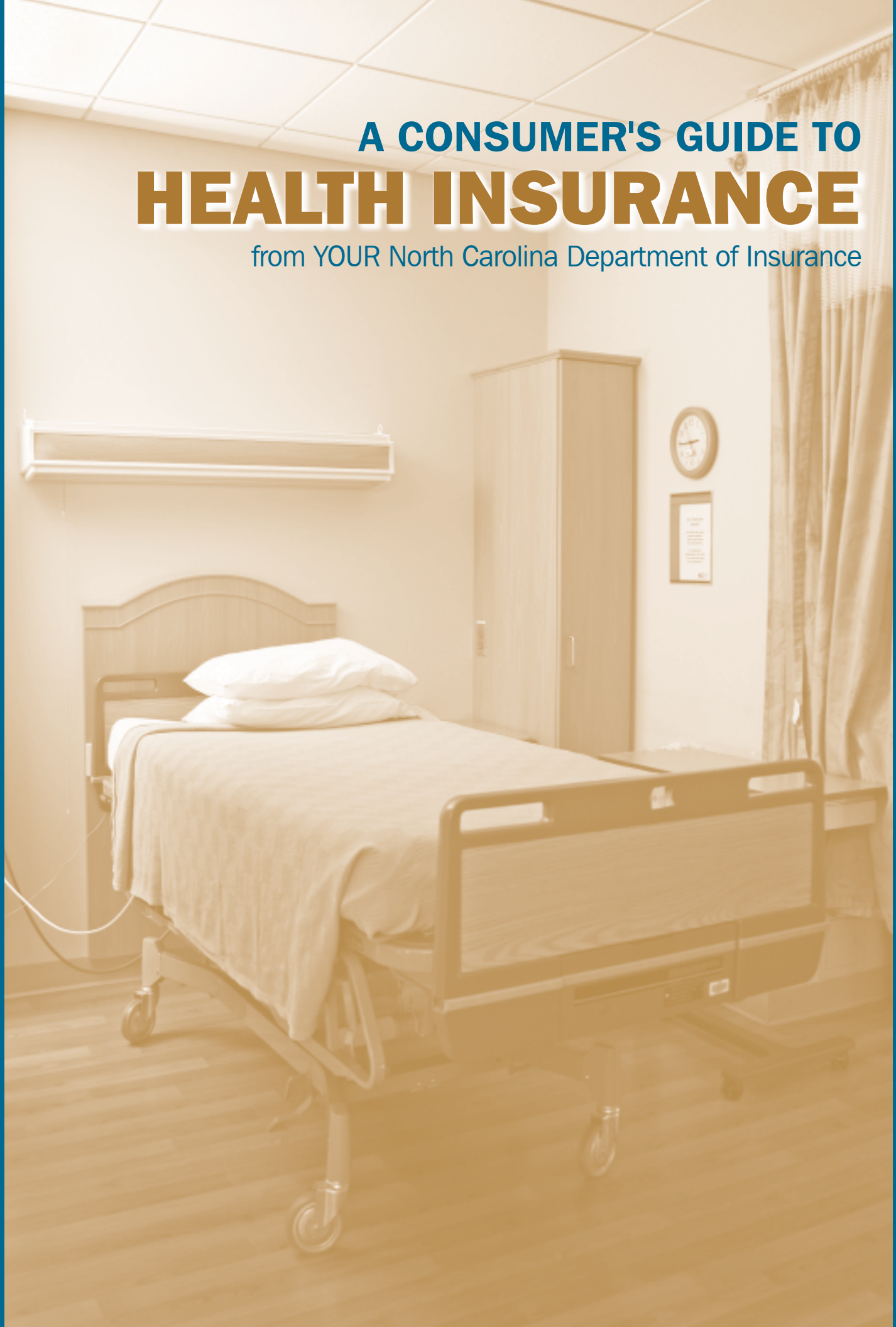

A CONSUMER'S GUIDE TO
HEALTH INSURANCE

from YOUR North Carolina Department of Insurance

CONSUMER'S GUIDE

A MESSAGE FROM YOUR INSURANCE COMMISSIONER

Greetings,

Whether you are enrolling in a traditional health insurance plan or a managed care plan, you should know your rights. This guide is made available to North Carolina consumers to help you make informed choices when purchasing health insurance. Choosing a health insurance plan is an important decision. I hope you will find this guide to be informative and helpful as you learn more about your health insurance options.

If you have any questions about health insurance that are not answered by this guide, your Department of Insurance has insurance specialists available to help you. Call us toll free (within North Carolina) at 1-800-546-5664, or visit us on the Web at www.ncdoi.com.

Sincerely,

Wayne Goodwin

Wayne Goodwin
Insurance Commissioner

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CONSUMER'S GUIDE TO LIFE INSURANCE

IF YOU HAVE QUESTIONS...

The Consumer Services Division of the Department of Insurance is here to help.

800-546-5664	Toll free
919-807-6750	Outside of North Carolina
919-715-0319	TDD (Telephone Device for Deaf Callers)
919-733-0085	Fax

You can find additional information as well as a downloadable copy of our complaint form on the North Carolina Department of Insurance Web site at www.ncdoi.com.

North Carolina Department of Insurance
430 North Salisbury Street
1201 Mail Service Center
Raleigh, NC 27699-1201
www.ncdoi.com

GLOSSARY

Appeal
An insurance company's review of its own non-certification decision, after you dispute that decision. This process is available any time a plan issues a non-certification decision. The appeal process is voluntary. Keep in mind that if your insurance company denies payment on a claim because the service is excluded from coverage, you do not have the right to appeal. Your certificate of coverage should clearly list what services are covered and not covered.

Certificate of Creditable Coverage
A document prepared by the prior health insurance company that discloses the beginning and ending dates of coverage. It is generally used to show a new health plan how much pre-existing condition limitation credit a new enrollee has earned.

Drug Formulary
A list of prescription medications that have been approved for use by the health plan. An open formulary allows coverage for non-formulary medications. A closed formulary limits coverage to those drugs in the formulary.

Emergency Care
Every insurance company shall provide coverage for emergency services to the extent necessary to screen and stabilize the person covered under the plan and shall not require prior authorization of the services if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. Payment of claims for emergency services shall be based on the retrospective review of the presenting history and symptoms of the covered person.

Evidence of Insurability
Proof that an applicant is an acceptable risk to the insurance company.

Exclusions (Limitations)
Provisions in an insurance policy that describe non-covered treatments and services or coverage limitations.

Experimental/Investigational
Until such time a treatment meets generally accepted standards of medical care in the community, it may be considered experimental or investigational.

Grievance
In addition to noncertification appeals, your rights under North Carolina law extend to other complaints against your health plan. Such complaints, called "grievances," can relate to any plan decision, policy or action related to the availability, delivery or quality of health care services; claims payment or handling; reimbursement for services or the contractual relationship between you and the plan.

Insolvency
The inability of a company to meet financial obligations or debts.

Insured
The person on whose life an insurance policy is written.

Medically Necessary Services or Supplies
Those covered services or supplies that are:

- Provided for the diagnosis, treatment, cure or relief of a health condition, illness, injury or disease and not for experimental, investigational or cosmetic purposes.
- Necessary for and appropriate to the diagnosis, treatment, cure or relief of a health condition, illness, injury, disease or its symptoms.
- Within generally accepted standards of medical care in the community.
- Not solely for the convenience of the insured person, the person's family or the provider.

Policyowner
The person or party who owns an insurance policy. The policyowner is often the insured person, but could be someone different. The policyowner is the only person who can make changes to a policy.

Primary Care Physician (PCP)
Doctors who provide general health care services and treatment. PCPs usually include family practitioners, general practitioners, pediatricians and internists.

Provider
A doctor, hospital, pharmacist or other health care professional or facility.

Provider Network
The doctors, hospitals, pharmacies and other health care professionals and facilities under contract with a health plan.

Rider
A modification or amendment to an insurance contract that may either expand, limit or exclude benefits.

Third Party Administrator (TPA)
A firm that provides administrative services to insurance carriers and/or employers.

Underwriter
A person employed by an insurance company who reviews applications for insurance and decides if the applicant is an acceptable risk.

You should consider several different options when shopping for a health insurance plan. This guide can help you choose the type of plan that best fits your needs.

MAJOR MEDICAL HEALTH INSURANCE

The two basic types of major medical (or comprehensive) health insurance plans are "traditional" plans and "managed care" plans. Many people are covered under major medical plans, either through an employer group or by purchasing individual policies.

Traditional Health Insurance

A traditional plan (also known as an "indemnity" or "fee for service" plan) is designed to cover a broad range of medical expenses such as hospitalization, doctor visits, surgery, diagnostic tests and prescription drugs. Most major medical policies require policyholders to satisfy out-of-pocket deductibles each plan year, and (after deductibles are met) to pay a portion of the cost ("co-insurance") for covered services. A traditional plan will allow patients to use a doctor or hospital of their choice. The plan will pay claims based on charges that your provider has agreed to in advance, or based on Usual, Customary and Reasonable (UCR) charges that represent an average charge for the service provided, in your local area. Many traditional plans limit the total amount of benefits that can be paid out during the policyholder's lifetime

Managed Health Care Plans

HMO, HMO Point of Service, and PPO benefit plans are the three most common types of managed care plans. The term "managed care" refers to health plans that attempt to manage both the cost and quality of health care services for their members. These plans involve certain processes and requirements that are different from those found in traditional health plans. These requirements are designed to encourage patients to seek the most appropriate health care in the most cost effective setting possible.

Some approaches used by managed care plans include:

- Requiring or encouraging members to use a contracted network of doctors, hospitals and other health care providers. This enables plans to negotiate discounts on behalf of members, thus keeping costs down. Members' out-of-pocket expenses are generally higher for care received outside of the plan network. Some HMO plans will not cover services received outside of the network (except for emergency services), while HMO Point of Service plans and PPO benefit plans cover some or all of the cost for services received outside of the network.
- Reviewing medical treatments and services before agreeing to pay. This process, known as Utilization Review, determines whether the treatment or service is medically appropriate for your health condition. If the Utilization Review process finds that the services you have requested are not medically necessary for your condition, then the plan will not pay for those services. More information about Utilization Review is on page 4.
- Limiting visits to specialists. Some managed care plans may require members to see their primary care physician (PCP) before seeing a specialist. Because charges for specialist's services are typically higher than for that of a PCP, this is a method of reducing unnecessary visits to expensive specialists. If a referral to a specialist is needed, the PCP can usually assist with the arrangements; however, it is the member's responsibility to verify with the plan that the referral has been approved.

Health Maintenance Organizations (HMO)

HMOs are organizations that provide or arrange for the delivery of health care services to their members in exchange for monthly premiums. Covered services typically include

hospitalization, surgery, routine doctor visits, diagnostic tests and prescription drug treatment. As with other managed care plans, HMO members usually pay a copayment when they visit a health care provider. HMOs in North Carolina use networks of contracted doctors, hospitals and other providers to keep costs low. One benefit of this is that the insured person will minimize out-of-pocket costs by using a network provider.

- Traditional HMO Plans — HMO members are generally required to seek health care treatment at designated hospitals, physicians, HMO facilities and other in-network providers, except in the case of emergency. Some HMO plans require PCP referrals in order to see a specialist, and all have UR programs that review the medical necessity of at least some requested health care services.
- HMO "Point of Service" (POS) Plans — POS plans are a more flexible type of HMO plan. POS members may choose to see out-of-network providers for covered services, but at a higher out-of-pocket cost. Such plans may cover certain services only when received from in-network providers. Sometimes, POS plan members must choose a primary care physician and obtain referrals to specialists from their PCP. Other POS plans are "open access," meaning that no PCP referral is required to see a specialist.

Preferred Provider Organization (PPO) Benefit Plans

PPO Benefit Plans are offered by insurance companies rather than HMOs. In many ways, these plans resemble HMO Point of Service plans; insureds may select from a network of contracted physicians, hospitals and other health care providers, or use an out-of-network provider and be required to pay a higher share of the cost. PPO plan members may generally see specialists without any prior referral or authorization.

Utilization Review (UR) Programs

Most health insurance plans, even traditional ones, make use of UR programs, which use established medical review criteria to determine whether requested medical services are "medically necessary." Only medically necessary services are covered under the plan. A plan's UR program must be administered by qualified health care professionals, under the direction of a medical doctor who is licensed in North Carolina.

A health insurance plan that uses Utilization Review must:

- Routinely evaluate the effectiveness and efficiency of its UR program.
- Coordinate the UR program with its other medical management activities including quality assurance, credentialing, provider contracting, data reporting, grievance procedures, customer satisfaction and risk management.
- Provide a toll-free number or a collect call number, so that members can contact staff to receive prior approval (known as pre-certification) of services when required.
- Limit requests for information to only information necessary to certify the admission, procedure or treatment, length of stay and frequency and duration of health care services.
- Notify members (and their providers) of the decision whether or not to certify services within three business days of receiving all information regarding a request for services.
- When an insurance company denies a request, it must:
  - Issue a written noncertification decision that includes all of the reasons for the denial and a reference to the medical criteria used to deny the request;
  - Inform the member on how to request a copy of the medical criteria; and
  - Advise the member of the right to appeal the decision and explain how to file an appeal.
- Have written procedures to address the failure or inability of a provider or covered person to provide all necessary information for review.

SUPPLEMENTAL HEALTH INSURANCE

Supplemental health insurance provides limited coverage and benefits for specific health care conditions and expenses. Supplemental policies should not be used as a substitute for comprehensive health insurance coverage. Following are some examples of supplemental policies.

Cancer

Cancer policies provide limited benefits when the insured person is diagnosed with cancer (as defined in the policy contract). Most policies contain a schedule of benefits describing the amount of payments for covered cancer treatments. Benefits under these types of insurance plans are normally paid directly to the insured person.

Dental

Dental insurance provides benefits for care and treatment of the teeth and gums. Benefits vary from policy to policy, as some may cover 100 percent of preventative care (such as semi-annual check-ups, fluoride treatments, etc.) while others may only cover a portion of preventative care. Typically, dental insurance plans provide limited benefits for preventative, basic, major and orthodontic services. There is normally an annual benefit maximum for covered services. Additionally, benefits for orthodontic procedures such as braces, retainers, etc. are usually very limited and have a lifetime benefit maximum.

Hospital Indemnity

Hospital indemnity policies provide benefits, usually a specified dollar amount, for each day of hospital confinement.

Medicare Supplement

The federal Medicare program covers most (but not all) medical expenses for people age 65 and older, and for individuals under age 65 receiving Social Security disability benefits. A Medicare Supplement policy may be purchased to help pay for deductibles, copayments and other expenses not covered by the Medicare program. By law, only 12 types (A through L) of Medicare Supplement policies may be sold, each of which offers a different combination of benefits. For information and counseling on Medicare Supplement policies, contact the Seniors' Health Insurance Information Program (SHIIP) at 1-800-443-9354 or visit www.ncshiip.com.

Specified Accident

Specified accident plans provide limited benefits for covered accidents. Loss of limb or sight in one or both eyes may also be covered.

LONG TERM CARE

Long Term Care policies generally provide benefits for skilled and intermediate nursing home care. Benefits for personal (custodial) care may also be provided for care received in approved facilities. These policies usually pay a fixed amount per day while the insured person is in a nursing home. Most policies contain waiting 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 cover care received in facilities that are licensed by the state, participate in Medicaid and Medicare, and meet the policy's definition of skilled, intermediate or custodial care. Information and counseling on long term care insurance is also available from the Department of Insurance's Seniors' Health Insurance Information Program (SHIIP), at 1-800-443-9354.

INDIVIDUAL COVERAGE VS. GROUP COVERAGE

Health insurance coverage is offered either through an individual policy or group coverage. Under an individual policy, the policyholder is the insured person. Under a group policy, the policyholder may be an employer, association, trustee, etc., while the insureds are the members of that employer or other organization. Under group policies, the group (policyholder) generally has the right to continue, terminate or request changes to the group plan which, in turn, affects the coverage of all individuals insured under the group. Under an individual policy contract, those rights rest with the insured individual.

INDIVIDUAL HEALTH INSURANCE

An individual health insurance policy is a contract between you and the insurance company. You are the policyholder and a party to the insurance contract. An individual health insurance policy may cover one person or several family members. Typically, individuals purchase this type of coverage when they are not employed, or when they are employed but do not have access to group coverage. Also, individual health policies may be used to supplement Medicare.

Although individual coverage is often more expensive than similar coverage under a group policy, it can be an important means of ensuring that a person has the health insurance coverage he needs, whether for a long time or for a short period between jobs. Most people applying for an individual policy are subject to being underwritten by the insurance company. This means that the insurance company may review the individual's health history, and refuse or limit coverage based on that history (this may not apply if you are a HIPAA-eligible individual. Read more about HIPPA on page 8). However, once an individual is covered, an insurance company may not terminate or refuse to renew an individual policy unless it offers each affected individual the option to purchase any other individual health insurance policy that it offers. This feature is known as "guaranteed renewability." Please note that a company may decide to terminate all of its individual health insurance policies with proper advance notice.

GROUP HEALTH INSURANCE

Many employers offer group health insurance to their employees as an employment benefit. Some employers offer only one plan while others offer a choice of plans. No employer is required to offer health insurance; however, if this benefit is offered, it must be offered to all eligible employees (eligibility requirements usually include permanent status and working 30 hours or more per week).

Under group coverage, a master group policy is issued to the group policyholder (the employer), and covered participants receive a certificate or handbook that summarizes the benefits and provisions outlined in the master group contract. Also, many group policies provide the option of covering dependent family members. Employers may require eligible employees to satisfy a waiting period of up to 90 days prior to being added to the plan. Under employer group health insurance plans, the employer is the policyholder and the employee is a plan participant. As the policyholder, the employer does not need the consent of plan participants to change insurance companies, make changes to the plan, cancel the policy or agree to new premiums or benefits. However, North Carolina law requires employers to provide 45 days notice to their employees when they plan to cease offering health insurance. No company may cancel or refuse to renew coverage for individual eligible participants if it continues to cover the rest of the group.

Small Groups
Small groups are those employers with one to 50 employees, including self-employed individuals.

Large Groups
In North Carolina, large employer groups are those with more than 50 eligible employees. When an employer applies for health insurance, the insurance company may fully "underwrite" that group by requesting health information and deciding whether or not to offer coverage. The group of employees must either be accepted or declined as a whole — no one employee can be singled out. Once coverage is issued, large employer groups have guaranteed renewal rights. In addition, large group premium rates usually are developed using each group's past claims history.

Multiple Employer Welfare Arrangements (MEWAs)
MEWAs provide coverage to employees of multiple employers in the same line of business. Rather than purchasing coverage from an insurance company, a group of similar employers may jointly establish a self-insured (self-funded) health benefit plan by pooling funds, and then using the pooled funds to pay members' health care expenses. The North Carolina Department of Insurance licenses and regulates these "Multiple Employer Welfare Arrangements" as it does insurance companies. However, the North Carolina Life and Health Insurance Guaranty Association does not cover MEWA insolvencies; if a self-insured MEWA runs out of money to pay claims, its participating employers may be held responsible for those unpaid claims.

Small Employer Group Health Coverage Reform Act

North Carolina's Small Employer Group Health Coverage Reform Act was enacted in 1992. The purpose of the Act is to promote the availability of accident and health insurance to small employers, eliminate abusive rating and underwriting practices, and improve fairness in the health insurance marketplace. All insurance companies who market or offer small group health insurance in North Carolina must offer all their plans to small employers who have one to 50 employees, provided that the employees reside within the insurance company's service area. Self-employed individuals (as defined by the IRS) do not have guaranteed access to all plans, but they must be offered two standardized plans established by state law (known as the Standard and Basic health plans) regardless of their health status. North Carolina General Statutes define a "small employer" as any individual actively engaged in business that, on at least 50 percent of its working days during the preceding calendar year employed no more than 50 eligible employees, the majority of whom are employed within this state, and is not formed primarily for purposes of buying health insurance and in which a bona fide employer/employee relationship exists.

Insurance companies have the right to verify whether small employers and self-employed individuals applying for coverage meet the above stated definitions. Insurance companies will most likely request tax and business documents during the application process and may refuse to issue coverage if proper proof is not provided. Additionally, those documents may be requested periodically after coverage is issued to verify ongoing eligibility. No company may single out a small group for termination or non-renewal if it will continue to serve other small groups in the same geographic area. The Small Employer Group Health Coverage Reform Act also establishes limits on how much insurance companies can vary premiums from one small employer to another.

WHAT HAPPENS IF I LOSE MY EMPLOYER GROUP COVERAGE?

When leaving an employer, continued coverage may be available through COBRA continuation, or through State continuation.

COBRA (Consolidated Omnibus Budget Reconciliation Act)

Federal COBRA Continuation law applies to employer groups covering 20 or more employees. This law generally allows eligible individuals to continue under the employer's group policy for up to 18 months, but the individual is responsible for paying the premiums. In some cases, the coverage can continue for longer than 18 months. COBRA continuation law applies to both insured and self-funded plans; however, it does not apply to church plans, plans covering less than 20 employees or plans covering federal employees. Detailed information on your rights under the federal COBRA laws can be obtained from the U.S. Department of Labor's Employee Benefits Security Administration, Atlanta Regional Office at (404) 302-3900. For a complete list of publications provided by the EBSA, call their hotline at 1-866-444-3272 or visit the U.S. Department of Labor's Web site at www.dol.gov.

State Continuation

North Carolina's State Continuation laws allow employees and dependents to continue coverage under the employer's group health plan after they terminate employment or otherwise lose eligibility. Under State Continuation guidelines, employees who terminate employment for any reason, whose hours are reduced or who lose eligible employee status may continue their basic health insurance coverage for up to 18 months. Upon termination or loss of eligible status, dependents covered by the policy will also be able to continue coverage for 18 months. Unlike COBRA, State Continuation laws do not provide for extensions of coverage beyond 18 months. In order to obtain more information about State Continuation contact the North Carolina Department of Insurance toll free at 1-800-546-5664. A "Consumer's Guide to State Continuation" is available on the Internet at www.ncdoi.com.

Conversion Policies

All insurance companies that sell group health insurance plans must offer an individual conversion policy to individuals who lose coverage under the group plan, without imposing exclusions of pre-existing conditions. Conversion policies may cost substantially more than your previous group coverage. Some people may qualify as HIPAA (Health Insurance Portability and Accountability Act) eligible individuals and also be eligible for coverage under individual conversion policies. If you find yourself having both of these options, you should carefully compare the premiums and benefits and choose the plan that best meets your needs.

HIPPA "Guaranteed Issue" Individual Health Insurance

All private insurance companies that sell individual health insurance must offer a choice of at least two "guaranteed issue" plans for qualified HIPAA-eligible individuals. Those two plans must contain benefits that are similar to those offered under the insurance company's other plans. Companies that choose not to designate two plans for

Fully Insured Vs. Self-Funded Group Health Plans

Fully Insured

Fully insured group health insurance policies are offered by licensed insurance companies. The insurance company collects premiums and uses the money collected to pay claims. These types of policies are regulated by the North Carolina Department of Insurance, and are protected by the Life and Health Guaranty Association in the event that a licensed insurance company becomes financially insolvent. If this occurs, the Association provides up to $300,000 per person to cover unpaid claims.

Self-Funded or Self-Insured

Some employers and labor unions provide group health benefits for their employees or members through what is called a self-funded health plan. In a self-funded plan, the employer or group collects premiums itself and uses those funds to pay for claims. While an insurance company or other company may be responsible for administering the plan (provider network, claims processing, customer service, etc.), the employer retains responsibility for making sure that there are enough funds to pay claims. Self-funded health plans do not involve a health insurance policy; therefore, they are not insurance plans, and are not subject to North Carolina insurance laws or the North Carolina Department of Insurance's regulatory authority. In addition, the North Carolina Life and Health Insurance Guaranty Association does not cover self-insured plans in the event of plan insolvency. Single employer and union sponsored self-funded health plans are regulated by the U.S. Department of Labor's Employee Benefits Security Administration, under the guidelines of the Employees' Retirement Income Security Act (ERISA) of 1974.

As noted earlier, self-insured MEWAs (which cover multiple employers) are licensed and regulated by the North Carolina Department of Insurance, but are not covered under the Guaranty Association.

HIPAA-eligible individuals must offer all of their individual insurance policies. However, there are no restrictions on the rates that insurance companies can charge HIPAA-eligible individuals for these plans, as long as there is an actuarial basis for the rates. This means that the policies HIPAA-eligible persons are entitled to buy tend to be rather expensive. To qualify as a "HIPAA-eligible individual," you must meet all of the following requirements:

- You must have had at least 18 months of continuous "creditable coverage," of which at least the last day must have been under an employer group health plan.
- You must have used up any COBRA or State Continuation coverage for which you were eligible.
- You must not be currently eligible for coverage under Medicare, Medicaid or another group health plan.
- You must not presently have health insurance. (If, however, you know your group coverage is about to end, you can apply as a HIPAA eligible individual for coverage to go into effect when your group coverage ends.)
- You must apply for health insurance as a HIPAA eligible individual no later than 63 days after losing your group coverage.

For more information on this topic, see "Your HIPAA Rights and Guide to Individual Health Insurance" on the Department of Insurance's Web site, www.ncdoi.com.

Government Sponsored Health Insurance

NC Health Choice for Children

NC Health Choice for Children (the State of North Carolina Children's Health Insurance Program) is a program funded by the federal and North Carolina governments. NC Health Choice may be discontinued at any time if federal money is no longer available. A child (under the age of 19) who lives in North Carolina and has no health insurance may be eligible, depending on family income. County health departments and social service departments determine whether a child qualifies for coverage under NC Health Choice. In order to obtain more information about this program, contact the North Carolina Division of Medical Assistance toll free at 1-800-367-2229. Information can also be found on the Internet at www.dhhs.state.nc.us/dms/cpcont.htm.

Medicaid

Medicaid provides medical assistance to low-income families and individuals of all ages participating in cash assistance programs. Federal and state governments jointly finance Medicaid. All states, the District of Columbia and some U.S. territories have Medicaid programs. Medicaid programs are governed by federal guidelines, but eligibility criteria and covered services can vary from state to state. In North Carolina, each county determines eligibility. For individuals who qualify for both Medicaid and Medicare, Medicaid pays Medicare cost-sharing amounts and fills in many gaps in Medicare's benefit package, especially in the area of long-term care services and prescription drugs. In order to obtain more information about this program, contact your county's Department of Social Services (DSS). You may go to the DSS to apply or ask them to send you an application in the mail. Applications are also available at your county's health department. You may complete the application yourself and return it in person, or mail it to the DSS. If you cannot locate the phone number for your local DSS or if you have further questions

regarding Medicaid eligibility, call the Office of Citizen Services CARE-LINE Information and Referral Service toll-free at 1-800-662-7030. For local calls or calls from outside of North Carolina, dial (919) 733-4261. The Office of Citizen Services has a dedicated TTY line at 1-877-452-2514 or for local TTY or TTY calls from outside of North Carolina, dial (919) 733-4851 for the deaf and hearing impaired.

Medicare

Medicare is a federal health insurance program for people age 65 years or older, people with certain disabilities, and people with permanent kidney failure being treated with dialysis or a transplant. Medicare has two parts: Part A (hospital insurance) and Part B (medical insurance). For more information concerning Medicare and Medicare supplements, contact the North Carolina Department of Insurance's Seniors' Health Insurance Information Program (SHIIP) toll-free at 1-800-443-9354, or visit our Web site at www.ncdoi.com.

BENEFITS

North Carolina law requires insurance carriers to include certain benefits in major medical health insurance policies that are offered in this state. Some of these benefits are:

Emergency Services
Every insurance company must cover emergency services necessary to screen and stabilize the insured person, if those services meet the "prudent layperson" standard (meaning that a layperson would have reasonably believed that an emergency medical condition existed). A managed care plan cannot require prior authorization for emergency services, or require that an in-network hospital's emergency room be used. Copayments and/or deductibles generally apply.

Minimum Hospital Stay Following Childbirth
Health benefit plans that provide maternity and childbirth benefits are required to cover both the mother and her newborn child for a minimum of 48 hours of inpatient care after normal childbirth, or for a minimum of 96 hours of inpatient care following a cesarean section, as long as the physician determines that inpatient care is appropriate. Unless the child is covered as a dependent under a parent's plan, coverage for the newborn's care will end after the first 48 hours (or 96 hours for a cesarean section). State law does not require health insurance plans to offer maternity care.

Mammograms and Pap Smears
Every policy must cover pap smears and low-dose screening mammography.

Bone Mass Measurement
Health benefit plans must cover scientifically proven and approved bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass in certain "qualified" individuals. To be a qualified individual, the insured person must meet at least one of the following characteristics:

- estrogen-deficient and at clinical risk of osteoporosis or low bone mass.
- possessing radiographic osteopenia anywhere in the skeleton.
- receiving long-term glucocorticoid (steroid) therapy.
- having primary hyperparathyroidism.
- being monitored to assess the response to or efficacy of commonly accepted osteoporosis drug therapies.
- having a history of low trauma fractures.
- having other conditions or on medical therapies known to cause osteoporosis or low bone mass.

Diabetes Treatment and Services
Policies must cover medically appropriate and necessary diabetes treatment and services. Outpatient self-management training and educational services, equipment, supplies, medications and laboratory procedures used to treat diabetes must also be covered.

Mastectomy Length of Stay and Reconstructive Breast Surgery Following Mastectomy
Insurance companies must allow the patient's physician and the patient to determine how long she will remain in the hospital following a mastectomy. Coverage must be provided for reconstructive breast surgery following a mastectomy performed in the course of treating cancer or breast disease.

Chemical Dependency
All insurance companies offering group policies must offer benefits for the care and treatment of chemical dependency.

Contraceptives
Every insurance company providing a health benefit plan covering prescription drugs or devices must also provide coverage for prescription contraceptive drugs or devices.

This includes outpatient contraceptive services if outpatient care is provided. Religion-based employers may request an exemption.

Newborn Hearing Screening

All health insurance companies are required to cover hearing screenings for newborn children, subject to the deductibles, copayments and coinsurance that generally apply to other services covered by the plan.

Clinical Trials

All health insurance companies are required to cover medically necessary expenses for phase II, III and IV clinical trials that are not directly related to conducting the trial itself, not provided by the parties conducting the trial, and that would be covered if provided outside of a clinical trial. To be covered, the trials must meet certain minimum medical and scientific requirements.

Adding Newborn Infants and Adopted or Foster Children

Newborn children, newly adopted children and newly placed foster children who are covered as dependents are considered to be covered from the moment of birth or moment of placement in a home, as long as the policy was in effect at that time. When coverage becomes effective in this manner, exclusions and waiting periods for pre-existing conditions may not be applied. If your existing policy automatically covers your new child with no additional premium, then the policy is considered to be in place at the moment of birth or placement, regardless of whether you provided your insurance company with advance notification of your new child. However, notifying the insurance company prior to or soon after birth or placement is a good idea in order to avoid delays in claim processing.

If your policy will require additional premium, however, you must notify your plan prior to birth or placement or within 30 days of birth or placement, in order for the coverage to be in effect from the moment of birth or placement. Otherwise your plan may exclude or place a waiting period on coverage for pre-existing conditions, including birth defects.

Mentally Retarded or Physically Handicapped Children

The age limitation for dependent children will not apply for a child who is, and continues to be:

- Incapable of self-sustaining employment by reason of mental retardation or physical handicap; and
- Chiefly dependent on the policyholder for support and maintenance.

Policy guidelines must be followed to properly notify the insurance company of any request to continue coverage for qualified children.

Network Adequacy

Managed care (HMO and PPO) plans must maintain adequate provider networks that provide access to covered services within a reasonable distance, and without unreasonable delay. If a managed care plan's network does not offer reasonable access to an appropriate provider, then the plan must allow its member to receive needed care from out-of-network providers, without holding the member responsible for any more than the standard in-network copayment, coinsurance or deductible. Managed care plans are required to establish their own standards for network accessibility.

Exceptions to Drug Management Requirements

All health plans that use a closed prescription drug formulary must cover drugs that are not on the formulary, under certain circumstances:

- A plan member's physician notifies the insurance company that the formulary drug has been used to treat the patient for the condition in question; and
- The formulary drug was either ineffective in treating the condition, harmful to the patient, or is reasonably expected to be harmful to the patient and therefore, the non-formulary drug is necessary to treat the condition.

Restricted access drugs (formulary drugs that are covered only with insurance company's prior approval, or only after other specified formulary drugs have been tried without success) must also be covered on an exception basis, without prior approval or first having to try other formulary drugs, when:

- A plan member's physician certifies to the insurance company that the other formulary drug(s) has been used to treat the patient for the same condition previously; and
- The drug(s) was either ineffective or harmful to the patient and is expected to be harmful if used again.

Standing Referrals to Specialists

Managed care plans that require members to obtain a referral from their primary care physician (PCP) before seeing a specialist must allow the PCP to issue a standing referral for up to 12 months if the patient has a serious or chronic condition that is degenerative, disabling or life-threatening and ongoing specialty care is necessary.

Transitional Coverage when a Provider Leaves the Network (Continuity of Care)

Managed care plans must allow members to continue receiving coverage for treatment from providers who leave the plan's network, in order to ensure continuity of care while the member changes providers. This coverage is dependent upon specific conditions being met, including:

- The member —
  - has a serious acute condition that requires treatment to avoid death or permanent harm, at the time he/she was notified that the provider was leaving the network (up to 90 days of transitional coverage is provided); or,
  - has a chronic condition that is life threatening, degenerative or disabling and requires treatment over a prolonged period of time, at

Related Publications Available from NCDOI

A Consumer Guide to Cancer Insurance
A Consumer Guide to External Review
Employees Guide to HIPAA Rights Regarding Health Insurance
Employers Guide to HIPAA Rights Regarding Health Insurance
Guide to Appeals and Grievances
Health Insurance Premium Assistance
Managed Care in North Carolina (Annual Status Report)
Managed Care in North Carolina (Annual HEDIS Supplement)
What Happens To My Coverage If My Job Status Changes (state Continuation)
Your HIPAA Rights and Guide to Individual Health Insurance
Getting Off to a Good Start with Medicare
Medicare Changes and Options
Medicare + Choice Comparison Guide
Medicare Supplement Comparison Guide
Guide to Long-Term Care Insurance

the time they were notified that the provider was leaving the network (up to 90 days of transitional coverage is provided); or,

- is in at least the second trimester of pregnancy, at the time he/she was notified that the provider was leaving the network (transitional coverage is provided through delivery and up to 60 days of postpartum care); or,
- is scheduled for surgery, organ transplantation or other inpatient care prior to being notified of the provider's termination (transition coverage is provided through the completion of the procedure or stay and up to 90 days of post-discharge care related to the hospital stay); or,
- is terminally ill and not expected to live longer than six months, at the time that the provider will actually leave the network (transition coverage is provided for the remainder of the member's life).

- The provider leaving the network must agree to continue treating the member, accept the plan's payment rates, and comply with other plan requirements.
- The member must, within 45 days of being notified that their provider will be leaving the network, notify the insurance company of his/her desire to take advantage of this coverage.

The same rights to continuity of care described above apply when your employer changes from one health plan to another, and your provider does not participate in the new plan's network. Continuity of care requirements do not apply when you choose to change plans.

Specialists as Primary Care Provider

Managed care plans that require the use of a PCP must allow members with serious or chronic conditions that are degenerative, disabling or life-threatening and require ongoing specialty care to select a specialist to act as their PCP. This is subject to the insurance company agreeing that the specialist is capable of coordinating the patient's care, and the specialist agreeing to abide by the insurance company's procedures for PCPs.

Direct Access to Specialists

Managed care plans are required to allow female members 13 years old or older to have direct access to an OB/GYN for OB/GYN services, without a referral from a PCP. Managed care plans are required to allow all members who are under the age of 18 to select a network pediatrician as their PCP.

Disclosure

North Carolina law requires all insurance companies to clearly and truthfully disclose the following information in their marketing materials and all health insurance policies:

- A clear description of health insurance benefits.
- A complete list of items and services that the health care plan does not cover (exclusions and limitations).
- An explanation of how the insurance company will calculate its own claim cost (share of a claim) and your share, including an example of how they make that calculation.
- Length of time you must wait in order to receive benefits if the policy contains preexisting health conditions limitations.
- Renewal terms and provisions.
- Premium rate terms and provisions.

LIMITATIONS AND EXCLUSIONS

No matter what kind of health insurance plan you have, be sure to review and study your policy. It is important for you to understand your rights, obligations, covered services and excluded services. If at any time you do not understand your policy or have questions, you can contact the Department of Insurance at 1-800-546-5664 from anywhere within North Carolina. Our specialists are here to help you.

Some common provisions, limitations and exclusions in health insurance policies are:

FREE-LOOK PERIOD

When applying for an individual health insurance policy, you may return the policy to the company within the free-look period and receive a complete refund of all premiums paid, if you are not satisfied for any reason. The minimum free look period is 10 days, beginning with the date of policy delivery. Returning the policy during the free look period voids all benefits from policy inception.

PREMIUM PAYMENT GRACE PERIOD

Health insurance companies must allow policyholders a grace period after each premium due date. During the grace period, the policy remains in full force and effect. However, if a premium is not paid prior to the expiration of the grace period, the policy will lapse. Benefits typically terminate on the last day of the premium period for which premiums have been paid. The industry norm for premium grace periods is 31 days. In some instances, though, the grace period might be less than 31 days.

DEDUCTIBLE

The deductible is an initial out-of-pocket amount that members must pay for covered services, before the plan begins to pay. For example, a health plan may require a $250 annual or a $250 per illness deductible. Choosing a higher deductible may help lower your premium.

COINSURANCE

Coinsurance is the amount (usually states as a percentage) that must be paid by the insured person for covered services, after the deductible has been met. For example, if a policy pays 80 percent of covered charges, then the insured person's coinsurance amount will be the remaining 20 percent of covered charges.

Note: When covering services rendered by out-of-network providers, some plans base their own payment and the member's coinsurance on "allowed" amounts. If the out-of-network provider's total charges are greater than the plan's allowed amount, the member may be billed by the provider for the remaining balance. Members who receive care from in-network providers should never be subject to balance billing, as long as the services were covered and (if necessary) properly authorized by the plan. Check your member handbook and contact your plan, if you have any questions about your out-of-pocket liability for health care services.

COPAYMENT

This is a fixed dollar amount (such as $10, $20, etc.) that insured persons are required to pay directly to the provider, for covered services.

COORDINATION OF BENEFITS

The Coordination of Benefits provision applies when a member is covered by two health plans. It spells out how the charges for covered services will be paid by the two plans, so that total benefits do not exceed total charges.

PRE-EXISTING CONDITIONS

A health plan may refuse to pay for treatment of health conditions that existed prior to your enrollment in a health plan. For group health plans, both federal and North Carolina laws place time limits on the exclusion period for pre-existing conditions. Under federal and North Carolina law, a pre-existing condition is one for which you received medical advice or treatment within six months prior to enrolling in the plan. The maximum pre-existing condition exclusion period for timely enrollees (individuals who enrolled in the group plan at the first opportunity to do so) is 12 months. An 18 month pre-existing condition exclusion period may be imposed on late enrollees (anyone who did not enroll when they were first eligible to do so). If you have an individual major medical plan, a pre-existing condition may be defined as a health condition for which you received medical advice, diagnosis, care or treatment within 12 months immediately prior to the effective date of your plan. The maximum pre-existing conditions waiting period for individual coverage is 12 months. Generally, pre-existing condition waiting periods under both group and individual plans can be reduced by the length of time that coverage was maintained under prior health insurance plans, provided that there was not a lapse of 63 days or more between plans.

PORTABILITY

For many years, people have been concerned about the effect that changing jobs can have on health insurance coverage. Previously, medical conditions covered under a prior plan were often not covered under the subsequent plan. The Health Insurance Portability and Accountability Act (HIPAA), though, guarantees that insured persons get "credit" for the time covered under the previous plan, provided that the period between plans is no more than 63 days. Specifically, insurance companies must reduce any pre-existing condition limitation periods by the amount of time that the insured person was covered under prior creditable coverage.

Any coverage under a group plan (including COBRA or State Continuation), individual health insurance policy, Medicare or Medicaid or North Carolina's Health Choice program or comparable children's health plan offered by another state is considered "creditable coverage." As proof of coverage, employers and/or insurance companies are required to provide a "certificate of creditable coverage" to insured persons when coverage ends. That certificate is used to show the person's new health plan the amount of pre-existing credit to which the person is entitled.

If your coverage with a plan ends for any reason, it is very important that you save this certificate of creditable coverage. Benefits for pre-existing medical conditions cannot be denied under any plan's pre-existing condition limitation provision if the person has had creditable coverage for at least 12 months without a break (or lapse) in coverage of more than 63 days.

INCONTESTABLE PROVISION

Generally, insurance companies can contest the validity of a policy within the first two years after the policy is issued (or reinstated), if they suspect that information on an application was misstated or misrepresented, and that this information affected the insurance company's decision to issue the policy.

LIFETIME LIMITS

Most health insurance policies limit the total dollar amount that the policy will pay over the course of the insured person's lifetime (such as $1 million). Once this limit has been reached, policy benefits will cease.

ANNUAL LIMITS

Annual limits cap the total dollar amount of benefits payable during the course of the policy year, and usually pertain to a specific type of benefit or covered service.

OUT-OF-POCKET MAXIMUMS

Many policies limit the total coinsurance amount you must pay each year. Once you reach the coinsurance limit specified in your policy, the insurance company will pay 100 percent of covered charges for the remainder of the year.

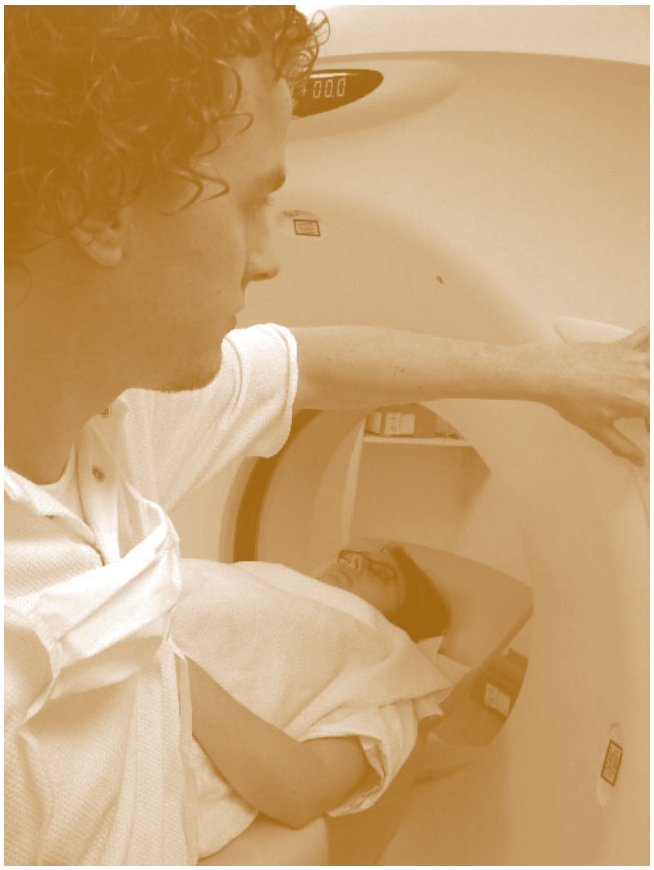
USUAL, CUSTOMARY AND REASONABLE (UCR) CHARGES

Insurance companies may (for some covered services) base their reimbursement amounts on Usual, Customary and Reasonable (UCR) charges, if permitted under the policy contract. This is typically the case for treatment received from out-of-network providers. Generally, UCR determinations are based upon average costs, in your local area, for the health care services in question.

COVERAGE EXCLUSIONS

Although you may purchase a plan that covers most medical, hospital, surgical and prescription drug expenses, no health plan will cover every conceivable medical expense you may incur. Examples of common exclusions include:

- Vision care (eye exams, glasses, contacts, etc.)
- Hearing aids
- Dental care
- Cosmetic surgery
- Experimental treatments
- Specific Treatments (e.g., sterilization, acupuncture, etc.)



NORTH CAROLINA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

To protect North Carolina insureds against company insolvencies, the North Carolina General Assembly created the North Carolina Life and Health Guaranty Association. The Guaranty Association provides up to $300,000 of benefits per person (for guaranteed policy benefits) on covered policies in the unlikely event of insurer insolvency. The association is funded by insurers licensed to do business in North Carolina.

SHOPPING FOR HEALTH INSURANCE

Most people enroll in their health plan through an employer. When this is the case, your employer selects the insurance company or companies and decides which plan or plans will be available to you. Many employers that offer health insurance pay at least some of the premium for the employee, and some employers also pay part of the premium to cover dependents. Health benefits are a large expense for employers, so employers must choose between different types of plans and benefit levels. If your employer offers a choice of plans, you will want to want to choose your plan with care. Likewise, if you decide to purchase individual health insurance, it is important to select a product that meets your specific health care needs.

WHERE TO SHOP

As with any major purchase, it is recommended that you shop around to make sure you get the best value for your money. Many insurance companies and agents advertise in the yellow pages, newspapers, television and/or radio. In addition, the Internet can be a valuable tool for researching specific companies and products, and in some cases obtaining preliminary quotes. Insurance agents must be licensed to sell insurance in North Carolina. Choose one with whom you feel comfortable and who will answer your questions. To verify that an agent is licensed, contact the North Carolina Department of Insurance, Agent Services Division at (919) 807-6800. Similarly, insurance companies must be licensed to conduct business in North Carolina. To verify that a company is properly licensed, you may contact the Consumer Services Division at (919) 807-6750 or 1-800-546-5664.

Seek Unbiased Information

The North Carolina Department of Insurance does not rate or recommend insurance companies, but can provide the date a company was licensed in North Carolina, as well as general information on the company's complaint history. Additional information is available to consumers through a variety of other sources, including the Internet, consumer magazines and publications, public libraries, consumer groups, etc. An insurance company's financial strength is very important. Independent rating organizations such as A.M. Best, Standard & Poor's, and Moody's Investors Service publish financial ratings. Consider checking at least some of these resources to evaluate a company's strength; they can be found in most public libraries, by asking your agent, or on the Web.

CHOOSING A PLAN

Aside from the type of plan and benefits covered, there are some other factors you may need to consider when choosing a health plan. The following items should be carefully considered.

Premiums

The premium is the amount paid for the insurance policy. Health insurance premiums can vary greatly, depending on applicant age and health history, the type of plan, the range of services covered by the plan, the plan deductible, lifetime maximum, and other factors.

Other Out-of-Pocket Expenses

In addition to monthly premium payments, most health plans require you to pay a portion of covered expenses, such as deductibles, coinsurance, copayments and excess charges when a provider's charges are higher than the plan's allowed amount. The out-of-pocket expenses for which you will be responsible should be considered along with the premiums when shopping for a plan.

Selecting the Right Managed Care Plan

If you have the option of choosing between two or more plans, you should carefully

compare the differences. Aside from the obvious differences in covered benefits, benefit levels (how much the plan pays) and premiums, you should also consider factors such as each plan's provider network, pre-authorization requirements, access to specialist care, etc. Many health insurance companies place their provider directory on their company Website so you can check on whether your providers participate in an insurance company's network.

In addition, before selecting a plan, review the plan summary carefully, call the plan for information, and (if possible) talk with coworkers and friends about their experiences with the plan you are about to select. Health plans are required by law to honor your request for a copy of the policy or evidence of coverage BEFORE you enroll. Information concerning coverage criteria for specific conditions, information on prescription drug formularies and coverage of experimental procedures is also available at your request.

QUESTIONS TO ASK WHEN SHOPPING FOR A PLAN

- What services does the plan cover? What is not covered?
- Will the plan cover preventative care, immunizations, well-baby care, substance abuse, organ transplants, vision care, dental care, infertility treatment, durable medical equipment or chiropractic care?
- Will the plan pay for prescriptions?
- Does the plan provide mental health benefits?
- Will the plan pay for long-term physical therapy?
- Do rates increase as you age?
- How often can rates be changed?
- How much do you have to pay when you receive health care services?
- Are there any limits on how much you are personally required to pay for health care services you receive?
- Are there any limits on the number of times you may receive a service?
- What are the restrictions on the use of providers or services under the plan?
- Does the health plan require you to see a provider in its network?
- Are the network providers conveniently located?
- Is the doctor you want to see in the network and accepting new patients?
- What do you have to do to see a specialist?
- How easy is it to get an appointment when you need one?
- Has the company had an unusually high number of consumer complaints?
- When calling the insurance company, how long does it take to reach a real person?

SHOPPING COMPARISON CHART

		Company Name	Company Name
Questions to Ask			
1	How much is the deductible?	$	$
2	Do I have to pay a co-insurance amount? If so, how much?	Yes No $	Yes No $
3	Are there waiting periods before certain illnesses are covered?	Yes No	Yes No
4	Does the policy have an annual benefit maximum? If so, how much?	Yes No $	Yes No $
5	Does the policy have a lifetime benefit maximum? If so, how much?	Yes No $	Yes No $
6	What are the limits on: ▪ Daily hospital room and board ▪ Medical tests or other hospital expenses ▪ Amount paid for doctor's visits	 $ $ $	 $ $ $
7	What is not covered?		
8	Will the policy pay for: ▪ Maternity care ▪ Prescriptions ▪ Immunizations ▪ Well baby care ▪ Vision care ▪ Dental care ▪ Infertility treatment ▪ Chiropractic care	 Yes No Yes No Yes No Yes No Yes No Yes No Yes No Yes No	 Yes No Yes No Yes No Yes No Yes No Yes No Yes No Yes No
Additional questions for managed care comparisons.			
9	How much is the co-payment?	$	$
10	Are my doctors in the network?	Yes No	Yes No
11	Do I need a referral to see a specialist?	Yes No	Yes No
12	Are non-emergency, out-of-network services covered?	Yes No	Yes No
13	Are network providers conveniently located?	Yes No	Yes No
14	Is the doctor I want to see accepting new patients?	Yes No	Yes No
15	Does the plan allow providers to balance bill me for the difference between allowed and actual changes?	Yes No	Yes No

This is only an example. You may need to tailor a comparison chart of your own to address your individual needs.

SUBMIT CLAIMS PROPERLY

Find out if you are responsible for filing your claims or if your provider will file them for you. If you are required to submit the claim, review the information to be sure it is complete and correct before forwarding it to the insurance company. File it as soon as you receive the bill from the provider. Send it to the correct address and keep a copy for your records.

ALLOW A REASONABLE TIME

For many types of health insurance plans, the insurance company must take action on a claim within 30 days after receipt. "Taking action" means the insurance company must pay, deny, or pend the claim for additional information. If the insurance company requires additional information, it must specify what is needed. After receiving the additional information, the company has an additional 30 days to take action on the claim.

EXPLANATION OF BENEFITS (EOB)

The Explanation of Benefits (EOB) is a statement sent to you from the insurance company, explaining its claim determination and benefit calculation. Information provided on the EOB should be carefully analyzed in conjunction with your medical bills and policy contract. Any questions or discrepancies should be promptly addressed with the insurance company.

Before You Receive Health Care Services

Plan Ahead
Read your policy or employee benefits booklet carefully to be sure what services are covered. Follow any managed care rules, such as the use of network providers. Give correct insurance information to your provider. If you, your spouse or your covered dependents have health care coverage under more than one group plan, you should review each employee benefit booklet to determine which policy is primary and which is secondary.

Pre-Certification
Many plans require you to contact the insurance company for approval before you check into the hospital, have elective surgery, visit specialists or have expensive tests. The steps should be spelled out in your policy benefits booklet. Pre-certification does not necessarily guarantee the payment of your claims. However, if your plan pre-certifies a service, it cannot later deny coverage on the grounds that the service was not medically necessary, unless the pre-certification was granted based on false information from you or your provider. Please note: An insurance company cannot require pre-certification for emergency medical services or treatment.

AND REQUESTS FOR EXTERNAL REVIEW

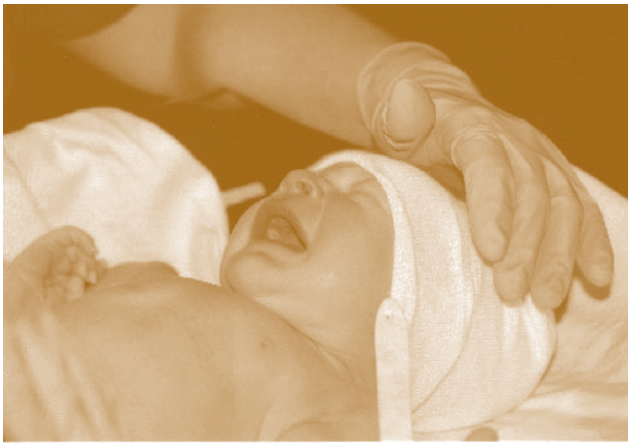
APPEALS AND GRIEVANCES

If you are dissatisfied with a claims decision made by your health insurance company, you may have the right to challenge that decision through an appeal and/or grievance process. A guide describing the appeal and grievance provisions in North Carolina law is available through the Department of Insurance by calling 1-800-546-5664 or visiting www.ncdoi.com. Laws regulating appeals and grievances apply to all types of full service health plans, including traditional indemnity, HMO and PPO plans. Patients with certain health conditions may be eligible for an expedited (quicker) appeal process. Details concerning your plan's appeal and grievance procedures should be included in your employee handbook, certificate of coverage and insurance policy.

EXTERNAL REVIEW OF HEALTH PLAN DENIALS

The North Carolina Department of Insurance Health Care Review Program (HCR) administers a free service called External Review, which provides another option for resolving certain coverage disputes between you and your insurance company. In North Carolina, external review is available when an insurance company denies coverage on the grounds that the requested service is not medically necessary (this is called a "non-certification" decision), or that the requested service is cosmetic or experimental for your specific medical condition.

For your request to be accepted for external review, you must meet the Program's eligibility requirements. A request is made directly to the HCR Program and each case is reviewed for completeness and eligibility. If accepted for external review, the case is assigned to an independent review organization (IRO) for a clinical review and final decision. Additional information about External Review can be found on the Department's Web site at www.ncdoi.com, or by calling the HCR Program at 1-877-885-0231.



BEFORE AND AFTER YOUR PURCHASE

FOR ALL TYPES OF HEALTH INSURANCE:

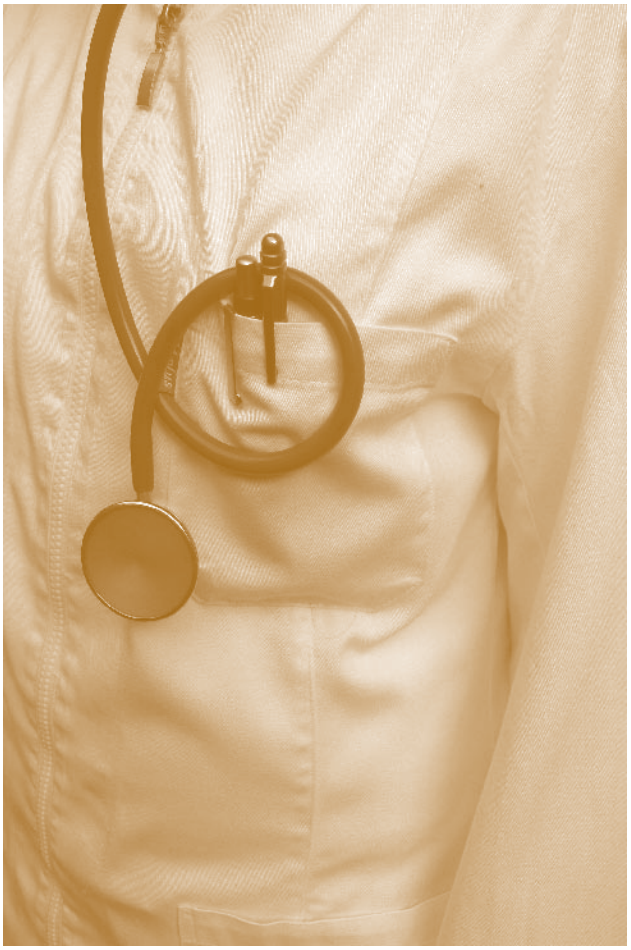
- Make sure all claim forms are filled out promptly, completely and accurately.
- READ YOUR POLICY and keep it in a safe and secure place.
- Ask questions.

FOR INDIVIDUAL INSURANCE:

- Shop around. Compare plans from more than one company. Do not feel pressured to make a quick decision.
- Verify that the agent and company you choose to do business with are licensed in North Carolina.
- DO NOT PAY CASH. When you purchase a policy, make your check or money order payable to the insurance company, NOT THE AGENT. Be sure to get a receipt.
- Make sure you fully understand any policy you are considering and that you are comfortable with the company, agent and product.
- Do not sign an insurance application until you review it carefully to be sure all the answers are complete and accurate.
- Keep in mind that you have a minimum 10-day "free look" period. If you cancel during the free look period, the company must return your premium without penalty.

DISCLOSURE

- North Carolina law requires all insurance companies to clearly and truthfully disclose the following information in their marketing materials and all health insurance policies:
- A clear description of health insurance benefits.
- A complete list of items and services that the health care plan does not cover (exclusions and limitations).
- An explanation of how the insurance company will calculate its own claim cost (share of a claim) and your share, including an example of how they make that calculation.
- Length of time you must wait in order to receive benefits if the policy contains preexisting health conditions limitations.
- Renewal terms and provisions.
- Premium rate terms and provisions.



FAQ'S

When I apply for insurance, what information will I be asked to provide?
To determine your eligibility, companies generally ask for medical and personal information.

Can an insurance company void my policy if I made a mistake in completing the application?
Health insurance companies may void contracts within the first two years, if the applicant provides inaccurate or incomplete responses to the application questions, and if the company relied on those responses in deciding to issue the policy. Always verify that answers and information submitted on any application for insurance are complete and accurate.

What are my rights to continue my health insurance if I lose my job?
You may be eligible to continue your group health insurance for up to 18 months by means of COBRA or State Continuation. The employer and/or insurance company cannot require you to pay more than 102 percent of your full group premium rate. See page 8 for more details.

What is association group health insurance coverage?
Under an association group arrangement, the master group policy is typically issued to the association, and coverage is offered to the association's members. Generally, each individual applicant must meet the company's underwriting guidelines. Applicants who fail to qualify may be denied coverage or exclusionary riders may be attached to the policy.

Am I guaranteed the right to purchase individual health insurance?
No. Except under certain circumstances, insurance companies have the right to fully review your application and determine whether you are an acceptable risk. If not, your application may be declined.

What is HIPAA (Health Insurance Portability and Accountability Act)?
HIPAA affects individuals who change from one employer group plan to another, and to those individuals who lose their eligibility for group coverage. Two of the most important features of HIPAA are health plan "portability" and the availability of "guaranteed issue" individual health insurance. Information on page 8 will provide you with more details.

Does the Department of Insurance set the rates and tell companies how much they can charge?
No, the North Carolina Department of Insurance does not have the authority to set health insurance rates. However, carriers are required to justify their rates and demonstrate that they are actuarially sound and not unfairly discriminatory.

I have a child who is going to be attending school outside my HMO's (or other managed care plan) service area. Will my child be covered?
Children who live and attend school outside the HMO's service area are subject to the same requirements as all other persons covered by the plan. The child must return to the plan's service area in order to receive full benefits. However, the plan must cover emergency treatment outside of the service area.

I am currently covered under my employer's HMO. I plan to leave my job and move to another state. Do I have any COBRA or North Carolina State Continuation rights?
If you move out of the plan's service area, your coverage will most likely be terminated.

I have an exclusion rider on my individual health policy. How long will it remain in effect? The rider will remain in effect for the length of time specified by the terms of the rider. If there is no time limitation specified, it will remain in effect for the duration of the policy unless the insurance company agrees to remove it.

The Consumer Services Division strives to respond promptly, clearly and courteously to consumers' insurance-related questions and complaints., in an effort to help consumers understand their options and resolve their insurance problems.

If you have a problem or concern with an insurance company or agent, the North Carolina Department of Insurance stands ready to assist you. A consumer complaint form is included in this brochure for your convenience on page 26.

WHAT WE CAN DO TO HELP

- Forward a copy of your complaint to your insurance company, and require the company to provide a response/ explanation.
- Review the company's response for compliance with applicable North Carolina statutes, regulations, and policy requirements.
- Require the company to take corrective action if we determine that the company's position does not comply with applicable requirements.
- Help you understand your insurance policy.
- Recommend courses of action that you can take to resolve your problem, if we do not have the regulatory authority to resolve it ourselves.
- If your situation involves a health plan's noncertification decision (denial based on lack of medical necessity), refer you to the Department of Insurance's Health Care Review Program (HCR Program), for further guidance.

WHAT WE CANNOT DO

- Act as your legal representative in or out of court.
- Intervene in a pending lawsuit, on your behalf.
- Consult with you if you are represented by an attorney, unless we have your attorney's written permission.
- Regarding a dispute between you and your insurance company, establish:
  - Who was negligent or at fault.
  - The value of a claim or the amount of money owed to you.
  - The facts surrounding the claim (that is, who is being truthful when there are differing accounts of what happened).
  - The facts regarding any other disagreement between you and another party.
- Address plans or companies that are not subject to the insurance laws of North Carolina, or that are governed by other state agencies.

The North Carolina Department of Insurance pledges to seek fair and equitable treatment of all parties in insurance transactions.

File Number: _____ (office use only)

PLEASE DO NOT STAPLE

NORTH CAROLINA DEPARTMENT OF INSURANCE

(Please type or print. You may also use the online version of this form at www.ncdoi.com)

DR.
MR.
MRS.
MS. _____
my name

_____
my address

_____
second address line (if needed)

_____ _____ _____
city state zip

_____
county

Phone: Work ____ /____ /_____ Ext.____

Home ____ /____ /_____

Alternate ____ /____ /_____

_____
name of insured

_____
insurance company

_____
agent

_____
adjuster

_____
policy or group number

_____
claim or certificate number

_____
date of loss

Type of Insurance (please check one): Life ❑ Health ❑ Auto ❑ Homeowners ❑ Other ❑

If Life or Health policy, show the state in which your policy/certificate was purchased: _____

Are you represented by an attorney in this matter? No ❑ Yes ❑ Name_____
(if yes, we must have your attorney's consent in writing)

Details of complaint (*attach copies of papers relating to this matter*)

_____

_____

_____

_____

_____

_____

_____

_____

The Insurance Department is authorized to send a copy of this document(s) to any company or agency involved. I authorize the release of all relevant information to the North Carolina Department of Insurance for its use in the review of this matter. Please note that consumer complaints become public records in accordance with North Carolina General Statute 58-2-100.

SIGNATURE _____ **DATE** _____

Mail to:
Consumer Services Division, NC Department of Insurance, 1201 Mail Service Center, Raleigh, NC 27699-1201

5,000 copies of this public document were printed at a cost of $##### or $### per unit.
(Revised January 2009)

North Carolina Department of Insurance
Wayne Goodwin, Commissioner
1201 Mail Service Center
Raleigh, NC 27699-1201
www.ncdoi.com