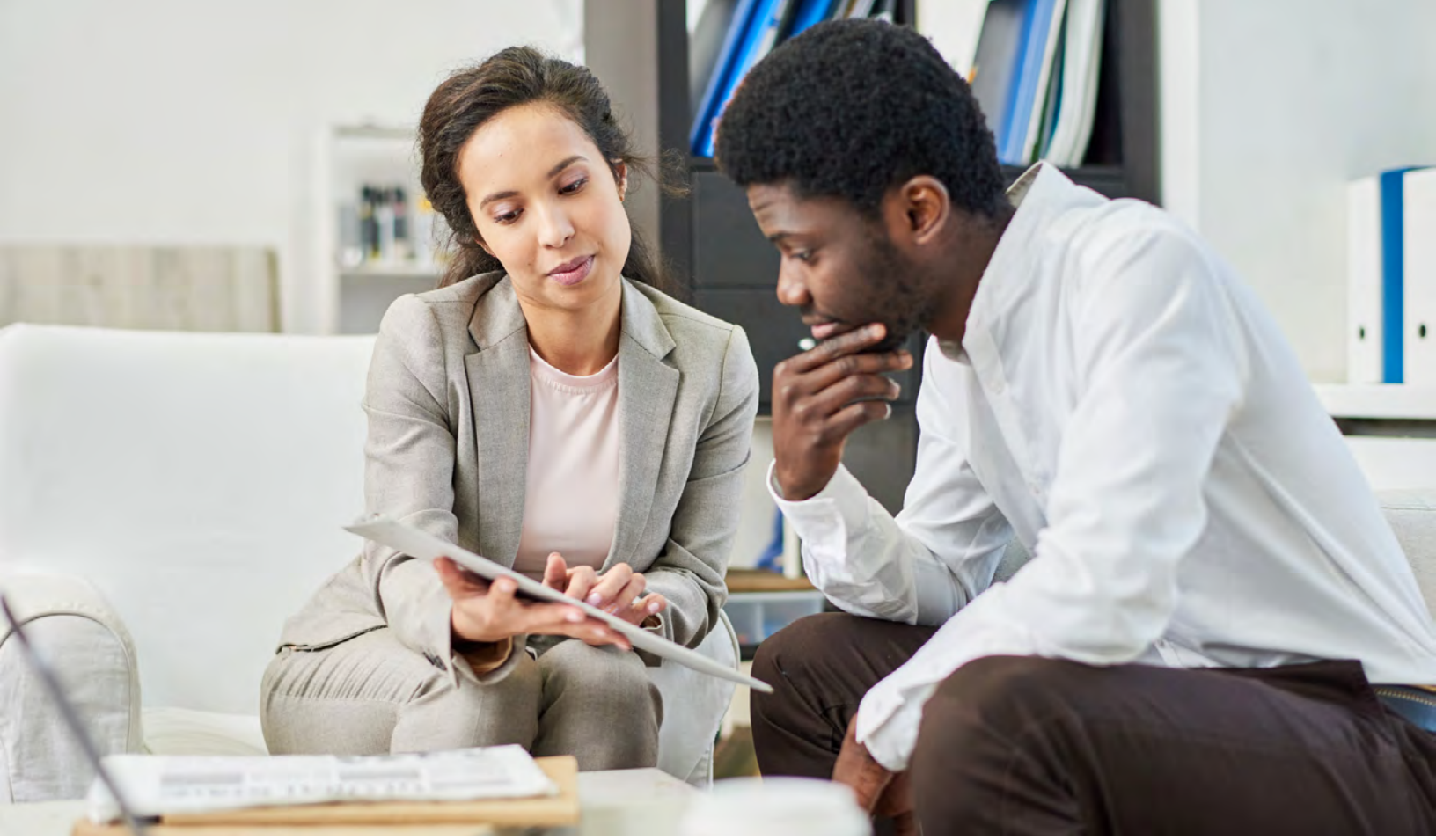
You may want to consider applying for financial assistance. One possible option is Ohio's Medicaid program.

Medicaid provides basic health care services for people with limited incomes and children or disabilities. The Ohio Department of Job & Family Services administers Medicaid. Apply at your local county Department of Job & Family Services or call the Ohio Medicaid hotline for information: 800-324-8680.



Keeping health insurance can be guaranteed by state and federal law. Once covered, you cannot lose coverage because you have an accident or get sick. Your health insurance cannot be cancelled unless the employer stops paying the premium for your employer-sponsored plan, you stop paying the premium for a plan you own, or commit fraud.

In general, if you leave a job where you participated in an employer group health plan, you may be able to stay covered no matter what happens next. Keeping health insurance is your right. Any new plan may be different and will likely cost you more, but if you follow the rules, you can keep your family covered.



Surviving Without Health Insurance

I don't qualify for Medicaid. Where can I get testing supplies, discounted medications, or insulin?

Explore Disability Medical Assistance (through the Ohio Association of Free Clinics, your local Department of Public Health and ODJFS), contact nonprofit associations such as the Central Ohio Diabetes Association or the Ohio United Way, or contact pharmaceutical companies directly to see if they have any prescription discount programs.

Where can I find affordable prescriptions since I do not have insurance?

The Columbus Public Health Department (614-645-6248) has compiled a list to help with prescription costs. Their list includes programs such as Prescription Access, Prescription for Good Health, Ohio's Best Rx, Rx for Ohio and Rx Outreach.

Check with your local health department about a similar list for your area or the Association of Health Commissioners: 614-221-5994 or aohc.net.

What benefits do local chapters of associations, such as those dealing with cancer, diabetes, lung, kidney, etc.) have for uninsured or underinsured people?

Associations may provide you with resources (discount prescription information), services (access to doctors) or educational materials (nutritional classes) which may be subsidized or free.

Check the association websites or call them with questions. You can also get information on your local associations from the United Way of Ohio.

As a person with a limited income who doesn't qualify for Medicare, Medicaid, employer or individual coverage, where can I find adequate and affordable health care assistance?

This guide addresses issues about medical assistance for various groups of people, including refugees, undocumented persons, noncitizen immigrants, veterans, children and persons with disabilities.

Contact information for health departments all over Ohio, information on oral, vision and behavioral health resources, subsidized care at local hospitals, community health centers and free clinics.

Ohioans who lack adequate health coverage may find help through certain Ohio organizations which provide services such as free or sliding scale clinics, community health centers, medications, supplies, preventative care classes and other networking information. Also, please contact the Ohio Family Coverage Coalition (uhcanohio.org/coalitions/famcovcoal.html) for a detailed brochure.

Running a Small Business or Self-Employed

My business is small but growing. Can I offer my workers a group health plan?

Your premium will be based on how many employees participate and their health status. You can negotiate directly with an insurance company or hire an insurance broker to identify a plan.

Insurance companies offer small and large group coverage. Comparison shop traditional insurance, Preferred Provider Organization (PPO) and Health Maintenance Organization (HMO) plans for coverage that suits you at a cost to fit your business model.

I've priced group coverage and it's expensive. What are my other options?

A Health Savings Account (HSA) may be another type of health insurance you could offer your workers. The account works with a qualifying high-deductible health plan to provide coverage. The HSA is used to pay routine expenses, and the high-deductible plan is used to pay more significant expenses. The high-deductible plan can be through an HMO, PPO or traditional insurance.

The HSA is funded with pre-tax dollars to pay eligible health care expenses including insurance policy deductibles, copayments and out-of-pocket medical expenses. Employers can establish HSAs for their workers; individuals can set them up for themselves as well. Required coverage amounts, out-of-pocket expense limits and annual contribution limits may apply.

Employer and employee contributions, earned interest and amounts used to pay eligible expenses are not taxed. You may take an HSA with you when you leave your employer.

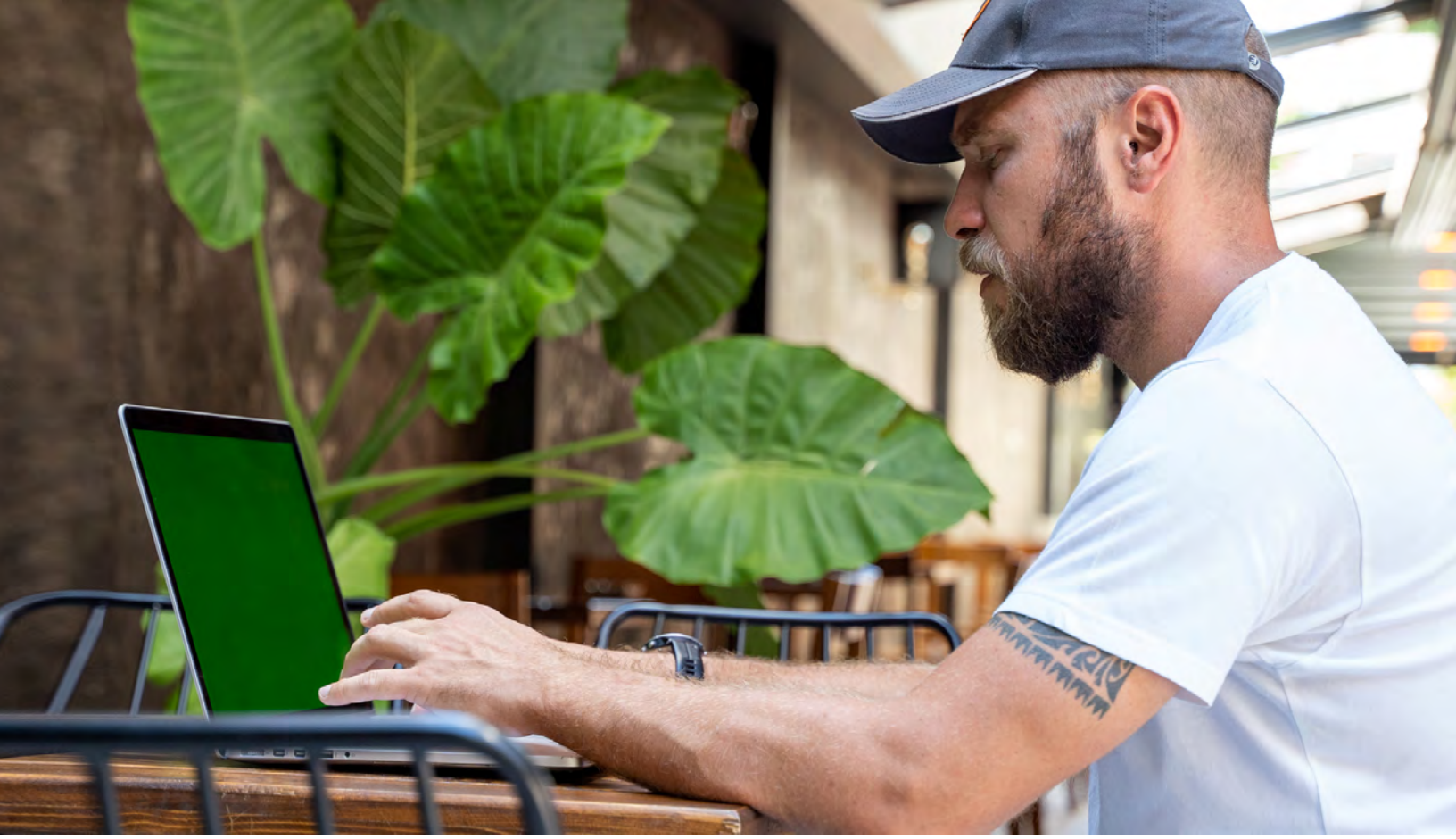
I've heard of small business alliances. How can they help?

A health care alliance is a cooperative of small businesses that band together to form a larger group in order to make coverage more affordable. Any employer group with fewer than 500 employees and meets the alliance's membership criteria (examples: being a member of a chamber of commerce or a member of a certain industry) can join. Employers who join such alliances may be entitled to certain tax benefits.

Most areas in Ohio have one or more small business alliances. To get a current list call the Department of Insurance Consumer Services Division at 800-686-1526.

Other health insurance shopping tips for small business owners

- Before purchasing any insurance, interview several licensed insurance agents who specialize in serving the health insurance needs of small businesses
- Understand the factors that can affect the cost of your small group health premiums
- Call ODI's Consumer Services Division at 800-686-1526 to determine if an agent or company is licensed to do business in the state or if you have any other insurance questions



How to Appeal a Decision by Your Health Plan Issuer

I disagree with my health plan issuer's decision — what can I do?

You have the right, under Ohio law, to request the health plan issuer reconsider their decision, also known as an adverse benefit determination.

What is an adverse benefit determination?

An adverse benefit determination is a decision made by the health plan issuer to do any of the following:

- Deny, reduce or terminate a requested health care service or payment in whole or in part
- Not to issue health insurance coverage to you through an individual policy or non-employer group certificate
- To cancel or discontinue your health benefit plan coverage back to the original effective date as if the coverage never existed

How do I request that the health plan issuer reconsider their decision?

You must first complete the health plan issuer's internal appeal process. If the health plan issuer continues to deny you services, payment or coverage you may then be eligible for their external review process.

How do I request an internal appeal?

You or your authorized representative must contact your health plan issuer to begin the internal appeal process. Some issuers will accept the request by phone, others may require a written request.

What if my situation is urgent?

You may be eligible for an expedited internal appeal or a concurrent expedited internal appeal and expedited external review. Your health plan issuer will provide the conditions in your notice of adverse benefit determination and in your policy, certificate or benefit booklet. Your treating physician may need to verify in writing that your medical condition is urgent.

When will I have a decision regarding my request for internal appeal?

- For individual and non-employer group coverage, it should take no longer than 30 days from the date when a complete appeal is received by the health plan issuer
- For employer group coverage, it should take no longer than 60 days from the date when a complete appeal is received by the health plan issuer
- When your situation is urgent it should take no longer than 72 hours after your request is received by the health plan issuer
- If the health plan issuer continues to deny the services or payment, a final adverse benefit determination will be issued and you may then be able to file a request for an external review

What is an external review?

An external review is performed by an outside organization not affiliated with the health plan issuer. When the internal appeal process is complete and the health plan issuer continues to deny benefits, the health plan issuer will issue a final adverse benefit determination.

When the final adverse benefit determination concerns a decision that is based on medical judgment or an experimental or investigational treatment, the review is performed by an Independent Review Organization (IRO). If the final adverse benefit determination is based on a contractual issue that does not involve medical judgment the review will be performed by the Ohio Department of Insurance. In the event your medical condition did not meet the definition of an "emergency" the requested review will be performed by an IRO. If the IRO upholds the health plan issuer's decision, you can request the Ohio Department of Insurance make a determination of whether the condition was an emergency based on the prudent layperson standard.

Do I have to complete the internal appeal process before I can request an external review?

You must exhaust the health plan issuer's internal appeal process before you can seek an external review except in the following instances:

- The health plan issuer agrees to waive the exhaustion requirement
- You did not receive a written confirmation of the health plan issuer's internal appeal decision within the required time frame
- The health plan issuer fails to meet all requirements of the internal appeal process
- You request an expedited external review at the same time as an expedited internal review

How do I request an external review?

You or your authorized representative must contact your health plan issuer to begin the external review process. Your notice of final adverse benefit determination should list the information necessary to file your request.

The request must be in writing and can be sent by mail, e-mail or fax. If your situation is urgent you can request your review over the phone. You must request the external review within 180 days of the date of the final adverse benefit determination.

If your situation is not urgent, your health plan issuer will let you know in writing that you have 10 business days to submit additional information to support your case. The additional information should be submitted directly to the entity performing the review, either the IRO or the Ohio Department of Insurance.

What if my situation is urgent?

You may be eligible for an expedited external review. Your health plan issuer will provide the conditions in your notice of final adverse benefit determination and in your policy, certificate or benefit booklet. Your treating physician may need to verify in writing that your medical condition is urgent.

When will I have a decision regarding my request for external review?

- If your situation is not urgent, it should take no longer than 30 days from when a complete request for external review is received by the health plan issuer
- When your situation is urgent, it should take no longer than 72 hours after your request is received by the health plan issuer
- If the IRO agrees with you the service, payment or coverage you requested will be provided to you, but if the IRO upholds the denial payment or coverage, the external review process is complete
- You have the right to file a private lawsuit and may request another external review of the decision only if new medical or scientific evidence is available and submitted to the health plan issuer

How will I be informed of the decision?

Once a decision is made, you will be notified in writing by the IRO or in the case of a contractual review, the Department of Insurance. In urgent care situations you may be notified by telephone, fax or email and will receive written confirmation within 48 hours of the decision.

If you don't agree with decisions your health plan issuer makes regarding your coverage, you can appeal within 180 days of the date of the issuer's decision.

About the Ohio Department of Insurance

The Ohio Department of Insurance is one of the state's largest consumer protection agencies. Our professionals offer free and objective information to help Ohioans understand insurance and resolve certain issues they may experience.

Filing a consumer complaint with the Ohio Department of Insurance:

If you believe your health plan is failing to pay a claim or denying a service or treatment, you must appeal with the plan provider. If you have other concerns regarding your plan such as your premiums or the time it takes to process your claim, contact the department's Consumer Services division at 800-686-1526.

Before the department can investigate, you must submit a written complaint. We can mail you a copy of our form to complete and return or you can file your complaint online at insurance.ohio.gov.

We will send the insurance company a copy of the complaint, and ask them to resolve it or explain its position. Insurance companies are required by law to respond to the department. We will review all the facts to make sure the carrier has followed its contract with you, and that it has complied with insurance rules and laws.

Provider Complaints

Healthcare providers can submit a complaint by visiting the Ohio Department of Insurance website and completing a Provider Complaint Form. Providers should follow all contract grievance and appeal procedures before filing a complaint with the department.

About the regulatory authority of the Ohio Department of Insurance:

In most cases, the Ohio Department of Insurance is authorized to make sure covered people get benefits as written in their health policy. In the case of "self-insured" plans, however, Ohio Department of Insurance authority may be limited.

The Ohio Department of Insurance cannot make decisions about medical necessity.

The Ohio Department of Insurance does not regulate the benefit or cost structure of group plans. As long as the contract meets Ohio's legal requirements, contract details are up to the policy owner. Such factors can include your right to extra benefits or the premium amount you pay for coverage.

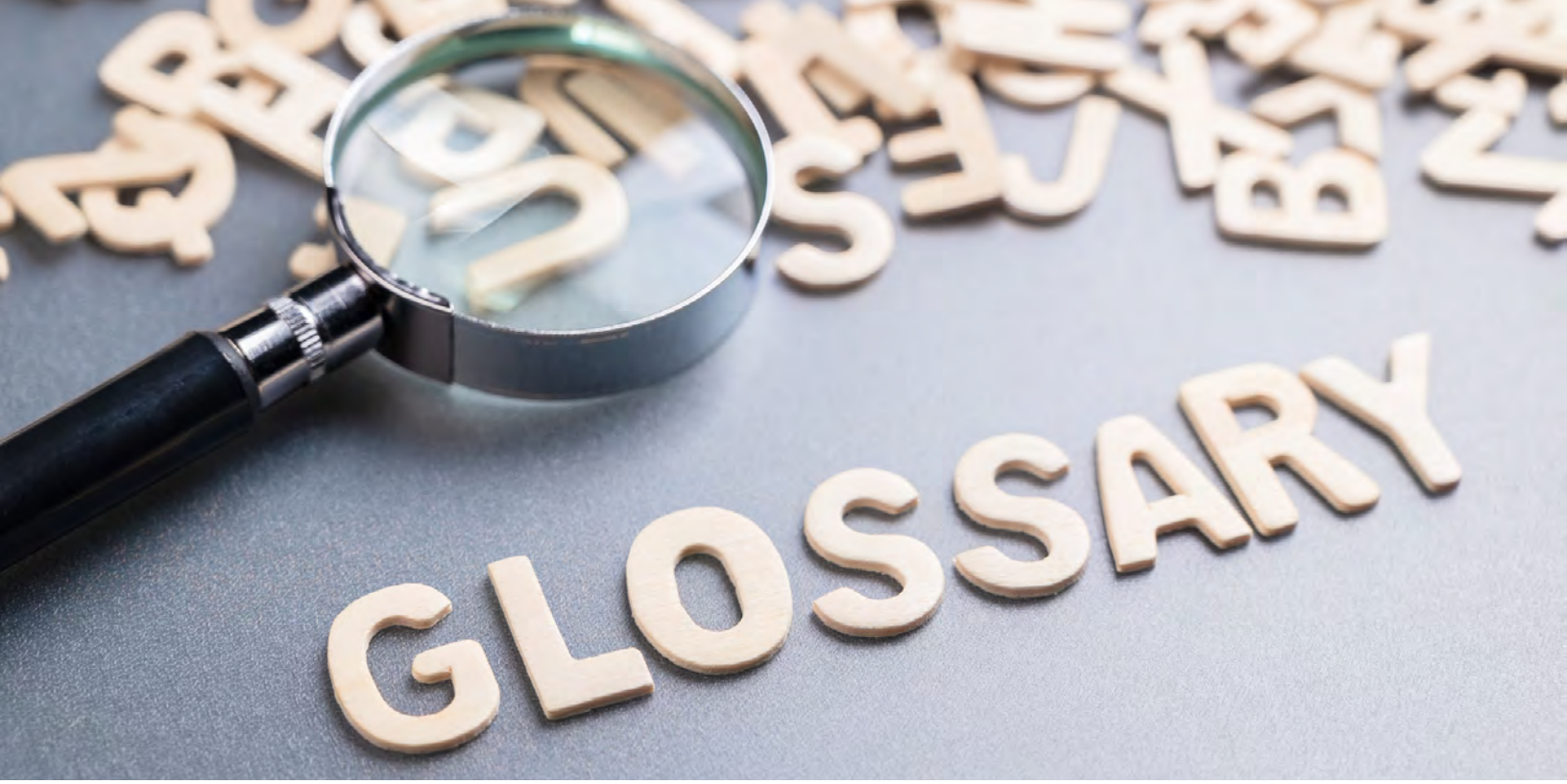
The Ohio Department of Insurance does not set insurance company premiums or rates. Each insurance company calculates its own premiums. The department reviews the rates and makes sure the insurance company meets Ohio's legal requirements.

What's Your Situation?

Choose the situation below that matches yours most closely. Then turn to the pages shown to read helpful general infomation.

Helpful Phone Numbers and Websites

Organization	Phone	Website
Ohio Department of Insurance - Consumer Services	800-686-1526	insurance.ohio.gov/consumers
Ohio Senior Health Insurance Information Program (OSHIIP)	800-686-1578	insurance.ohio.gov/01-oshiip
U.S. Department of Labor	866-487-2365	dol.gov
Ohio Department of Health	614-466-3543	odh.ohio.gov
Ohio Medicaid	800-324-8680	jfs.ohio.gov
Medicare	800-633-4227	medicare.gov
Ohio Public Health Department	614-221-5994	aohc.net
Ohio Family Coverage Coalition	800-634-4442	uhcanohio.org



Glossary

Approved Amount - The dollar amount on which an insurance company bases its payments and your copayments. This may be less than the billed charge.

Beneficiary - A person who receives the benefits of any insurance plan or policy.

Benefit Maximum - The most a health insurance policy will pay for a specified loss or covered service. The benefit can be expressed as either a period of time, a dollar amount or a percentage of the approved amount. Benefits may be paid to the policyholder or a third party.

Benefit Period - The time for which benefit payments from an insurance policy are available. A policy may include different benefit periods for different kinds of treatment or services.

Billed Charge - The dollar amount a health care provider bills to a patient for a particular medical service or procedure.

Certificate Holder - An employee or other insured named under a group health insurance policy.

Chronic Condition - A continuous or prolonged illness or condition. Examples: asthma, diabetes, varicose veins.

Claim - A request for payment for services.

COBRA (Consolidated Omnibus Budget Reconciliation Act) - Federal law requiring that workers who end employment for specified reasons have the option of continuing group insurance through the employer for a limited period of coverage (usually 18 months; can be 29 months or 36 months).

Conditionally Renewable - An insurance policy that the company will renew with each premium payment, as long as you meet certain conditions.

Coordination of Benefits (COB) - Procedures used by insurers to avoid duplicate payments when a person is covered by more than one policy.

Copayment (coinsurance) - A specified dollar amount or percentage of covered expenses which an insurance policy or Medicare requires a beneficiary to pay toward eligible medical bills.

Covered Services - Services for which an insurance policy will pay.

Deductible - A specified dollar amount of covered medical expenses which the beneficiary must pay before an insurance policy will pay.

Enrollment Period - Period during which people can enroll for an insurance policy or Medicare.

Exclusion - A procedure or condition which an insurance policy does not cover.

Experimental - Medical treatment which is not generally accepted within the medical profession. Policies sometimes do not cover these procedures.

Explanation of Benefits (EOB) - A statement from an insurance company showing which payments have been made on a claim.

Federally Eligible Individual (FEI) - A person who meets federal standards for continuing or obtaining health care coverage under HIPAA.

Fee For Service - Traditional insurance that does not place restrictions on which doctors you can use. The insurer pays a percentage of the expense you incur.

Free Look - The period during which you may reconsider the purchase of an insurance policy, cancel and get a full refund. Individual health policies have a free look of at least 10 days; Medicare supplement and long-term care policies have 30-day free look periods.

Grace Period - A set period after an insurance policy premium payment is due, during which the policyholder may still make a payment. The policy remains in effect during the grace period.

Group Insurance - A contract between an insurer and an employer or association.

Guarantee Issue - A type of health insurance policy that is issued regardless of health.

Guaranteed Renewable - An agreement by an insurance company to insure a person for as long as premiums are paid.

HIPAA (Health Insurance Portability and Accountability Act) - Federal law that guarantees health care plan eligibility for people who change jobs, if the new employer offers group insurance.

Health Insuring Corporation (HIC) - A term for certain managed care insurers in Ohio, including all HMOs. The Department of Insurance regulates HICs. Health Maintenance Organization (HMO) - A managed care plan that provides comprehensive care for a monthly premium. Office visits with your doctor usually require a copayment. You must live in an HMO's service area to join. You usually must use the plan's providers and facilities before the plan will pay its share for covered health services.

Health Savings Account (HSA) - A savings fund that allows the insured to pay for medical expenses with pre-tax dollars. Such an account must be paired with a high-deductible health plan.

High-Deductible Health Plan - A health plan for which you accept a more expensive deductible. Because you take more risk, you pay a lower premium.

Hospital Indemnity Policy - Pays a fixed dollar amount for each day you are in the hospital, regardless of actual hospital bills.

Inpatient - A person who has been admitted to a hospital or other health care facility to receive diagnosis, treatment or other health services.

Insured - An individual or organization protected by an insurance policy.

Lifetime Maximum - The total amount a policy will pay for covered expenses during an insured's lifetime.

Long-term Care (LTC) Insurance - Insurance that pays for care given in a skilled nursing facility, adult care facility or at home. Covers chronic medical conditions and helps with activities of daily living.

Loss - The basis for a claim under an insurance policy. In health insurance, loss can refer to medical expenses (or, in a disability policy, loss of income) resulting from illness or injury.

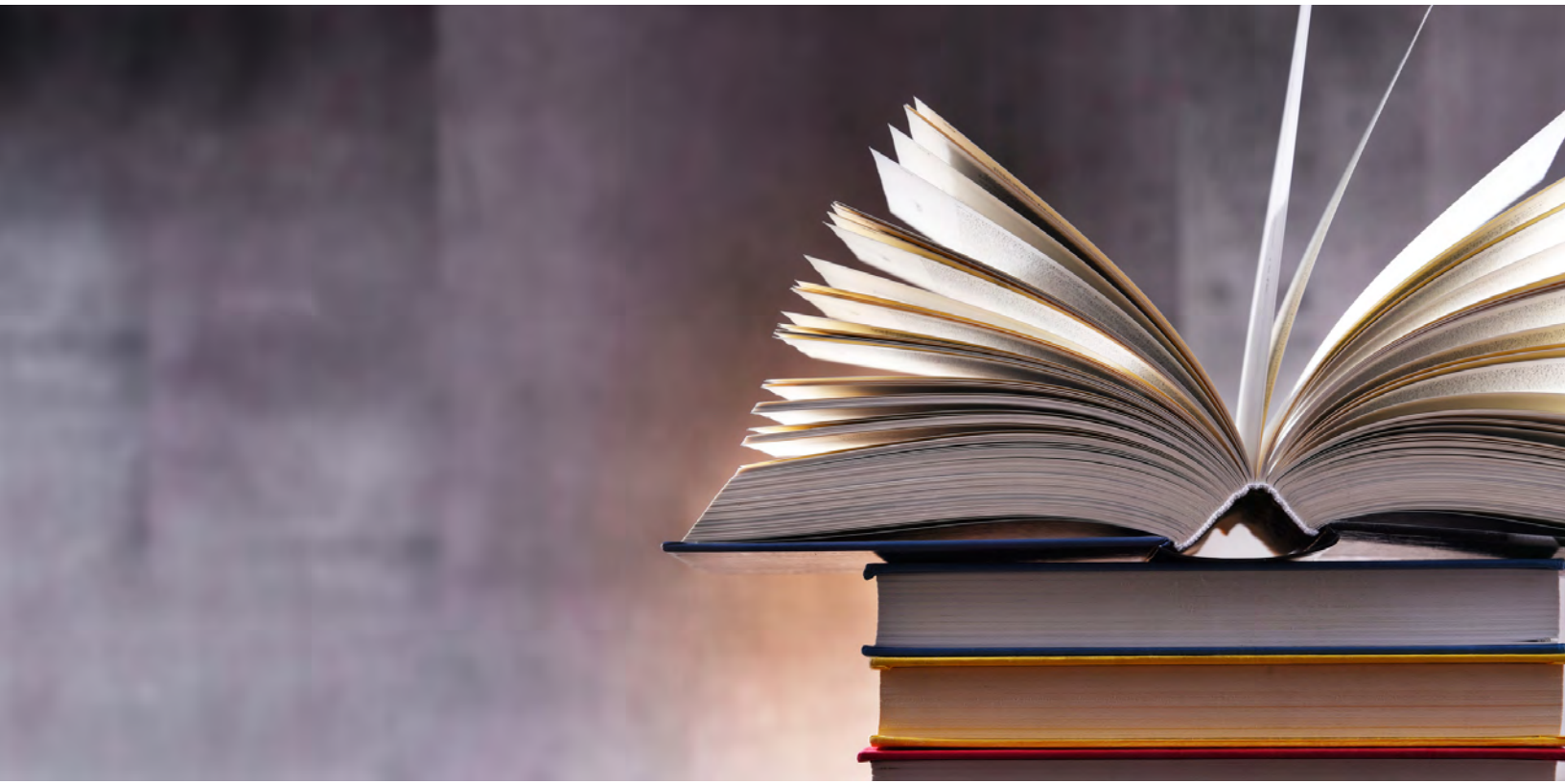
Loss Ratio - The dollar amount an insurer pays in claims compared to the amount it collects from all customers in premiums. Loss ratio is usually the percentage of each dollar collected in premiums which is paid out in claims.

Medically Necessary - Treatments or services an insurance policy will pay for as defined in the contract. Check your policy for specific language defining medically necessary.

Multiple Employer Welfare Arrangement (MEWA) - An organization of employers who join together as a group to provide health care benefits for their employees. Ohio law requires a MEWA to either buy an insurance policy that covers its members' employees, or meet the financial standards for an insurance company.

Open Enrollment - A period of time when new subscribers may enroll in a health insurance plan regardless of their health.

Out-of-State Group Policies - A group policy that is sold outside of Ohio. Example: you live in Ohio and are covered by a policy your group purchased in Indiana. The policy may be regulated by Indiana law rather than Ohio law.



Contact Us:

Medicare/OSHIIP 800-686-1578
Consumer Services 800-686-1526
Fraud & Enforcement 800-686-1527

TDD/TTY phone users, please call Ohio Relay Service 9+711

For many department services and
publication updates, please visit our website
insurance.ohio.gov

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