

HEALTH INSURANCE

CEIS

CONTINUING EDUCATION INSURANCE SCHOOL

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Health Insurance

TABLE OF CONTENTS

INTRODUCTION	1
CHAPTER ONE - TYPES OF HEALTH INSURANCE	3
DISABILITY INCOME INSURANCE	3
SPECIAL FORMS OF DISABILITY INCOME INSURANCE	6
Business Overhead Expense Benefits	6
Key Employee Disability Insurance	6
Buy and Sell Agreements	6
Accidental Death and Dismemberment	7
MEDICAL EXPENSE INSURANCE	8
Basic Medical Expense Policies	9
Major Medical Insurance	10
Comprehensive Medical Insurance	13
Special Medical Expense Insurance Policies	13
CHAPTER TWO - MAJOR MEDICAL POLICY PROVISIONS	17
MAJOR MEDICAL INSURANCE CONTRACT	18
CANCELLATION PROVISION	19
SCHEDULE OF BENEFITS (EXAMPLE)	20
COINSURANCE PERCENTAGE PAYABLE BY YOUR INSURANCE COMPANY FOR COVERED SERVICES AND/OR SUPPLIES	20
INDIVIDUAL MAXIMUM OUT OF POCKET COINSURANCE EXPENSE	21
MEDICAL EMERGENCY & OR ACCIDENT CARE	21
GENERAL TERMS	22
DEFINITIONS	22
PROVIDERS	22
Mental And Nervous Disorder	23
Alcohol And Drug Dependency Lifetime Maximum Benefit	24
ADMISSION CERTIFICATION	25
GENERAL TERMS	27
APPLICATIONS	36
Representations By the Contract Holder/insureds/Applicants	36
Individuals Covered	37
Dependents Coverage	37
Period of Child Eligibility	39
Adding a Dependent	41
Termination of Dependent's Coverage	41
Foster Children	42
Natural Children	42

CONTRACT CHANGES	42
Change In Benefit Coverage	43
Identification Card	43
PREMIUM PAYMENT	44
Application Misstatements	45
Grace Period	45
Premium Adjustments	46
POLICYHOLDER REQUIREMENTS	46
DEDUCTIBLE REQUIREMENT	46
INDIVIDUAL CARRY OVER PROVISION	46
CHAPTER THREE - POLICY PROVISIONS CONTINUED	49
COINSURANCE	49
MAXIMUM OUT-OF-POCKET COINSURANCE EXPENSE	49
RESTORATION OF BENEFITS	50
MEDICALLY NECESSITY	51
PROVIDER ALTERNATIVES	52
IN SERVICE AREA (PPO PLANS ONLY)	52
OUTSIDE SERVICE AREA	55
MEDICAL EMERGENCY/ACCIDENT	56
Coverage Provided by Other Health Care Professionals	57
COVERED INSTITUTIONAL BENEFITS	57
Hospital Expense Benefits	57
Skilled Nursing Facilities	58
Home Health Care	59
Home Health Services include:	60
Home Health Services do not include:	60
MEDICAL AND SURGICAL BENEFITS	61
SERVICES PROVIDED Out of THE Hospital	61
Inpatient Medical Visits	61
Additional Physician Benefits in Hospital	62
Surgical Services	62
Simultaneous Surgical Procedures	62
Incidental Surgical Procedures	63
Physician Surgical Assistant	63
Anesthesia	64
Consultations	64
Outpatient Visits	65
Diagnostic Services	65
Therapeutic Services	65
Mammogram Screening Services	66
Other Covered Benefits	67
Complications of Pregnancy	67
Sterilization	68
Newborn Care And Transportation	68
Well Child Care	69
Ambulance Services	70
Prescription Drugs	71
Prosthetic Devices	71
Orthotic Devices	72
Durable Medical Equipment	72
Services Outside Of The United States	72
Transplant Services and Supplies	73

CHAPTER FOUR - GENERAL LIMITATIONS, EXCLUSIONS & PROVISIONS 81

COORDINATION OF BENEFITS	81
SUBROGATION	84
PRE-EXISTING CONDITIONS LIMITATIONS	85
GENERAL EXCLUSIONS	87
CONDITIONS EXCLUDED BY RIDER	91
TERMINATION AND REINSTATEMENT	91
EXTENSION OF BENEFITS	93
CONVERSION	94
GENERAL PROVISIONS	95
How To File A Claim	95
Written Notice of Claim	95
Claim Forms	95
Proof of Claim	96
Time of Payment of Claims	96
Payment of Claims	97
Physical Examination and Autopsy	98
Legal Action	98
Survivor Rights	98
Time Limit on Certain Defenses	98
Notice	99
Fraudulent Submission of Claims	99
THE PROCESSING OF YOUR CLAIM	100
CLAIMS REVIEW	101
ENDORSEMENTS	103
ENDORSEMENT - DIABETES	103
ENDORSEMENT - PRESCRIPTION DRUGS	104
ENDORSEMENT - REGISTERED NURSE FIRST ASSISTANT	105

CHAPTER FIVE - GROUP HEALTH INSURANCE PROVISIONS 108

SCHEDULE OF BENEFITS	109
INSUREDS' FINANCIAL RESPONSIBILITIES FOR COVERED SERVICES	109
BENEFIT MAXIMUMS	109
UTILIZATION MANAGEMENT PROGRAMS WITH POTENTIAL PENALTIES	110
REPRESENTATIONS ON APPLICATION AND ENROLLMENT FORMS	111
ELIGIBILITY FOR COVERAGE	111
EXTENSION OF ELIGIBILITY FOR DEPENDENT CHILDREN:	112
ENROLLMENT AND EFFECTIVE DATE OF COVERAGE	112
ENROLLMENT RECORDS	116
PAYMENT OF PREMIUMS	117
GRACE PERIOD	117
OTHER PREMIUM PAYMENT REQUIREMENTS	118
INSUREDS' FINANCIAL RESPONSIBILITIES	118
COINSURANCE REQUIREMENT	119
RESTORATION OF BENEFITS	120
HEALTH CARE PROVIDERS	120
COVERED SERVICES	120

MATERNITY CARE	120
HOSPICE CARE	122
SECOND SURGICAL OPINION	122
MEDICAL NECESSITY	124
PRE-EXISTING CONDITIONS	124
BENEFIT LIMITATIONS	127
EXCLUSIONS	127
COORDINATION OF BENEFITS	127
SUBROGATION	130
TERMINATION OF THE GROUP CONTRACT	130
COBRA CONTINUATION OF COVERAGE	131
CONVERSION TO AN INDIVIDUAL POLICY	134
MEDICARE SECONDARY PAYER PROVISIONS	135
CHAPTER SIX – FEDERAL REGULATIONS OF INTEREST	138
(HIPAA) HEALTH INSURANCE PORTABILITY ACT OF 1996	138
Guaranteed Access And Renewability	139
Medical Savings Accounts	142
Deductibility For The Self-Employed	142
MENTAL HEALTH PARITY ACT OF 1996	143
THE NEWBORNS’ AND MOTHERS’ HEALTH PROTECTION ACT OF 1996 (NMHPA)	144

INTRODUCTION

This text is furnished solely by C.E.I.S. as a reference to be used in Continuing Education. It is to be used as educational material only and it is not intended to provide advice, legal or professional. The readers of this text must consult their own legal advisor for legal advice on any information contained herein.

Because Health Insurance is a rapidly changing area, the latest available information on this subject is contained in this text; however, due to legislation, legal situations or industry practice, the information contained in this text may change frequently and could become obsolete. This text should never be used as an original source of authority on any legal matters.

Any laws and regulations that are referenced in this text have been edited and summarized for purposes of brevity and clarity.

Any names used in this text are fictional and have no relationship to any person, living or deceased.

Please Note: Throughout this text examples and illustrations of the application of provisions will appear as “Consumer Applications”, and for sake of brevity, will be headed “C.A.” The purpose of the Consumer Application is to illustrate how a particular provision(s) affect the Consumers who are insureds or potential insureds. Also Note: important statements and provisions are shaded for emphasis.

General and Specific information regarding Disability Income Insurance, Accidental Death and Dismemberment Insurance, Basic and Surgical Insurance and Special Indemnity Policies are discussed initially, followed by Individual Major Medical Insurance and Group Major Medical Insurance which are explained in more detail, including sample (illustrative) provisions. Policy provisions of the Individual Major Medical are so comprehensive that provisions contained in those policies are very similar to provisions contained in most Health Insurance policies. The policies discussed in provision detail constitute the majority of health insurance plans being sold today.

Obviously it is not possible to discuss in detail all of the provisions of all health insurance products in this text as it would prove huge and unwieldy if a discussion of all of the myriad provisions were to be explained. Further, the provisions of Health Maintenance Organizations (HMO) contracts, plus the wide variety of other Managed Care contracts, are outside the scope of this text.

Familiarization with the provisions and principals set forth should prove invaluable to the student in understanding the details of any similar policy they may market and explain to others.

Health insurance provides payment of benefits for loss of income and/or expense arising from illness or injury. Health insurance is often called accident and sickness insurance or accident and health insurance. Many different kinds of health insurance coverages are available. Unlike

automobile or homeowners insurance, there is no standard health insurance policy. Health insurance varies according to the methods of underwriting, injury or illness covered types of benefits, types of losses covered and amount of benefits available.

Health insurance is written in individual, group, and franchise policies. Policies may cover either accident of sickness or both, or only specific accidents or sicknesses. Plans to provide for loss of income and expenses arising from illness or injury are provided by commercial insurance companies, by nonprofit service organizations such as Blue Cross/Blue Shield, and by federal and state governments.

Health Insurance is politically attractive as voters can become easily aroused by any publicity regarding health care issues. Voter pressure on politicians at the State (and in some cases, local) level has created a variety of provisions, and the provisions are by no means considered standardized. The National Association of Insurance Commissioners has introduced “model” legislation and many of the provisions described in this text reflect this legislation. However, because of the wide variance in state regulations, the provisions described herein are those that are used in most of the states, there may be some differences in any particular state. The student should always review the regulations and statutes of the state in which he/she operates.

Even though insurance is regulated primarily by the State Insurance Departments, the Federal Government continually expands its authority into Medicare and Medicaid. The Employee Retirement Income Security Act (ERISA) passed in 1974 and was originally designed to protect pension-plan funds against raids by unscrupulous labor leaders. It promulgated regulations that safeguards retirement funds, but it also included a clause which preempted any state laws from regulating certain employee benefit programs, including health insurance. This act is considered by many as an intrusion of the Federal Government into the business of insurance.

C.A.

Johnson Matrix is a small company that has elected to provide health insurance for its employees. Johnson soon found that there was a wide variety of plans available and decisions had to be made on such items as:

Is maternity coverage to be provided?

What type of plan does he want a Point of service, Preferred Patient Provider or something in between?

How high a deductible will his employees have to pay?

What is the coinsurance to be paid after the deductible?

How financially strong is the insurer?

Does he want an HMO? If so, are local doctors participating?

How much of the premium is the company willing to pay?

How much of the premium for dependents is the company willing to pay? (Continued)

How many employees will participate?

How long will an employee have to wait before becoming eligible for insurance?

What coverage, if any, will be provided for an employee eligible for Medicare?

CHAPTER ONE - TYPES OF HEALTH INSURANCE

There are three types of health insurance: Disability income, Accidental Death and Dismemberment, and Medical Expense Insurance.

DISABILITY INCOME INSURANCE

Disability income insurance provides periodic payments when the insured is unable to work because of injury or sickness. These policies provide a weekly or monthly income benefit to replace a portion of the salary or wages lost due to the insured's inability to work. An individual policy covers only the wage earner and does not cover family members. If another family member produces income, then that person must obtain his/her own Disability insurance.

Disability income insurance policies vary as to:

1. the definition of disability,
2. the amount of the payment,
3. the Elimination Period (time before benefits are payable),
4. the Maximum Benefit Period,
5. and the relationship to workers compensation benefits

Disability Definitions

Total Disability

The definition of disability varies from policy to policy, but the traditional definition specifies that total disability is the "inability to work at any gainful occupation" (referred to as "Any Occ"). Under this definition, if the insured can do any job - for even a portion of his former income - the insured is not considered totally disabled. Some older policies require that the insured must also be confined to the house and under the treatment of a doctor. This tightly constructed definition may not be allowed in several states. A more liberal and current definition defines total disability is the "inability to perform the duties of any occupation for which he is reasonably suited by education, training, or experience." Another definition is "inability to perform all of the substantial and material duties of his regular occupation." (Referred to generally as "His Occ")

A typical disability definition states that for a specified time after the beginning of the disability, the insured is totally disabled if he is completely unable to engage in his occupation (His Occ). After the specific time period, commonly one, two or five years, the insured is considered totally disabled only if he is unable to perform the duties of any occupation for which he is reasonably suited by education, training or experience ("Any Occ").

Partial Disability

Contracts may provide partial disability benefits, particularly in the case of disability caused by accident. Partial disability is often defined as the "inability of the insured to perform one or more of the important duties of his occupation." Some policies provide that benefits are only payable for a partial disability immediately following a period of total disability for which benefits were payable. The partial disability benefit usually pays a percentage (usually 50%) of the weekly or monthly indemnity payable for total disability for a limited period (usually three to six months).

Policies may provide benefits for residual disabilities. A residual disability benefit provides benefits for loss of earnings after a return to work from total disability, if the insured cannot earn as much as he did prior to the disability. The residual benefit is expressed as a percentage of the amount payable for total disability.

Amount of Benefits

The amount of the weekly or monthly payment applied for is usually based on the insured's earnings and is usually limited to a percentage of the insured's earned income. The benefits may be capped (such as: 75% of stated annual income, with a maximum monthly benefit of \$5,000).

Special care should always be taken in computing the benefit amount. There can be wide variances in qualifications, and all sources of income must be stated. It should be emphasized that overstating income so that the benefit maximum can be increased, can, at the very least, create an anti-selection element; and can even be grounds for denying benefits at time of disability. Reporting of income varies by company and policy, and the reporting requirements must be stringently followed.

Probation Period

The probationary period provision applies to sickness and disabilities, and states that no benefits will be paid for sickness contracted during the first few days of the policy period. In effect, it protects the company from an illness that existed before the policy inception date, and said illness was unknown. This probationary period is commonly fifteen days. The Probationary Period does not apply to disabilities caused by accident, as, obviously, accidents are not predictable.

Elimination Period

The Elimination Period is the period of time immediately after the onset of the disability measured in time (usually days) during which benefits are not payable. The Elimination Period is similar to a deductible; however deductibles are usually expressed in dollar amounts. The purpose is to eliminate small claims, as the insured is expected to be able to provide for short

disability periods. Many employers have a salary continuance plan, either formal or informal, before the Disability Insurance begins.

Elimination periods can range from three days to one year but usually is 7, 14, 30, 60, 90, and 180 days, (30 days being the most popular). Usually, the accident coverage either has no Elimination Period or, infrequently, the Elimination Period is the same as for the sickness coverage. Policies may provide that if the insured is disabled beyond the Elimination Period, benefits will be paid retroactively back to the first day of the disability.

Maximum Benefit Period

The Maximum Benefit Period is the length of time disability benefits will be paid under the contract and can range from six months to lifetime (if disability caused by accident). The most common Maximum Benefit Periods are 1, 2, 3, 5, and 10 years, and to age 65. Policies may provide for a lifetime sickness benefit period for any period of disability commencing before the insured reaches 50 and is usually available only with a lifetime accident maximum. Disability income policies are classified as long or short term, based on the length of the sickness Maximum Benefit Period.

C.A.

Doctor Johnson, a Medical Doctor and a Surgeon, are leaving the staff of a hospital, and are starting his own practice. One of his prime considerations is the loss of income should he become disabled since he no longer has a large hospital to rely upon for lost income. Obviously, he must have Total Disability coverage since surgery will be a large part of his income; he will want to obtain a policy that defines disability as "inability to perform all of the substantial and material duties of his regular occupation (referred to as "his occ"). He should try to get a policy that allows his sufficient time to establish a practice should he be unable to operate before the plan changes to partial disability (any occ).

He should also investigate a residual disability provision, as if he loses his ability to perform surgery; this would help him make up the difference in his income.

The amount of benefits available may be a problem here, as if he has no track record of being self employed, the company rules will in most cases, take a conservative approach. He may be restricted to a lower percentage of his former income until such time that a pattern of earnings can be established.

The doctor will have to determine how long he can continue financially without income, and then determine the Elimination Period. Depending upon his savings and any outside income (such as from investments), he would pick at least 30 days.

The Maximum Benefit Period will depend upon his age and the number of years before normal retirement. Also, he must weigh the cost of the policy against the benefits desired, particularly in the benefit period. If it is affordable, a period to age 65 would be attractive. However, considering that if he became disabled and was unable to perform surgery, there is a good probability that he could still practice medicine in another field.

Later, if the doctor takes on a partner, and a buy-sell agreement is in effect, they should consider a policy covering the buy-sell agreement whereby if one partner becomes disabled, and

then funds will be available to buy out the partner. These policies usually have a one-year Elimination Period with a monthly benefit of 1 to 2 years.

SPECIAL FORMS OF DISABILITY INCOME INSURANCE

Disability Income Insurance under Life Policies

Disability income insurance may be offered as a rider to a life insurance policy that provides for a monthly indemnity in the event of total disability before a certain age (usually 55 or 60). The amount of the monthly benefit is a function of the face amount of the life insurance and normally has a six month Elimination Period. The Maximum Benefit Period is “to - age – 65”. Frequently there is a provision that provides that if the insured is still, and continually, disabled at the end of the benefit period, then the life insurance benefits will be paid as an endowment and the policy premium will be waived. Optional benefits, such as for partial disability, are usually not available.

Waiver of Premium in cases of disability is traditionally available on most life insurance policies (but does not pay monthly indemnity payments).

BUSINESS OVERHEAD EXPENSE BENEFITS

Business Overhead Expense insurance provides funds to pay certain expenses required for the operation of a business or professional office for a specified time period when the insured owner is totally disabled. This is an area that is very important to self-employed professionals and business owners. This is a highly specialized field of health insurance, and additional concentrated training is necessary to properly represent this product, which is beyond the scope of this text. It is closely related to Key Employee Insurance, and Buy & Sell Agreements, described below.

KEY EMPLOYEE DISABILITY INSURANCE

Key Employee coverage pays a monthly benefit to a business for the purpose of hiring and training additional help or services, when a Key Employee is disabled. Practically, it has a two-pronged effect: it covers the disabled person’s salary, and pays for a temporary replacement during the period of disability.

BUY AND SELL AGREEMENTS

Closely linked to the business uses of Disability insurance as outlined above, Buy and Sell Agreements specify the terms partner(s) or stockholder(s) by which a disabled partner's, or stockholder's, interest can be purchased by the other partner(s) or stockholder(s), with the insurance policy providing the necessary funds for the buy-out. Policy terms must mirror the Buy & Sell Agreement as to the Elimination Period, amount of benefit, and benefit period. These policies usually have a one-year Elimination Period with a monthly benefit period of 1 – 2 years.

ACCIDENTAL DEATH AND DISMEMBERMENT

Accidental Death policies provide a death benefit which is payable in the event of death resulting from accidental bodily injury. An Accidental Death and Dismemberment policy also provides benefits for loss of limbs or sight (dismemberment coverage).

Accidental Death and Dismemberment (AD&D) is usually presented as a schedule listing dismemberment's and losses of sight covered by the policy, and for which a specified sum will be paid to the insured. The amounts may be expressed as a multiple of the weekly indemnity amount, or if the policy does not have weekly disability income benefits, it is expressed as a percentage of the death benefit limit, or as a percentage of the Capital Sum (policy limit).

SAMPLE SCHEDULE	
Loss of:	Sum equal to Weekly indemnity for:
Both hands, or feet, or sight of both eyes	200 weeks
One hand and one foot	200 weeks
Either hand or foot and sight of one eye	200 weeks
Either hand or foot	100 weeks
Sight of one eye	65 weeks
Thumb and index finger of either hand	50 weeks

The dismemberment feature provides a lump sum payment that can be used during the rehabilitation period and job training. If the policy also provides disability income, in most situations when the dismemberment amount has been paid, the disability income payments also stop. If during a disability period, a dismemberment loss is suffered, the insured will be paid disability income up to the maximum dismemberment period.

Most AD&D policies provide that if a loss of limb or sight occurs within 90 days of an accident, the sums in the schedule will be paid.

CA

Jim Brown works in warehouse and travels 15 miles each way to work, in very heavy traffic. His employer furnishes health insurance in case of sickness, but Brown is concerned about being injured in an accident.

The employer recently provided an Accidental Death and Dismemberment policy that pays for 90 days of weekly indemnity for disability and a schedule for dismemberment. His death benefit is \$20,000 and weekly indemnity is \$200.

Brown loses an arm at work when a crate in the warehouse is dislodged and falls on him. His medical costs are covered by the group health plan and by Workers Compensation. Workers Compensation provides a small income after Brown is released from medical care. However, his dismemberment proceeds of \$20,000 can be used for job training and rehabilitation not otherwise covered.

NOTE: Many policies offer a set amount of Accidental Death benefits, and Dismemberment is a factor of the death amount. In that case, with a death benefit of \$20,000, the policy would usually offer 50% of the death amount, or \$10,000 in this case.

MEDICAL EXPENSE INSURANCE

Medical expense insurance provides benefit payments for medical care. The providing of benefits may be by:

1. reimbursement to the policyholders for medical expenses incurred,
2. paying those who provide the services directly,
3. Paying a set amount regardless of the amount charged for medical expenses. (This is referred to as an "Indemnity policy").

A policy may cover an individual, his or her spouse and children.

The categories generally accepted, for Medical Expense Insurance, are

1. basic medical expense insurance,
2. major medical insurance,
3. comprehensive medical insurance and
4. special policies

BASIC MEDICAL EXPENSE POLICIES

Basic coverages provided by an individual medical expense policy include basic hospital expense, basic surgical expense, and basic medical expense. (The term basic medical expense is used in a more narrow sense to mean the non-surgical services of a physician). These three basic coverages may be sold together, or coverage can be offered on a stand-alone basis.

Basic hospital expense coverage provides benefits for daily hospital room and board and miscellaneous hospital expenses while the insured person is confined to the hospital. The policy may provide for a certain dollar amount for the daily hospital room and board benefit, (such as \$100 a day units, with a maximum of a multiple, i.e. \$500 maximum) although paying the semi-private room rate (as a maximum) is gaining in popularity.

Policies usually provide for additional benefits while the insured is in an intensive care unit, either as an included benefit, or as an additional (“add-on”) benefit. The amount paid for Intensive Care is frequently a multiple of the daily benefit amount.

A time limit for coverage is also specified, with usual dates of 30 or 60 days.

Miscellaneous hospital expenses include such items as dressings, drugs, charges for operating rooms, anesthetics, services of anesthetists, lab work, and x-ray treatments. Usually coverage is limited to a certain dollar amount, such as \$2,000, but may also be limited as a multiple of the daily hospital benefit charge. (For example, up to 15 times the daily hospital benefit maximum.)

Basic surgical expense coverage provides benefits for the surgical services of a physician performed in or out of the hospital. Surgical expense benefits are usually limited to a dollar amount, although they may be expressed as multiples of the hospital benefit maximum. Usually a schedule of operations is attached to the policy and the maximum amount payable for each operation is listed. A surgical expense policy may be sold as part of a hospital and medical expense policy, or on a stand-alone basis.

Higher benefits are paid for the more serious and complicated surgeries. While the surgical schedule cannot refer to all surgeries, for those that are not listed in the schedule are covered on the same basis as comparable operations that are listed. Surgical schedules may also assign a relative value (unit) to each procedure, and the amount to be paid by the insurer is derived by formula using the relative value unit.

Historically, basic medical expense policies covered the insured only while confined to a hospital and limited to a dollar amount per day, for a specific number of days. Many policies now include diagnostic x-ray and laboratory expenses on an outpatient basis, with a dollar limit. Radiotherapy on an outpatient may be available, with a maximum limit.

Emergency hospital treatment with a per-visit limitation may be included with a limit per trip.

Basic medical expense policies may also include nursing care coverage, which provides payment for private duty nursing care by order of a doctor while the insured is in the hospital. The benefit is usually limited to a maximum amount per day for a maximum number of days.

In addition, maternity expenses and or indemnity payment may be offered with some plans. Maternity expense benefits usually provide limited coverage for medical expenses due to pregnancy and are based on a multiple of the daily hospital room benefit. In some plans, a flat amount is paid and has no relation to the actual expenses incurred (indemnity coverage). In some cases, the surgical schedule may provide a specified physician's fee for delivery.

Except for the Maternity Expense benefit, other policy benefits do not cover normal childbirth. However, complications of pregnancy specifically described may be covered.

Extended care benefits may also be provided by the payment of a maximum daily benefit for confinement in a skilled nursing facility. There is usually a waiting period after hospital discharge (14 days is usual). The benefit amount payable is usually one half of what the policy would pay for hospital confinement. The benefit period varies from one month to one year.

Some basic medical expense policies have deductibles for each hospital confinement.

C.A.

John purchases a Basic Medical Policy that pays for hospital expenses and sold in \$100 units. John elects a 5-unit plan, which would pay \$500 per day for hospital room and board.

Intensive Care Benefit provides for 3 times the daily benefit, or \$1500 while in Intensive Care.

This plan pays up to 5 times the daily benefit, for miscellaneous hospital expenses, or \$2500.

This plan also offers surgical benefits of 5 times the daily benefit for one surgeon and 50% of that amount for a second surgeon when necessary. It would pay \$2500 for a surgeon and \$1250 for a second surgeon.

John may purchase an outpatient rider, which pays a maximum of 50% of the daily benefit for emergency room and other outpatient surgeries. It also provides diagnostic x-ray and laboratory expenses on an outpatient basis, with a maximum of \$2,000.

There is no deductible under this plan. If John should later elect to superimpose a Major Medical plan on top of this Basic policy, then the Major Medical deductibles will not kick in until the Basic plan has paid the maximum benefits.

MAJOR MEDICAL INSURANCE

Major medical insurance provides benefits for serious or prolonged injury or illness. These policies may be written to complement basic medical expense policies; however this is becoming less attractive as a choice. Major Medical Insurance is the most popular medical

insurance plan, by far, on an individual and group basis. Most employees have been covered by a Major Medical Plan, and when it become necessary to purchase their own coverage (without employer participation) they understandably want the same type of comprehensive coverage.

Deductibles are a necessary function of the Major Medical policy, which keeps the cost of insurance down because of the elimination of small claims whose expenses to administer frequently exceed the claims payment. In addition, participation in costs by the insured presupposes a high interest of the insured in the control of benefits. Deductibles are usually defined as a specific dollar amount paid for covered medical expenses. If a Major Medical Policy is superimposed on a Basic Medical plan, then the Deductible may not be incurred until the Basic plan has paid the maximum benefits under its coverage.

The deductible may apply to each accident or illness, or to each calendar year, and to each covered person. Most policies provide that if a family is insured, a maximum of three deductibles apply per family per year: that is, if three family members have “met their deductible” during the specified deductible period (usually a calendar year), then any medical costs experienced by a fourth family member would not be subject to a deductible.

There is usually a common accident provision, which states that if members of a family are injured in a common accident, only one deductible applies. Many companies also include a carry-over provision which states, for example, that expenses incurred during the last three months of a calendar year may be used toward the deductible in the following year, provided the deductible for the prior year has not been met.

Most policies have a coinsurance provision. A coinsurance provision provides for the sharing of medical costs after the deductible has been met (satisfied), generally up to a maximum, at which point the insurer pays 100% of medical costs. Typically, coinsurance is 90/10 (the insured pays 10% of the medical costs after satisfying the deductible, the insurer paying 90%); 80/20; 75/25, or 50/50. The more that the insured has to pay, the lower the premium will be. As an example, a 90/10 plan would be noticeably more expensive than a 75/25 plan.

The maximum benefit payable under a Major Medical policy applies to each person, so each member of an insured family is insured for the maximum benefit. The benefit also is expressed as a “lifetime” benefit. If an insured had medical expenses after deductible and coinsurance of the policy maximum, the insurer would not pay any further claims. If the insured’s spouse had medical claims, they would be separate and distinctive from the insured’s claims when calculating the maximum benefit. Many major medical policies have a restoration of benefits provision which allow a percentage or (usually) a dollar amount that can be restored each year the policy is in force. The Restoration of Benefits provision may, or may not be affected by the claims paid.

The coverage provisions of major medical expense policies are very broad. The term covered expenses is usually defined to include doctors fees, nurses fees, hospital charges for room and board, miscellaneous hospital charges, charges in connection with pregnancies, cosmetic surgery, nervous or mental disorders, and alcoholism or drug addiction.

Coverage is usually provided on a blanket basis, without specifying individual dollar limitations on the coverage of various medical expenses. But there may be “inside” limits, which apply to specific expenses (such as hospital room and board and surgery) and may be expressed as a maximum dollar amount. If there are inside limits, they are considerably higher than the amounts allowed under basic medical policies.

C.A.

Margaret has an individual Major Medical policy with a deductible of \$1,000 (3-deductibles per family maximum), 80/20 coinsurance, \$1500 out-of pocket, lifetime benefits of \$1,000,00, \$10,000 maximum for mental and nervous disorders, 3-month deductible carryover, 2-year pre-existing condition, and a waiver of deductible for injuries as the result of an accident.

Margaret has no idea as to what she has!

At the very least, the agent should explain to her the following:

Before benefits are paid by the insurer, every calendar year she must pay the first \$1,000 of every medical expense including hospital, doctors offices, surgeons, medication, etc.

After she has paid the first \$1,000, the insurer will pay 80% of all medical bills, until such time that she has paid an additional \$1,500 out of her pocket, for a total of \$2,500 that she has to pay. After \$50,000, the insurer will pay 100% of all approved medical expenses. (She has no family, but if she did, after 3 members of the family have met their deductible in any calendar year, deductibles of other family members would be waived.)

If she is injured in an accident, she does not have to pay a deductible, and the insurer will start paying 80% of the medical bill automatically.

Any medical costs that were incurred the last 3 months of the year and which have not been used to meet the deductible for that year can be carried forward to the following year.

In case she needs medical attention for mental or nervous disorders, the plan will pay a maximum of \$10,000 for any hospitalization or treatment.

Any medical condition that exists for a period not exceeding two years, will not be covered until the policy has been in force for two years. (Note: If Margaret had been covered under a group plan, and her COBRA benefits have expired and her previous company cannot offer her additional coverage, she may be eligible for a plan wherein the pre-existing conditions will be waived under provisions of the HIPAA of 1996 – discussed in detail later in the text).

COMPREHENSIVE MEDICAL INSURANCE

The popularity of Comprehensive Medical insurance has been replaced by Major Medical plans, as Major Medical insurance has become “comprehensive” and so competitive in price, that the original Comprehensive medical insurance concept is not often used. Comprehensive Medical Insurance in this context is a combination of basic medical expense coverage and major medical coverage. The first dollars of expense are covered under the basic medical policy, usually with a low (\$50 or \$ 100) deductible. The major medical portion of the policy begins to pay when the benefits of the underlying basic medical expense policy are exhausted. In effect the basic medical expense portion of the policy provides a deductible before the major medical coverage applies.

A corridor deductible is frequently found in a comprehensive policy, which is a fixed amount the insured pays after the basic coverage is exhausted - but before the major medical coverage benefits are payable. To illustrate, the basic medical coverage pays until its limits are exhausted. At that point a deductible must be satisfied. When medical expenses exceed “A” (the amount of the basic plan) plus “B” (the deductible), the major medical coverage goes into effect. With these arrangements, the major medical benefits are equal to a percentage of the total medical expense (see coinsurance description above). An individual comprehensive medical insurance policy would have to meet the minimum standards requirements for basic hospital expense policies, basic medical-surgical expense policies and major medical expense policies.

SPECIAL MEDICAL EXPENSE INSURANCE POLICIES

There are a variety of special health insurance policies providing limited coverage, such as specified disease or dread disease insurance. This provides a variety of benefits for only certain (specified) diseases, usually cancer or heart disease. Benefits are usually on a scheduled basis, paying an indemnity amount depending upon the procedure or type of disease. Recently, plans that pay a specified amount – usually in \$10,000 increments – upon diagnosis of a particular disease (usually cancer) have become quite popular. These plans are designed to pay in addition to any medical expense insurance (coordination of benefits provisions on other health insurance policies do not apply) and are used for paying added expenses that accrue when a person contracts the particular disease or condition.

Hospital Indemnity insurance pays a specified sum on a daily, weekly or monthly basis while the insured is confined to a hospital. The amount of the benefit is not related to expenses incurred or to wages lost while the insured is hospitalized. These plans are marketed as individual or franchise-group plans. They are attractive to the industry as claims payment are simple (must be in the hospital) and amounts are modest. Usually these products are Guaranteed Issue.

Accident - only insurance provides coverage for injury from accident and excludes sickness. Benefits may be paid for all or any of the following: death, disability, dismemberment, or hospital and medical expenses. Accident - only coverage is a very inexpensive type of coverage and frequently is added to other plans.

C.A.

Felix considers purchasing a “Cancer Plan” that pays benefits to an insured when he is diagnosed as having cancer. The amount of the benefit depends upon the type and severity of the cancer. If Felix had ever been diagnosed with cancer, he could not have qualified for the policy.

Felix is approached by an agent who represents a company that offers plans that pays a pre-determined flat amount as soon as cancer is diagnosed, and is sold in units of \$10,000. Felix likes this plan because it pays the full amount regardless of the type or severity of the cancer. He purchases 5 units (\$50,000).

Either plan pays in addition to his health insurance plan. Felix is later diagnosed with lung cancer, which involved removing the cancer. His insurance covered the medical costs; however he went to Sloan-Kettering which specializes in cancer research. Since this clinic was not an approved clinic under his PPO health plan, he had to pay some costs out of his own pocket, plus he had to pay for travel expenses for him and his wife, and pay lodgings and meals for his wife while he was in the hospital. The \$50,000 covered most of the additional cost.

STUDY QUESTIONS

1. 1. Health Insurance may be written in
 - A. Individual, Group and Franchise policies.
 - B. Group Health insurance only.
 - C. Individual Major Medical policies only.
 - D. Individual and Group basis only.

2. The two types of disability are
 - A. Total and Partial.
 - B. Lifetime and Temporary.
 - C. Accident and Sickness.
 - D. Apparent and Implied.

3. The Maximum Benefit Period of a disability income policy is
 - A. the length of time benefits will be paid under the policy.
 - B. a period of time not to exceed 10 days.
 - C. period of time before benefits are paid.
 - D. the maximum period of time that the policy will stay in force.

4. Dismemberment features on an Accidental Death & Dismemberment is designed to provide funds that can be used for
 - A. nursing care.
 - B. for medical expense.
 - C. For car payments
 - D. rehabilitation and job training

5. An indemnity policy pays
 - A. the actual cost of medical care.
 - B. the anticipated cost of medical care.
 - C. a set amount.
 - D. for medical costs to another person injured in an accident.

6. Basic coverage's frequently include
 - A. double benefits for organ transplants.
 - B. comprehensive major medical charges.
 - C. cancer insurance.
 - D. basic hospital and surgical expense and medical expense

7. If a Basic Medical Expense policy excludes maternity coverage,
 - A. delivery costs are paid in full.
 - B. complications of pregnancy may still be covered.
 - C. cesarean sections only are not covered.
 - D. it will still pay for normal delivery, but not for delivery room charges.

8. In a Major Medical policy, a deductible is
 - A. a percentage of total medical costs.
 - B. paid after the coverage's are paid by the insurer.
 - C. a specified dollar amount paid for covered medical expenses.
 - D. the annual premium less the commission paid the agent.

9. In a Major Medical policy, the more of the medical costs an insured pays, the _____ the premiums.
 - A. lower
 - B. higher
 - C. more confusing
 - D. the benefits increase and the more stable

10. Hospital Indemnity insurance pay benefits
- A. while the assured is in the hospital.
 - B. to the attending physician.
 - C. directly to the hospital.
 - D. to the beneficiary.

ANSWERS TO STUDY QUESTIONS

1A 2A 3A 4D 5C 6D 7B 8C 9A 10A



CHAPTER TWO - MAJOR MEDICAL POLICY PROVISIONS

To fully understand the benefits offered under the Major Medical Policy, the provisions illustrated are typical of policies offered by major health insurance organization. Please understand that laws vary widely by jurisdiction, and some of the policy provisions shown below may not specifically apply in your state. Conversely, your state may have requirements that are not shown in this discussion.

Provision wording is very similar to either individual or group coverage. As a general rule, provisions in a group policy are more liberal as they are more susceptible to political and consumer influence and with a larger base of risk, pricing can become more definitive. In addition, employers, especially large employers, can dictate more easily the terms of certain popular coverage's. For instance, individual policies rarely cover maternity benefits except by rider at an additional cost. Group policies almost always either offer or include maternity benefits. (Some states now require that maternity benefits be covered by ALL group health insurance plans).

Wording will also vary by type of health insurance. The provisions discussed below are from a "Preferred Provider Organization" (PPO – discussed in detail later in this text) whereby the insurance company pays the Providers (doctors, nurses, hospitals, etc.) directly based upon a contractual agreement. The "Fee – for – Service" type of contract differs in that the insurer pays the Providers directly, outside of a contract, and pays on a "usual and customary", or "reasonable and customary" basis. Other than the payment basis provision, the policies are quite similar. Of course a Health Maintenance Organization (HMO) would have different wording, as at the very least, the relationship between the HMO and the "insured" or "policyholder" is different.

It is not possible to identify all of the health insurance changes that have occurred, or to accurately forecast future changes. However, once the basics of providing needed health care is understood, changes can be more accurately anticipated and the relationships between existing programs and new programs can be more easily assimilated.

C.A.

Sam left his employer and has to purchase an individual health policy. He is not familiar with the various plans available today. He asks his agent for assistance.

Sam has expressed an interest in continuing with the same doctor he has had for the past 20 years. The agent explains that a “Point of Service” plan allows full flexibility to choose his doctor and hospitals. The disadvantage is that it is more expensive than other plans, and it will pay on a “usual and reasonable” basis, meaning that Sam may have to pay the difference out of his own pocket.

A reasonable alternative is a Preferred Provider Organization (PPO) plan. The disadvantage is that he would want to use the Providers “in the book” or pay a higher percentage of costs after the deductible has been satisfied. The major advantage is that the Providers will all accept what the insurer pays, so there is less chance of Sam having to pay some of the medical expenses out of his own pocket. However, he has a wide choice of doctors, and there is a good possibility of Sam's doctor being an approved Provider.

Another popular plan is an HMO. Dollar-for-dollar, it probably is the best buy. However, the list of approved Providers (Primary Care Physicians) is quite limited, and all medical referrals must be made through the PCP.

NOTE: The wording of the provisions sections immediately following, are typical of Preferred Provider Organizations (PPO's) and would not appear in this fashion in a Fee-for-Service policy, or an HMO. The PPO example is used as they have become increasingly popular as they provide considerable flexibility to the policyholders in comparison with an HMO.

ALSO NOTE: Hereafter in this text, Sample or Illustrative provisions will be italicized, and Comments regarding such provisions will normally precede the actual illustration and will be in normal type. Significant and important information will be shaded.

MAJOR MEDICAL INSURANCE CONTRACT

The following text is typical of the language and provisions used on the first page of the Major Medical policy. Much of this information is required by state regulations and may vary by state.

IMPORTANT NOTICE

(NOTE: In most, if not all, jurisdictions, the copy of the Application becomes part of the insurance contract/policy, again stressing the necessity of complete and accurate information on the Application)

Please carefully read the copy of your application attached to this Contract and notify Your Insurance Company, Inc. within 10 days if any information on it is incorrect or incomplete, or if any past medical history has been left out of the application. Your application is a part of your Contract, which has been issued on the basis that the answers to all questions and all information shown on the application are correct and complete.

This Contract Contains a Deductible Provision

(This statement required in most jurisdictions when applicable)

(The following is the Identification section, and while the format may vary by company, it is the minimum required in most jurisdictions)

CONTRACT NUMBER:

GROUP #

CONTRACT TYPE:

EFFECTIVE DATE:

MONTHLY RATE:

During the terms of this Contract, Your Insurance Company agrees to provide to covered individuals the health insurance benefits specifically provided in this Contract, subject to all the terms, conditions, limitations, and exclusions.

(The following refund statement or one very similar is used in used in most states, but this “10-day – no questions asked” provision is the most typical)

IF, AFTER EXAMINATION OF THIS CONTRACT AND COPY OF YOUR APPLICATION, YOU ARE NOT FULLY SATISFIED FOR ANY REASON, YOUR PREMIUM PAYMENT WILL BE REFUNDED PROVIDED YOU RETURN THE CONTRACT AND IDENTIFICATION CARDS TO YOUR INSURANCE COMPANY, INC. WITHIN 10 DAYS OF THE DELIVERY DATE. (THIS REFUND DOES NOT INCLUDE A REFUND OF THE APPLICATION FEE)

CANCELLATION PROVISION

This provision allows the company to cancel according to the provisions contained in the contract, but most states require that a statement of this type be on the first page.

This Contract will stay in effect as long as you remain eligible for coverage and you pay your Premiums on time, This Contract can be canceled if you have made a Fraudulent or Material Misrepresentation or omission on your application or we terminate the Contract for everyone covered by it.

We want you to understand and be satisfied with the terms of this Contract. As you read through it, remember that the words "we", "us" and "our" refer to Your Insurance Company, Inc., the insurer (hereinafter referred to as YOUR INSURANCE COMPANY). We use the words "you" and "your" to mean you, the Insured and your Covered Dependents.

We have issued this Contract in return for the completed application (which is made a part of this Contract) and initial Premium payment.

(NOTE: The above typically completes the first page of the contract. In some states, if a company is marketing their health insurance policies from an out-of-state trust (ERISA account), thereby removing or restricting the authority of the Department of Insurance to act in regards to that policy, some notification may be required. One state requires a statement to appear in red ink on the first page, which states essentially that the provisions of that policy are under the jurisdiction of another state other than the one in which the policy is issued.)

SCHEDULE OF BENEFITS (EXAMPLE)

TOTAL LIFETIME MAXIMUM BENEFIT PER INSURED,.....\$1,000,000

HOSPITAL INPATIENT DAYS PER INSURED PER CALENDAR YEAR:.....Unlimited

INDIVIDUAL MAXIMUM DEDUCTIBLE AMOUNT PER CALENDAR YEAR.....\$1,000

(Applies to each Covered Insured)

(These amounts are rather typical but can vary depending upon policy, company and state)

COINSURANCE PERCENTAGE PAYABLE BY YOUR INSURANCE COMPANY FOR COVERED SERVICES AND/OR SUPPLIES

To reiterate: The following language, and most of the language used in these provisions, is typically those used in a Preferred Provider (PPO) policy. Statements referring to “Service Area” and PPO organizations, etc., would not appear in a Fee for Service or HMO policy.

(The coinsurance provisions assume an 80/20 PPO plan with 60/40 when non-PPO Providers are used.)

For Insured’s who resided in a Service Area at the time the service or supply was rendered, and for Insured’s who received the service or supply in a Service Area:

Preferred Patient (PPO) Hospitals Preferred Patient (PPO) Physicians, and all Medical Professionals and Suppliers...80% of the applicable Preferred Patient (PPO) Schedule;

Non-PPO Hospitals and Non-PPO Physicians ... 60% of the average of the PPO Schedule(s) for the applicable Service Area;

(NOTE: The limited coinsurance does not automatically mean that an insured will be liable for only 40% of the bill when treated by a non-PPO Provider under this provision. Pay close attention to the wording: “60% of the average of the ... schedule. This means that since the company has no contract with the Provider as to allowances, then an insured could easily pay more than the 40%, as the company only pays 60% of the average of the schedule, which in many cases, is lower than the Provider charges. The insured is responsible for the difference!)

Skilled Nursing Facilities and Home Health Agencies ... 80% of the Allowance;

For Insured's who did not reside in a Service Area at the time the service or supply was rendered and did not receive the service or supply in a Service Area:

All services and supplies from all providers ... 80% of the Allowance.

Those who reside within the Service Area and elect to receive medical treatment outside the Service area ... 60% of the Allowance.

NOTE: *Please refer to your PPO Directory (and updates) to determine which Providers are PPO Providers.*

(It is still the responsibility of the INSURED to make sure that the Provider is still contracted with the insurer. Insured's should ALWAYS verify the Provider standing as the list changes periodically.)

INDIVIDUAL MAXIMUM OUT OF POCKET COINSURANCE EXPENSE
AMOUNT PER CALENDAR YEAR (Applies to each Covered Insured.) \$XXXX

Maximum Out-of-Pocket Coinsurance Expense does not include (1) the amount applied toward the Deductible, (2) any benefit reduction, non-covered services, (3) your Coinsurance amount for covered services and supplies for Inpatient and Outpatient Mental and Nervous Disorders and Inpatient Alcohol and Drug Dependency, (4) your Coinsurance amount for covered services of a Non-Preferred Patient Hospital or Physician, or charges in excess of the PPO Schedule or Allowance (whichever is applicable), unless related to covered Medical Emergency/Accident Care services and supplies. These amounts are your responsibility.

MEDICAL EMERGENCY & OR ACCIDENT CARE

This provision is frequently used and states simply that medical emergency or medical charges as the result of an accident are treated as being within the PPO.

Services by a Preferred Patient Provider ... 80% of the Preferred Patient Schedule

Services by a Non-Preferred Patient Provider in or Outside of the Service Area ... 80% of the Allowance

For An Insured Residing In the Service Area and Traveling Out of Area: Paid as a Medical Emergency

GENERAL TERMS

Accident: *An unintentional, unexpected event, other than the acute onset of a bodily infirmity or disease, which results in traumatic injury. Some examples include, but are not limited to, serious burns and poisoning.*

Medical Emergency: *The sudden, unexpected onset of a Condition of such a severe nature that immediate care must be given to prevent death of the Insured or serious impairment of the Insured's health or bodily function as determined by YOUR INSURANCE COMPANY. Some examples include but are not limited to the following: unusual or excessive bleeding and convulsions.*

DEFINITIONS

Definitions are provided by regulations by most states, as a result of attempts to make the insurance policies more “friendly” to the consumer. You will note the informality of the wording in the contract, used in most, if not all, jurisdictions

The following section provides you with the definition of many Providers and the meaning of many of the terms we use in this Contract. If you read this section carefully, you will better understand the rest of this Contract.

The first part of this section defines covered Providers and the second part of this section defines general terms.

PROVIDERS

*An **Ambulatory Surgical Center** is a Facility properly licensed pursuant to State Statutes, or other states' applicable laws, the primary purpose of which is to provide elective surgical care to a patient, admitted to and discharged from such Facility within the same working day, and such Facility is not a part of a Hospital.*

*A **Certified Registered Nurse Anesthetist** is a properly licensed nurse who is a certified advanced registered practitioner within the nurse anesthetist category pursuant to State Statutes, or other states' applicable laws.*

*A **Home Health Agency** is a state-licensed public agency or private organization which has been approved for payment by us and which provides Home Health Services and other services to people who are essentially confined at home (home bound). This treatment takes the place of continued Hospital care. A Home Health Agency may operate independently or as part of a general Hospital and must be approved for payment by us.*

Home Health Services are health and medical services and supplies, furnished to an Individual, by a Home Health Agency or others under arrangements with the Home Health Agency, on a visiting basis, in the Individual's home.

Hospital

The term **Hospital** means an institution, licensed as a Hospital and operating pursuant to law, which has been recognized as a Hospital approved for payment by us and which:

- provides Inpatient services and is compensated by or on behalf of its patients;
- primarily provides medical and surgical facilities to diagnose, treat, and care for the injured and sick;
- has a staff of Physicians licensed to practice medicine;
- provides nursing care by or under the supervision of Registered Nurses on duty 24 hours a day;

The term Hospital does not include:

- an Ambulatory Surgical Center, as defined by and licensed under State law;
- a convalescent, rest, or nursing home;
- facilities primarily providing custodial, educational or Rehabilitative Care; birthing centers, or
- A Veterans Hospital or a Hospital contracted for or operated by the national government for treatment of members or ex-members of the Armed Forces.

NOTE: If services specifically for the treatment of a physical disability are provided in a licensed Hospital which is accredited by the Joint Commission on the Accreditation of Hospitals, The American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities, payment for these services will not be denied solely because such Hospital lacks major surgical facilities and is primarily of a rehabilitative nature. Recognition of these facilities does not expand the scope of benefits provided by this Contract; it only expands the settings where covered Contract services may be performed.

Maximum Skilled Nursing Facility Days per Insured per Calendar Year: 60 (example)

Maximum Home Health Care Visits Per Insured per Calendar Year: 60 (example)
(Up to 2 hours per Visit)

MENTAL AND NERVOUS DISORDER

Lifetime Maximum Benefit \$10,000

Many, if not most, policies have some restrictions on Mental and Nervous Disorders, and Alcohol and Drug Dependency benefits. There continues to be political pressure to increase these limitations, or to remove them entirely.

Inpatient Care - Inpatient days and Inpatient medical Visits in a Hospital, to a maximum of 30 days/30 Visits or a maximum payment of \$2,000 per Calendar Year, whichever occurs first, for treatment provided by a Physician or Psychologist? Your Coinsurance responsibility for covered services and supplies rendered by a PPO Psychiatric Facility will be based upon the PPO Schedule amount or the Facility's charge(s), whichever is lower.

Outpatient Care - Maximum of 30 Visits or maximum payment of \$600 per Calendar Year, whichever occurs first, for treatment provided by a Physician or Psychologist.

C.A.

Bills wife, Ann, was covered under his policy. After her father's death, she became very distraught and after several weeks, she started believing that her father was talking to her every day. She went to a psychiatrist and it was determined that she needed psychiatric care.

She visited the Sunnyside Clinic on an outpatient basis three times a week for 6 weeks. Her bill for this treatment was \$900 (\$50 per session). Her condition worsened and she entered the Sunnyside Mental Hospital for treatment and remained there for 30 days when she was discharged. Her total bill for that period of time was \$9,000.

Her policy only paid for 30 days or 30 visits to a hospital for mental or nervous disorders, with a maximum of \$2,000 per calendar year. For the outpatient visits, the limits were maximum of 30 visits, or maximum of \$600 per year.

Her policy had a \$500 deductible, 80/20 coinsurance with out-of-pocket of \$1500. Therefore, the outpatient visits satisfied her deductible and left \$400 for coinsurance. The company paid 80% or \$320.

For the hospital charges, the company paid 80% of \$9,000, or \$7,200.

The insured, Ann, was liable for 20% of \$400 (\$80) for outpatient, and 20% of \$9,000, or \$1,800. Since the maximum out of pocket was \$1500, and she paid a total of \$1,880, the insurance company paid an additional \$330. Ann was also liable for the difference between what the clinic and hospital charged, and the policy limits. Therefore, she was also liable for \$300 for the clinic and \$7,000 for the hospital. The total amount that Ann must pay is \$9,300 (deductible \$500; out of pocket \$1500 and excess charges of \$7,300).

(Please Note: Many policies have provisions regarding out-of-pocket expenses, which do not consider medical expenses for mental and nervous disorder for the out-of-pocket maximum [as discussed later in this text]. Therefore, in that situation Ann would owe an additional \$330).

ALCOHOL AND DRUG DEPENDENCY LIFETIME MAXIMUM BENEFIT

\$2,000 (Inpatient, Outpatient or any combination of these benefits)

Inpatient Care - Inpatient days and Inpatient Visits are paid up to the lifetime maximum, for treatment provided in a general, specialty or Rehabilitative Hospital. Your Coinsurance responsibility for covered services and supplies rendered by a PPO Substance Abuse Facility

will be based upon the PPO Schedule amount or the PPO Substance Abuse Facility's charge(s), whichever is lower.

Outpatient Care - Lifetime Maximum of 44 Outpatient Visits will be paid up to a maximum of \$35 per Visit for treatment provided by a Physician or Psychologist.

(NOTE: Most policies state that detoxification shall not be considered as a benefit under this outpatient program)

ADMISSION CERTIFICATION

Admission Certification is required on all Admissions to a PPO Hospital. For non-certified admissions to PPO Hospitals, the penalty is a reduction in payment to the PPO Hospital by the amount specified in that PPO Hospital's Contract with YOUR INSURANCE COMPANY. This reduction will be the responsibility of the PPO Hospital and Physician, and will not affect your benefits.

NOTE: This Contract contains a Qualified Exclusion for Expenses Related to AIDS or ARC.

*An **Independent Clinical Laboratory** is a laboratory properly licensed pursuant to State Statutes, or other states' applicable laws, where examinations are performed on materials or specimens taken from the human body to provide information or materials used in the diagnosis, prevention, or treatment of a Condition.*

*A **Licensed Practical Nurse** is a person properly licensed to practice practical nursing pursuant to State Statutes, or other states' applicable laws.*

*A **Massage Therapist** is a person properly licensed to practice massage, pursuant to State Statutes, or other states' applicable laws.*

*A **Medical Professional** is any person, other than a Physician, who is duly licensed by the state in which the person is engaged in the practice of their health care specialty, and is recognized by for payment purposes (for example, Registered Nurse (RN), Licensed Practical Nurse (LPN), Registered Physical Therapist (RPT), Psychologist, Occupational Therapist, Speech Therapist, or Pharmacist).*

*An **Occupational Therapist** is a person who is duly licensed by the state in which the person is engaged in the practice of Occupational Therapy.*

*A **Pharmacy** is an establishment licensed as a pharmacy pursuant to State Statutes, or other states' applicable laws.*

*A **Pharmacist** is a person properly licensed to practice the profession of pharmacy pursuant to State Statutes, or other states' applicable laws.*

*A **Physical Therapist** is a person properly licensed to practice physical therapy pursuant to State Statutes, or other states' applicable laws.*

*The title **Physician** includes individuals practicing medicine and licensed, or;*

- *Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.)*
- *Doctor of Dental Surgery (D.D.S.) or (D.M.D.);*
- *Doctor of Podiatric Medicine (D.P.M.);*
- *Optometrist (O.D.); and*
- *Chiropractor (D.C.) - (all above) when acting within the scope of their licenses.*

C.A.

Marie LaBeau suffered from stomach pains and had been treated by a gastroenterologist (M.D.) but he was unable to offer much relief. Her sister had suffered similar discomfort some months previously, but seemed to have been cured by taking a treatment of herbs and vitamins. Marie's doctor refused to prescribe any such treatment, calling it "quackery."

Marie decided to take matters into her own hands, and went to the "Doctor" who claimed to be a Doctor of Naturapath Healing (N.D.). He prescribed certain vitamins and herbs and a diet that would help her, and after 3 weeks of this treatment her stomach pain left, and as long as she stayed essentially on the diet and took the prescribed herbs and vitamins, she felt that she was cured.

Since her policy had a definition of Physician that did not mention a ND, they would not cover this treatment, even though her gastroenterologist later confirmed that her problems no longer existed. The gastroenterologist, being a Medical Doctor, was paid for his services under the policy.

*A **Psychiatric Facility** is a Facility properly licensed under State law, to provide necessary care and treatment for Mental and Nervous Disorders. For purposes of the Contract, a Psychiatric Facility is not a Hospital.*

*A **Psychiatrist** is a Physician who is licensed to practice medicine and who specializes in the study and treatment of mental disorders.*

*A **Psychologist** is a person properly licensed to practice psychology pursuant to State Statutes, or other states' applicable laws.*

*A **Registered Nurse (RN)** is a person properly licensed to practice professional nursing pursuant to State Statutes, or other states' applicable laws.*

*A **Skilled Nursing Facility** is a state-licensed institution which provides 24 hour nursing care for a patient who's Condition does not warrant hospitalization and has been approved for payment by us. The Facility can operate independently or as part of a Hospital.*

*A **Speech Therapist** is a person properly licensed to practice speech therapy pursuant to State Statutes, or other states' applicable laws.*

*A **Substance Abuse Facility** is a Facility properly licensed under State law, or other states' applicable law, to provide necessary care and treatment for Alcohol or Drug Dependency. For purposes of the Contract, a Substance Abuse Facility is not a Hospital.*

We do not supply you with a Physician, Hospital, Home Health Agency, or Skilled Nursing Facility. You may select your own Provider. We are not responsible for any injuries or damage you may suffer due to the actions of a Provider.

C.A.

Mrs. Johannsen had a heart attack and was taken to the Emergency Room. She had no family doctor and had not seen a doctor for many years. After being released by the Emergency Room she picked a doctor from the book of Preferred Providers furnished her by her insurance company. The doctor referred her to a heart specialist, also on the PPO list, who recommended that she have a by-pass at the local hospital (also a PPO Provider).

During the surgery, a nerve was severed, resulting in paralysis of her left arm, hand and shoulder. Her attorney also sued the insurance company, claiming that the insurance company "made" her use the doctor and hospital, both of which were responsible for her paralysis. They contended that because the insured would have to pay a higher portion of the medical bills if she chose a doctor outside of the network, and the other doctors would charge more than the PPO doctors would.

The attorney did not succeed in his suit against the insurance company as there were no restrictions in the policy in the Providers to be used, plus the policy plainly stated that the insurer does not furnish the insured with a doctor or hospital, and the insured may always select their own Provider. Further, there is a statement, highlighted in a prominent position in the policy, that states they (the insurer) are not responsible for any injuries or damage you may suffer due to the actions of a Provider.

GENERAL TERMS

NOTE: There are a lot of items under this section, but these terms will be used later in the policy, particularly in the Benefits section. Therefore, there is little in the way of Consumer Applications that is applicable here, however all agents that market Health Insurance should be familiar with the following terminology.

***Accident** - see Medical Emergency.*

***Admission Certification** means certification must be received from YOUR INSURANCE COMPANY to receive full Contract benefits for ALL Inpatient Hospitals Admissions (i.e., elective, planned, emergency and maternity) to PPO Hospitals.*

Adoption or Adopt is the act of creating the legal relationship between parent and child where it did not exist, thereby declaring the child to be legally the child of the adopted parents and their heir-at-law and entitled to all the rights and privileges and subject to all the obligations of a child born to such adopted parents, or as otherwise defined by State Statutes.

Alcohol or Drug Dependency is a Condition where a person's alcohol or drug use:

- * injures his or her health; or
- * interferes with his or her social or economic functioning; or
- * Causes the individual to lose self-control.

A person is **Drug Dependent** when he or she is dependent on or in imminent danger of becoming dependent on any controlled substance.

Allowance is, when applicable as indicated on the Schedule of Benefits, the maximum benefit YOUR INSURANCE COMPANY will provide for covered services and/or supplies under this Contract. This amount is determined solely by YOUR INSURANCE COMPANY, and may vary depending upon many factors, including, but not limited to: the type of Provider; the type of service or supply; the geographic area in which the service was rendered; the charge(s) of the Provider; the charge(s) of similar Providers within a particular geographic area, as established by YOUR INSURANCE COMPANY; various pre-negotiated payment Allowances; and the cost of providing the services or supplies. However, for Providers other than Hospitals, the Allowance or maximum allowable payment ("MAP") will not be greater than the Provider's charge(s). YOUR INSURANCE COMPANY may modify the Allowance for a particular service or supply at any time.

Ambulance is a ground or water vehicle, airplane, or helicopter equipped to transport and staffed to provide Medically Necessary care. The Ambulance must be state-certified.

The **Anniversary Date** is the annual return of the Effective Date of this Contract.

Assign Benefits is a procedure where you assign your Benefits to certain Providers. In those instances where such assignment is allowed under this Contract, you must sign the claim form in the appropriate space indicating that you want payment to be made directly to the Provider.³

Bone Marrow Transplants means human blood precursor cells administered to a patient to restore normal hematological and immunological functions. Human blood precursor cells may be obtained from the patient in an autologous transplant or an allogeneic transplant from a medically acceptable related or unrelated donor, and may be derived from bone marrow, the circulating blood, or a combination of bone marrow and circulating blood. If chemotherapy is an integral part of the treatment involving Bone Marrow Transplantation, the term "Bone Marrow Transplant" includes both the transplantation, the administration of chemotherapy and the chemotherapy drugs. The term Bone Marrow Transplant also includes any services or supplies relating to any treatment or therapy involving the use of high dose or intensive dose chemotherapy and human blood precursor cells and includes any and all Hospital, Physician or

other health care Provider services or supplies which are rendered in order to treat the effects of, or complications arising from, the use of high dose, intensive dose, or standard dose chemotherapy or human blood precursor cells (e.g., hospital room and board and ancillary services).

*A **Calendar Year** begins January 1st and ends December 31st in any given year.*

*A **Catastrophic Illness** is a severe Condition that has rendered a person temporarily or permanently disabled.*

***Coinsurance** means the sharing of expenses by your insurance company and the Insured. After you satisfy the Deductible requirement, we pay the percentage of the PPO Schedule or Allowance (whichever is applicable), as specified on the Schedule of Benefits for covered services. The unpaid portion of the PPO Schedule or Allowance (whichever is applicable), constitutes your Coinsurance obligation.*

*A **Condition** means any covered disease, illness, ailment, injury, or bodily malfunction of an Insured.*

***Conditional Receipt** is a process by which the proposed Insured/applicant signs and receives a copy of a receipt for Premium collected and is assigned an Effective Date of coverage contingent upon the proposed Insured/applicant being Medically Acceptable to YOUR INSURANCE COMPANY.*

C.A.

Applicant Don was given a Conditional Receipt when he gave the agent the first premium. His present policy (not COBRA) expires on the 31st; the application was taken succeeding 5th.

On the 27th, he was mugged and spent 3 days in the hospital, incurring large medical bills.

Typically if the insurance company had completed their underwriting and he was considered eligible for insurance, then the medical bills would be covered.

If during the underwriting, it was discovered that Don had a hernia that would soon require surgery, and he was aware of this but had not stated so in the application (actually, even if he had stated it on the application) he would not be eligible for the insurance, and the policy would be canceled and the premiums refunded. The policy would not cover the costs associated with the mugging.

*The **Contract** includes this document, the application for coverage signed by the Contract Holder, the identification card(s) issued to the Contract Holder, and any Rider(s) and Endorsement(s).*

*The **Contract Holder** is the person who has contracted with YOUR INSURANCE COMPANY to provide health care benefits.*

***Cosmetic Surgery** is surgery primarily to improve the appearance of the individual but not to restore bodily function or to correct a deformity.*

*A **Covered Dependent** is a family member of the Contract Holder who meets and continues to meet the eligibility requirements set forth in this Contract, and is actually covered by this Contract. A Covered Dependent must be the Contract Holder's spouse or unmarried natural children, Newborn children, Adopted children, Foster children or stepchildren. (Children must be under the limiting age specified in the Eligibility section of this Contract.)*

*A **Crippling Injury** is an injury that has changed the normal action of an organ or body part.*

*The **Deductible** means the amount of charges for covered services and supplies, up to the relevant PPO Schedule or Allowance (whichever is applicable), that you must pay each Calendar Year before our reimbursement for covered services begins. The Deductible amount applies to each Insured each Calendar Year.*

***Durable Medical Equipment** is equipment that can withstand repeated use and is used solely for medical purposes.*

*The **Effective Date** means 12:01 a.m. Eastern Standard Time, on the date this Contract is issued as it appears on the cover of this document.*

*An **Endorsement** is an amendment to this Contract that modifies the terms of this Contract.*

***Experimental or Investigational** means any evaluation, treatment, therapy or device which involves the application, administration, or use of procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, drugs, pharmaceuticals, or chemical compounds if, as determined solely by YOUR INSURANCE COMPANY:*

- *such evaluation, treatment, therapy or device cannot be lawfully marketed without approval of the United States Food and Drug Administration or the State Department of Health and Rehabilitative Services and approval for marketing has not, in fact, been given at the time such is furnished to the Insured;*
- *reliable evidence shows that such evaluation, treatment, therapy, or device is the subject of an ongoing Phase I, II, or III clinical investigation, or under study to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question;*
- *reliable evidence shows that the consensus of opinion among experts is that further studies, research, or clinical investigations are necessary to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question;*
- *reliable evidence shows that such evaluation, treatment, therapy, or device has not been proven safe and effective for treatment of the Condition in question, as evidenced in the most recently published medical literature in the United States, Canada or Great Britain,*

using generally accepted scientific, medical, or public health methodologies or statistical practices;

- *there is no consensus among practicing Physicians that the treatment, therapy or device is safe and effective for the Condition in question; OR*
- *Such evaluation, treatment, therapy or device is not the standard treatment, therapy or device utilized by practicing Physicians in treating other patients with the same or similar Condition.*

"Reliable evidence" shall mean (as determined by YOUR INSURANCE COMPANY):

- *Reports, articles, or written assessments in authoritative medical and scientific literature published in the United States, Canada, or Great Britain.*
- *published reports, articles, or other literature of the United States Department of Health and Human Services or the United States Public Health Service, including any of the National Institutes of Health, or the United States Office of Technology Assessment;*
- *the written protocol or protocols relied upon by the treating Physician or institution, or the protocols of another Physician or institution studying substantially the same evaluation, treatment, therapy or device; or*
- *the written informed consent used by the treating Physician or institution, or by another Physician or institution studying substantially the same evaluation, treatment, therapy or device; or*
- *The records (including any reports) of any institutional review board of any institution which has reviewed the evaluation, treatment, therapy or device for the Condition in question.*

*A **Facility** is any duly licensed Hospital, Skilled Nursing Facility, Outpatient Surgical Center, Home Health Agency and any free-standing emergency center or Dialysis Center, providing that Facility has been approved for payment by us.*

***Foster Children** is a person under the age of 18 who is placed in the Insured's residence and care by the State Department of Health & Rehabilitative Services in compliance with State Statutes.*

*A **Full-time Student** is one who is enrolled in, and actually attends, an accredited college or university for five months during the Calendar Year in which this Contract is in effect.*

*The **Grace Period** is the thirty-one (31) day period immediately following the Premium due date as indicated on the front of this Contract.*

*A **Home Health Care Visit** means that a Home Health Agency employee provides services to you, in your home after a written plan of treatment has been submitted to and approved by us.*

***Home Health Services** are medical services and supplies, furnished to an individual, by a Home Health Agency or others under arrangements with the Home Health Agency, in the individual's home. A written plan of treatment must be submitted to and approved by us.*

*An **Inpatient** means a patient who is admitted to a Facility as a bed patient and is charged for room and board for Medically Necessary care or treatment upon the orders of a Physician working within the scope of his/her license.*

*An **Insured** is the Contract Holder (the person purchasing this Contract) and any of the Contract Holder's Covered Dependent(s).*

***Investigative** see "Experimental or Investigational".*

***Massage Therapy** is the manipulation of superficial tissues of the human body by hand.*

***Material Misrepresentation** is the omission, concealment of facts or incorrect statements made on an application or medical statement by an applicant, Insured or Contract Holder which would have affected our underwriting decision to issue this Contract, issuance of different benefits, or issuance of this Contract only at a higher rate had they been known.*

***Medical Emergency/Accident** is the sudden, unexpected onset of a Condition of such a severe nature that immediate care must be given to prevent death of the Insured or serious impairment of the Insured's health or bodily function as determined by YOUR INSURANCE COMPANY. Some examples include but are not limited to the following: unusual or excessive bleeding, serious burns, poisoning, unconsciousness and convulsions.*

***Medically Acceptable** means that you have submitted a medical history application and based on our underwriting regulations have been approved by us to be acceptable for coverage.*

***Medically Necessary** means that, in the opinion of YOUR INSURANCE COMPANY, a specific medical, health care, or Hospital service is required for the identification, treatment, or management of a medical symptom or Condition. A service, care, or supply is Medically Necessary if, in the opinion of YOUR INSURANCE COMPANY it is: 1) consistent with the symptom, diagnosis, and treatment of the Insured's Condition; and 2) in accordance with standards of good medical practice; and 3) approved by the appropriate medical body or board for the Condition in question; and 4) is not primarily for the convenience of the Insured, a Physician, or other Provider; and 5) is the most appropriate, efficient, and economical medical supply, service, or level of care which can be safely provided. (Note: See "Medically Necessary" under the section entitled "Your Obligations")*

Medicare means the two programs of health insurance provided under Title XVIII of the Social Security Act. The two programs are sometimes referred to as Health Insurance for the Aged and Disabled Act. Medicare also includes any later amendments to the initial law.

A **Mental and Nervous Disorder** is any and all disorders set forth in the diagnostic categories of the most recently published edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, regardless of the underlying cause or effect, of the disorder. Examples include but are not limited to attention-deficit hyperactivity, anorexia nervosa, bulimia, bipolar affective disorder, autism, mental retardation, and Tourette's disorder.

Newborn is a child that is (typically) 60 days of age or less. Note: Newborn coverage will be provided in accordance with the provisions of the Contract and will continue so long as the Contract remains in effect and any applicable Premiums are paid by the Insured.

A **Non-Preferred Patient Provider** is a Provider who has not entered into an agreement with YOUR INSURANCE COMPANY, to participate in our PPO Organization.

One **Person Contract** is a Contract covering only the individual named on the identification card.

Occupational Therapy is treatment that follows a Catastrophic Illness or Crippling Injury and is designed to help a patient learn to use a newly restored or previously impaired function.

An **Orthotic Device** is any rigid or semi-rigid device needed to support a weak or deformed body member or restrict or eliminate body movement.

An **Outpatient** means a patient who receives care or treatment in a Hospital (without being charged for room and board), Physicians' office, and patient's home, Ambulatory Surgical Center, a free standing emergency center or dialysis center.

A **Physically Disabled Person** is one who has an anatomic loss or impaired function of a body part following Catastrophic Illness or Crippling Injury which significantly interferes with his/her activities of daily living.

Physical Therapy is the treatment of disease or injury by physical or mechanical means. Such therapy may include traction, active or passive exercises, or heat treatment.

Placement or to Place is the process of a person giving a child up for Adoption and the prospective parent receiving and adopting the child, and includes all actions by any person or agency participating in the process, or as otherwise defined by State Statutes.

*A **Planned Admission** is an Inpatient Hospital admission which is not of an urgent or emergency nature and can be scheduled in advance at a time which is convenient for you and your Physician without risking your well being.*

*A **Pre-existing condition** is any condition which manifested itself, or which there were symptoms which would cause a reasonable person to seek diagnosis or treatment, or which was the subject of medical advice or treatment by a Provider during the 24 month period immediately preceding the Effective Date of the insured's coverage.*

*A **Preferred Provider Organization (PPO)** is a network of Providers with which YOUR INSURANCE COMPANY has entered into an agreement to provide services to you at a pre-negotiated fee.*

*A **Preferred Patient (PPO) Provider** is a Provider who has an agreement with YOUR INSURANCE COMPANY, to participate in our Preferred Provider Organization.*

***Preferred Patient (PPO) Schedule** is, when applicable as indicated on the Schedule of Benefits, the maximum benefit YOUR INSURANCE COMPANY will pay for covered services and/or supplies rendered by a health care Provider, who at the time the service or supply was rendered, was a PPO Provider under this Contract. This schedule is a list of pre-negotiated fees. The fee schedule is determined solely by YOUR INSURANCE COMPANY, and may vary depending upon many factors, including but not limited to: the Provider; and the geographic area in which the service was rendered or the supply was furnished.*

*The **Premium** is the total amount you must pay YOUR INSURANCE COMPANY for your coverage under this Contract. The Premium is determined on the basis of the applicable Rate(s) and the number of individuals covered under your Contract.*

*A **Prescription** is a request for medication or supplies by a Physician and/or pharmacist acting within the scope of his/her license,*

*A **Prescription Drug** is any medicinal substance, remedy, vaccine, biological product, drug, pharmaceutical or chemical compound which can only be dispensed pursuant to a Prescription and which is required to bear the following statement or similar statement on the label: "Caution: Federal Law prohibits dispensing without a Prescription".*

*A **Prosthetic Device** is equipment which replaces all or part of a permanently inoperative or malfunctioning body organ.*

*A **Provider** is a Hospital, Home Health Agency, and Skilled Nursing Facility, Physician, Medical Professional, or a Supplier, who has been appropriately licensed and is recognized by YOUR INSURANCE COMPANY for payment purposes.*

*The **Rate(s)** is the amount(s) YOUR INSURANCE COMPANY charges Preferred Patient Contract Holder(s) for coverage. The Rate will vary depending upon the Insured's Risk Class.*

Rehabilitative Services are health care services, the purpose of which is to correct functional defects which remain after a Catastrophic Illness or Crippling Injury, and includes, but is not limited to, Rehabilitative Services related to Alcohol or Drug Dependency, Mental and Nervous Disorders, pain control, or pulmonary or cardiac rehabilitation.

A **Rider** is an amendment we add to this basic agreement where the scope of coverage under this Contract is restricted.

A **Risk Class** is a grouping of Insured's who have similar characteristics. For example, Insured's who: are the same sex; in the same age bracket; have similar medical conditions (including whether they use tobacco products); live in the same geographical area; and who have elected the same benefit plan may be grouped into a Risk Class. Your Risk Class is determined by YOUR INSURANCE COMPANY.

Service Area is a geographical location in which YOUR INSURANCE COMPANY has established a Preferred Provider Organization to provide health care services based upon a pre-negotiated fee for services rendered under a Preferred Patient Contract.

Skilled Nursing Services means the performance of those acts requiring substantial specialized knowledge, judgment and nursing skill in the administration of medications and treatment as prescribed or authorized by a duly licensed Physician.

Speech Therapy is the treatment of speech and language disorders by means such as, but not limited to, language assessment and language restorative therapy services.

Supplier is any entity, other than a Hospital, Physician, or Medical Professional which is duly licensed by the state in which the entity is engaged in the practice of supplying health care goods, and is recognized by YOUR INSURANCE COMPANY for payment purposes (for example, Ambulance companies, Durable Medical Equipment companies, and Pharmacies).

Totally Disabled means that you are unable to work at any gainful job for which you are suited by education, training, or experience, due to a Condition. This would also apply to an Insured who, although not engaged in an occupation (i.e., student, non-working spouse, or children) might be in such condition as to be unable to perform those normal day to day activities which they would otherwise be able to perform.

An **Unplanned Admission** is an Inpatient Hospital admission which is of an urgent or emergency nature and cannot be scheduled in advance.

A **Visit** means the Physician personally examines you while you are an Inpatient or Outpatient in the Hospital, Physicians office, Ambulatory Surgical Center, free standing emergency center or in your home.

Well Child Care is defined as Physician-delivered or Physician-supervised, periodic services not related to a specific Condition, provided for a Covered Dependent child up through 16 years of age.

APPLICATIONS

REPRESENTATIONS BY THE CONTRACT HOLDER/INSUREDS/APPLICANTS

In the absence of fraud, all statements made by applicants or Insured's will be deemed to be representations and not warranties. No statement made for the purpose of affecting coverage will avoid coverage or reduce benefits unless contained in a written application signed by the Contract Holder and a copy of such documents has been furnished to the Contract Holder.

Eligibility for coverage under this Contract is determined by medical risk classifications applicable to the applicant and his or her dependents. Among the factors we consider when making our underwriting decision are the medical information requested on the application, and the sex and age of the applicant and his or her dependents.

*Material Misrepresentations, omissions, concealment of facts and incorrect statements made on an application or a medical statement by an applicant, Insured or a Contract Holder which is discovered within two years of the issue date of the Contract may prevent payment of benefits under this Contract and may void this Contract for the individual making the misrepresentation, omission, concealment of facts or incorrect statement. Fraudulent misstatements in the application or medical statement discovered at any time, may result in **voidance** of this Contract or denial of any claims for the individual making or responsible for the fraudulent misstatement.*

In the event of fraud or misrepresentation pertaining to, but not limited to, medical information, geographical area, or the sex and/or the age of applicant or his or her dependents made on an application or medical statement by an applicant, Contract Holder or Insured, the sole liability of YOUR INSURANCE COMPANY shall be the return of any unearned Premium, less benefit payments. However, at our discretion, we may elect to cancel the Contract with forty-five (45) days prior written notice (Time may vary by state regulation &/or company practice) or continue this Contract provided that the Contract Holder makes payment to us for the full amount of the Premium which would have been in effect had the true facts been stated by the applicant, Contract Holder, or Insured.

C.A.

Bernadette was diagnosed with breast cancer in Oregon. Her doctor in Oregon told her that she needed surgery as soon as possible. However, since she was not employed and had no insurance, she decided to move back home to Indiana.

She found a job in Indianapolis, but it had no benefits. Therefore she applied for an individual major medical policy. She did not tell the agent about her cancer and the policy was issued on a standard basis with no riders.

60 days after the policy was issued she had a “routine” mammogram” which “discovered” the cancer. She told the radiologist at the clinic that she had had a mammogram about a year earlier, at a public health clinic. She did not mention the finding, however. She was immediately admitted to a hospital in Indianapolis and a mastectomy was performed.

During a routine claims review, the insurer sent an inquiry to the Public Health Service in Oregon, which duly reported the earlier findings. Based upon these findings, the insurer canceled the policy based upon a material misrepresentation and refused to pay for any of the medical costs.

INDIVIDUALS COVERED

This Contract will provide coverage for the following individuals only when the person(s): (1) were named on the application; and (2) were Medically Acceptable; (3) the Premiums were paid; and (4) a Contract was issued by us:

- *You; or*
- *You and your spouse; or*
- *You, your spouse, and your unmarried natural children, Newborn children, Adopted children, Foster children or stepchildren.*

(Some individual policies may not contain a section regarding coverage for any person(s) other than the named insured)

DEPENDENTS COVERAGE

Spouse

Your spouse may be covered until legal separation or divorce.

Children

Your unmarried natural children, Newborn children, Adopted children, or stepchildren may be covered from birth to the end of the Calendar Year in which they reach the limiting age of 19. Foster children or children in court-ordered custody of the Insured may be covered to the end of the Calendar Year in which they reach the age of 18.

Newborn Children

The Contract Holder is responsible for notifying YOUR INSURANCE COMPANY of the birth of the Newborn child within 30 days of the date of birth. If notice is received by YOUR INSURANCE COMPANY within this 30 day period, the Newborn child will be covered from the moment of birth and the Contract Holder will not be charged any additional Premium for the first 30 days of coverage.

If YOUR INSURANCE COMPANY does not receive the notice of the birth of the Newborn within the 30 day notice period, the Newborn child will be added as of the date of birth so long as any applicable Premium is paid back to the date of birth.

With respect to a Newborn child of a covered family member other than the Contract Holder or Contract Holder's spouse, the coverage for the Newborn child terminates 18 months after the birth of the Newborn child.

C.A.

Insured has 3 children covered under his 2-year-old family policy, ages 10, 17 and 18, all dependents. The 18 year old daughter has a baby out-of-wedlock. The baby would be covered until it was 18 months old, and then would be responsible for its own coverage. If the company offered a child-only policy, that would be one alternative.

C.A.

Louise is a widow and lives with her daughter, Pam, age 19. Louise has a family policy covering herself and her daughter, as she is the sole support of the daughter who is attending a local college. Pam, although unmarried, has a baby. She elects to keep the baby and the father is not to be involved by mutual consent. The baby is covered under the family policy until such time that Pam reaches the maximum age (typically 23) or graduates from college. Maternity costs would be covered only if the policy has such a provision. In most cases, only complications of pregnancy would be covered, and if she had a cesarean the delivery would be covered.

Note: If an applicant and his wife have a pregnant daughter living at home with them at time of application, the majority of insurers will not insure any member of the family.

C.A.

David Brey applied for a Major Medical policy, listing his wife, his 15 year-old daughter, and an adopted baby, Soo Chin, age 18 months. He has another daughter, Peggy, age 19, who is married and living away from home. After the policy had been in force for a year, Peggy and her husband file for divorce. Peggy is dropped from her husband's insurance.

David and his wife felt that the domestic problems of his daughter were temporary, and they hoped that they would reconcile. Anticipating this reconciliation, David did not bother to add his daughter to the policy until Peggy became quite ill and was admitted to the hospital with a form of hepatitis. David filed a claim against his insurer, claiming Peggy as a dependent. (Continued) (Continued from previous page) The insurer refused payment as (1) the daughter, Peggy had not been named on the application or added within the specified period of time as a dependent (30 days), and (2) she was not medically acceptable when the insurer was notified of her existence.

Adopted Children Foster Children

The Contract Holder is responsible for notifying YOUR INSURANCE COMPANY of the placement of an Adopted or Foster child in the residence of a Contract Holder within 30 days of such placement. If notice is received by YOUR INSURANCE COMPANY within this 30 day period, coverage for the Adopted or Foster child (other than an Adopted Newborn child) begins when the child is placed in the residence of the Insured, in compliance with State law and the Contract Holder will not be charged any additional Premium for the first 30 days of coverage.

Coverage for Adopted Newborn children will begin the earlier of: (a) the moment of birth, provided that a written agreement to Adopt such child has been entered into by the Contract Holder prior to the birth of such child and further provided that YOUR INSURANCE COMPANY receives notice before or within 30 days after the birth of the child; or (b) the date the Newborn child is placed in the residence of the Contract Holder in accordance with State law, provided YOUR INSURANCE COMPANY receives notice before or within 30 days after the date the child is so placed.

If YOUR INSURANCE COMPANY does not receive the notice of placement (for Adopted or Foster children) or birth (for Adopted Newborn children) within the 30 day period, the Adopted or Foster child will be added to the Contract Holder's Contract as of the date of placement (for Adopted or Foster children) or birth (for Adopted Newborn children) so long as any applicable Premium is paid back to the date of placement or birth, whichever is applicable.

In compliance with State law, YOUR INSURANCE COMPANY will waive the Pre-Existing Condition limitation for Adopted children; however, the Pre-Existing Condition limitation will apply to Foster children or children in other court-ordered custody.

There are provisions under consideration by some states, have been under consideration, or will be under consideration in the near future, to include a same-sex partner not related to the insured. However, at this time most proposed legislation pertains only to group insurance.

Also, some states treat common-law situations treat a common-law partner as a “spouse” and would be treated as such under the policy benefits. The appropriate state laws regarding common-law marriages should be carefully researched.

PERIOD OF CHILD ELIGIBILITY

Students

A Covered Dependent children may be covered to the end of the Calendar Year in which they reach the limiting age of 23 (Typical restrictive age, but may vary by state, insurer or policy), if attending a college or university which has been accredited by the State Board of Education, on a full-time basis (as defined by the school and this Contract). The children's legal residence must be with you and the children must depend on you for support.

C.A.

A student, who is attending a local college for a minimum period specified in the application, is considered a full-time student. Difficulties arise when a student fulfills the full-time requirement for the year, then at the beginning of the following year, at time of application, the student is working and even though he states that he will probably go back to school early enough to fulfill the time requirement for that year, there can be a question raised. If after the required time has passed and the student has not gone back to school, then the child can be dropped from the policy and be required to carry his own policy.

Handicapped Children

Coverage of Covered Dependent children will not terminate upon attainment of the limiting age for dependent children specified in this Contract, if the child is and continues to be both;

- *incapable of self-sustaining employment by reason of mental retardation or physical handicap; and*
- *Chiefly dependent upon you for support and maintenance.*

(NOTE: Most policies contain an explanation as to meeting the requirements as shown above. Policy wording may be similar to: If a claim is denied under this Contract because the child has attained the limiting age for dependent children, the burden is on the Contract Holder to establish that the child meets and continues to meet the criteria for extended eligibility. For handicapped children, proof of such dependency (written documentation from your Physician) will be required. The handicap or retardation must have commenced prior to reaching the limiting age, as previously defined, and the child must have been covered under the Contract when he/she reaches the limiting age.)

C.A.

Roger Minor has a Major Medical Policy covering himself, his wife, his daughter age 13, and a son, William, age 19 whom resides at home. William is retarded to the point to where he cannot read nor write, and will never be self-sufficient but has no other health problems. Rogers' policy has an age limitation of 23.

When William reached age 23, Roger neglected to ask for continuation of coverage, as the agent knew that his son was retarded so Roger assumed that the insurance company knew it also. This situation continued until William was 25, when he fell and broke an arm and shoulder. The insurance company denied the claim as William had reached (and passed) the limiting age.

Roger obtained a letter from the family physician, stating that William was not self-sufficient. He also submitted psychological tests that William had had throughout the years. Since Roger had continued paying the premium for coverage including William, and William was insured prior to age 23, the insurer added William to the policy and covered his medical costs.

ADDING A DEPENDENT

Each eligible dependent that was;

- *named on the original application;*
- *Medically Acceptable; and*
- *paid the Premium*
- *Is covered by this Contract.*

Please notify us if a Newborn, Adopted, Foster child or child in other court-ordered custody is to be added to your existing Contract for coverage which is acceptable to us and you pay an additional Premium for coverage to be provided to the new dependent(s). (See above). There is an additional Premium for each dependent added to your Contract.

*If other eligible dependents were not named on the application, they can become covered when you file a **medical application**.*

(Note that the dependent to be added is subject to the medical underwriting requirements of the company. Of course, in those situations where the policy is guaranteed issue, {such as COBRA Continuation} or in many states, for Group Coverage only, the addition of dependents is only a bookkeeping entry, depending upon the insurer and the jurisdiction)

All dependents except those listed below added to your Contract after the Effective Date of coverage will be subject to the Pre-Existing Condition clause contained in this Contract:

- *Adopted child or Adopted Newborn child;*
- *Natural Newborn child.*

Note: *Newlyweds should make application to add their spouse within 60 days prior to, or as soon as possible after, marriage.*

TERMINATION OF DEPENDENT'S COVERAGE

Adopted Children

If the Adopted Newborn child is not ultimately placed in the residence of the Contract Holder, there shall be no coverage for the Adopted Newborn under this Contract. It is the responsibility of the Contract Holder to notify YOUR INSURANCE COMPANY within (typically) 10 calendar days if the Adopted Newborn is not placed in the home.

For all children covered as Adopted children, if the final decree of Adoption is not issued, coverage shall not be continued for the proposed Adopted child under this Contract. Proof of final Adoption must be submitted to YOUR INSURANCE COMPANY. It is the responsibility of the Contract Holder to notify YOUR INSURANCE COMPANY if the Adoption does not take place. Upon receipt of this notification, YOUR INSURANCE COMPANY will terminate the coverage of the child on the first billing date following our receipt of your written notice.

FOSTER CHILDREN

If the Contract Holder's status as a Foster parent is terminated, coverage shall not be continued for any Foster Child under this Contract. It is the responsibility of the Contract Holder to notify YOUR INSURANCE COMPANY that the Foster Child is no longer in the Contract Holder's care. Upon receipt of this notification, YOUR INSURANCE COMPANY will terminate the coverage of the child on the first billing date following our receipt of your written notice.

NATURAL CHILDREN

The Contract Holder may terminate the coverage of a child born to them by submitting a change application to YOUR INSURANCE COMPANY. The Effective Date of such termination shall be the first billing date following our receipt of your change application.

C.A.

The Stinsons adopted a baby on a private basis after being childless for many years. They applied for adoption of the child when the mother who had agreed to the adoption presented the newborn to them by the Stinsons. They notified their insurance company and the baby was covered under their Major Medical plan.

After several months, the natural mother changed her mind and after a hearing, she was awarded the custody of her baby.

Just as it was the responsibility of the Stinsons to add the baby to their policy, it is their responsibility to notify the insurance company of the change.

CONTRACT CHANGES

Entire Contract

The Entire Contract provision is for legal purposes, but is very important as to the action of an agent in changing any provision of the contract.

This Contract, with the application and attached papers, is the entire contract between you and YOUR INSURANCE COMPANY. No change in this Contract will be effective until approved by an officer of YOUR INSURANCE COMPANY. No agent may change this Contract or waive any of its provisions.

YOUR INSURANCE COMPANY may amend or replace this Contract with a new Contract at any time.

The terms of this Contract cannot be changed unless we agree in writing to the change and must be approved by one of our executive officers. Any change will be issued as a new Contract, or a Rider, or as an Endorsement to this Contract. If we make a change in the terms of this Contract, we will notify the Contract Holder in writing at the Contract Holder's last address shown in our records, at least 30 days in advance.

CHANGE IN BENEFIT COVERAGE

With most companies offering a typical Major Medical policy, the increasing/decreasing of benefits refers to the Deductible &/or Coinsurance percentages. The basic rule, as spelled out more specifically below, is that if the insurer is going to be more at risk, then a full application may be needed. If the insurer's risk is going to be less, then most will allow a change by simply requesting the change. This provision may vary by company or policy.

Should you wish to change your current enrollment option to increase benefits, you may apply for a change on your Anniversary Date only.

When requesting a change in coverage, you must:

- *submit a medical history application no later than 60 days prior to your Anniversary Date; and*
- *receive approval from us*

You will receive full credit for continuous coverage under the previous option if approved by us for a change in coverage.

If you wish to decrease your benefits or have any questions regarding a change in your present coverage, please contact your agent or your local YOUR INSURANCE COMPANY office.

C.A.

The insurance agent for the Jacksons offered three deductibles when they applied for a Major Medical policy - \$250, \$500 or \$1,000. They elected the \$500 deductible.

Two years later, after having three children, they felt that since children seem to have more medical bills, they would be better with a lower deductible. Therefore, they notified their insurer that they wanted to change to the \$250 deductible. The insurance company required evidence of good health before they would accept the change. The agent explained that this was to avoid anti-selection, as if a person was diagnosed with a serious illness, they could otherwise get a lower deductible and end up paying less money for the treatment.

Later, as the children got older, and Mr. Jackson's business grew, they felt that they could easily afford to pay a higher deductible, so they requested that the deductible be increased to \$1,000. This, in effect, decreased the benefits; therefore the insurance company granted their request with no evidence of insurability.

IDENTIFICATION CARD

We will provide you with an identification card. Your identification card will be issued in your name and you or any of your Covered Dependents may use this card.

PREMIUM PAYMENT

Your Contract will not be in force until your application for coverage has been submitted, is medically acceptable to us, and we have received your first Premium payment. All subsequent Premium payments are payable in advance or within the Grace Period. The amount of your initial (usually monthly) Premium is indicated on the front cover of this document. Failure on our part, for whatever reasons, to provide you with a Notice of Payment Due does not justify your non-payment of Premiums. It is your responsibility to submit the indicated Premium by the end of the Grace Period or to notify us that a billing was not received.

(Note: This provision is typical, although some jurisdictions may require the receipt of a billing notice before a policy can be cancelled, however that is rare. This is frequently a problem where an insured doesn't pay the premium and makes claims during this period, and uses the lack of a renewal notice as an excuse.)

Your Premium will automatically change if you change Risk Classes, or if the number of individuals under your Contract changes. For example, your Premium will change if you move to a different geographical area, or if you change benefit plans. Additionally, your Premium may increase each year on your Contract Anniversary Date due to the increase in your age and your covered spouse's age (depending upon the contract. Some policies may not increase at all, others may be "step-rated", i.e. increases occur every stated period of time, such as 5 years).

C.A.

When Kenneth Lowe took out a Major Medical policy, his agent commented that his premiums were low because he lived in Albemarle County. Six months later Lowe was transferred to Hillsborough County. He did not notify his insurance company, and when some medical services were needed, he continued with his family doctor in Albemarle County.

Soon the premium notices were returned to the company with notation "moved - address unknown." Lowe had a habit of paying premiums only when he received a premium notice so the policy lapsed and the Grace Period expired. Shortly thereafter, he fell off a ladder at home and was admitted to the hospital. The insurance company refused to pay. In an effort to save a few dollars every month, he discovered that he was responsible for a sizable medical bill.

If we accept Premium for coverage for a Covered Dependent for a period extending beyond the date, age, or event specified for termination of such Covered Dependent, then coverage for such a Covered Dependent shall continue during the Grace Period for which an identifiable Premium was accepted, except if such acceptance resulted from a misstatement of Age or residence. Additionally, if we accept a Premium, which is paid on an annual or semi-annual basis by an Insured for coverage extending beyond an Insured's 65th birthday, and such Insured's coverage is terminated, we will refund any unearned Premium.

APPLICATION MISSTATEMENTS

If any information relevant to determining your Risk Class has been misstated on the application, the Premium amount owed under this Contract will be what the Premium would have been had you given the correct information on the application. If such misstatement causes YOUR INSURANCE COMPANY to accept premiums for a time period that we would not have accepted Premium for if the correct information had been stated, our only liability will be the return of any unearned Premium. YOUR INSURANCE COMPANY will not provide any coverage for that time period. This right is in addition to any other rights YOUR INSURANCE COMPANY may have under this Contract and applicable laws.

C.A.

Albert applied for an insurance policy and gave his date of birth to the agent as 1/1/59. The agent erroneously wrote down his date of birth as 1/1/53. The applicant did not check his policy or review a copy of the application for 5 years when he was comparing his present policy with that of another company. The difference in premium was nearly \$500 over the 5 year period. Upon notification and submission of a copy of the birth certificate, the insurance company refunded the amount overcharged.

GRACE PERIOD

After your first Premium payment, you will be entitled to a Grace Period for all subsequent Premium payments. This means that if a Premium is not paid on or before the date it is due, it may be paid during the thirty-one-(31) day Grace Period. During the thirty-one (31) day Grace Period this Contract will remain in force.

The Grace Period will not apply if, at least 45 days before the Premium due date, we delivered or mailed to your last address shown in our records written notice of our intent to terminate your Contract. Additionally, the Grace Period will not apply if you notify us that you are canceling your Contract. Coverage will end on the last day of the month through which you paid Premiums.

If payment of the required Premium is not received within the Grace Period, this Contract is automatically terminated as of the end of the Grace Period.

C.A.

The Grace Period on most policies is 31 days from the due date, which is usually on the day of the month that the policy was issued. If an insured forgets about the due premium, and personally delivers it to the agent on the last day of the Grace Period, the premium is considered to have been paid. Therefore, if this situation arises, it is wise for the policyholder to get a dated receipt from the agent, or the local office of the insurance company.

If an insured misses the deadline, the insurance company may, at their discretion, continue the coverage. If too much time has elapsed, as stated in the reinstatement provision of the policy, the insurance company may require a physical examination or other proof of good health in order to reinstate the policy. In many states, there are regulations that limit the amount of time that a company can continue a lapsed policy, or issue a new plan.

PREMIUM ADJUSTMENTS

From time to time, Rate adjustments for Preferred Patient Contract Holders may be necessary. In the event of a Rate adjustment, we will mail a written notice to the Contract Holder at least 45 days prior to the Effective Date of the new Rate.

POLICYHOLDER REQUIREMENTS

Companies frequently have a special section of the policy that pertains as to what the duties and obligations of the policyholders are, as opposed to the duties and obligations of the insurance company. The following provision wording continues in the “easy-to-read” style required by most states.

DEDUCTIBLE REQUIREMENT

This provision assumes that the plan has a Deductible. Some policies have a “one-time” deductible, i.e. once the deductible is satisfied, and it never has to be satisfied again. Other policies have a “per-occurrence” provision whereby each occurrence or each hospital admission, requires a separate deductible. For ease of discussion, the annual deductible provision is used as it is the most prevalent

Under this Contract, the maximum Deductible amount per Insured, as specified on the Schedule of Benefits, must be satisfied before our reimbursement of covered services begins for the Insured.

INDIVIDUAL CARRY OVER PROVISION

This provision varies by company and by policy, and frequently is not included in policies of this type. It is used here for discussion purposes.

Any charges we apply toward an Insured's Deductible requirement for covered services received during the last three months of the preceding Calendar Year will be carried over to reduce that individual's Deductible requirement amount for the next Calendar Year.

STUDY QUESTIONS

1. PPO means
 - A. Personal Producers Organization.
 - B. Primary Care Physician.
 - C. Preferred Provider Organization.
 - D. Primary Provider Organization.

2. The maximum out-of-pocket coinsurance expense, does not include
 - A. emergency room charges.
 - B. Doctor's office visits, after the deductible has been satisfied.
 - C. the insured's coinsurance percentage.
 - D. the amount applied toward the deductible.

3. An Ambulatory Surgical Center
 - A. provides surgery in a hospital
 - B. provides hospital emergency room surgery
 - C. is not part of a hospital
 - D. is the headquarters of the ambulance service.

4. Allowance" in a Major Medical policy is the maximum benefit provided by
 - A. the insurance company.
 - B. the deductible.
 - C. the coinsurance allowance.
 - D. the hospital.

5. If an insured requests on a claims form that benefits are to be paid to a particular hospital or doctors, this is called
 - A. subrogation.
 - B. assignment of benefits.
 - C. coordination of benefits.
 - D. contractual referral.

6. Medically Necessary definition in a typical Major Medical policy means that
 - A. your doctor says that it is necessary.
 - B. you go to the hospital.
 - C. in the opinion of the insurer, a specific treatment is required for the treatment of a medical condition.
 - D. a life-or-death situation.

7. Under a typical Major Medical policy, a pre-existing condition is defined as treatments or symptoms of an illness manifesting itself during a specific period prior to the effective date of the policy.
- A. This statement is true.
 - B. This statement is totally untrue.
 - C. A pre-existing condition is not important in a Major Medical policy.
 - D. This is a typical pre-existing condition clause in a Long Term Care policy, not Major Medical.
8. With most Individual Major Medical policies, if a dependent is added after the family policy has been issued,
- A. a medical application does not need to be provided
 - B. the dependent can be added automatically.
 - C. the dependent must take out his own policy.
 - D. a medical application must be provided.
9. If a Major Medical policyholder wants to increase benefits
- A. the insurance company may require a medical history application.
 - B. it can be increased automatically.
 - C. the insurer will not allow benefit increases.
 - D. the original policy must be voided and a new application taken.
10. Typically, with a PPO Major Medical policy , if a policy holder moves his Residence out of the original service area,
- A. the premiums are guaranteed to remain the same.
 - B. the insured will have his policy cancelled and he must re-apply.
 - C. the premium may change.
 - D. the benefits may change but the premium will remain the same.

ANSWERS TO STUDY QUESTIONS

1C 2D 3C 4A 5B 6C 7A 8D 9A 10C



CHAPTER THREE - POLICY PROVISIONS CONTINUED

COINSURANCE

After you satisfy the Deductible, the benefits for covered services will be provided at the percentage specified on the Schedule of Benefits. The unpaid portion of the PPO Schedule or Allowance (whichever is applicable) constitutes your Coinsurance obligation. Your choice of a Provider will determine the percentage we pay of the PPO Schedule or Allowance (whichever is applicable) and will determine your obligation.

C.A.

Henry has a Major Medical policy with \$500 deductible, 80/20 coinsurance, maximum out-of-pocket of \$2,000.

Total medical bills =	\$25,000	
Less Deductible	<u>500</u>	
Available for coinsurance	\$24,500	
Insured pays 20%	4,900	
Less out-of-pocket	<u>2,000</u>	
Maximum paid by insured	2,500	(deductible of \$500, + OOP of \$2,000)
Insurer pays	\$22,500	

MAXIMUM OUT-OF-POCKET COINSURANCE EXPENSE

Again, please note that these provisions pertain generally to a PPO policy, and the coinsurance provisions are particularly affected by PPO and Non-PPO Providers. For Fee for Service plans, the coinsurance would be more simply described as the percentage payable by the company and the insured after satisfaction of the deductible.

The annual Maximum Out-of-Pocket Coinsurance expense for covered services is the amount specified on the Schedule of Benefits. This is an accumulation of the Coinsurance amount not paid under this Contract for covered services and supplies provided by the following:

- Preferred Patient Providers;
- Suppliers in or out of a Service Area;
- Non-Preferred Patient Provider services for Insured's residing out of a Service Area only; and
- Covered Medical Emergency/Accident Care related services.

When an individual Insured has satisfied (paid out of his/her pocket) the Maximum Individual Out-of-Pocket Coinsurance Expense amount specified on the Schedule of Benefits, we will pay

covered services and supplies at 100% of the PPO Schedule or Allowance (whichever is applicable) to be determined by the Provider and Service Area as specified on the Schedule of Benefits.

The Maximum Out-of-Pocket Coinsurance Expense does not include the amount applied toward the Deductible, any benefit reduction, non-covered services, your Coinsurance amount for covered services and supplies for Inpatient and Outpatient Mental and Nervous Disorders and Inpatient Alcohol and Drug Dependency, your Coinsurance amount for covered services of a Non-PPO Hospital or Physician, or charges in excess of the PPO Schedule or Allowance (whichever is applicable). These amounts are your responsibility.

For Fee-for-Service plans in particular, this would vary as all services would be applied to the deductible in most cases. Also, some states may not allow restrictions for Mental and Nervous Disorders, or Alcohol and Drug Dependency.

C.A.

Frances purchased a PPO Major Medical Plan that paid 80% of medical costs after the deductible for participating Providers. For non-participating Providers, it would pay 60% of the approved amount. Frances went to a non-participating doctor for minor surgery.

After the deductible (\$1,000) was satisfied, the doctor bill was \$3,000. Frances expected to pay 40% of the \$3,000 or \$1200, as this was a non-participating doctor. However, she received a bill for \$1800 and questioned the insurance company.

As with most PPO policies, the insurer will pay 60% of the approved amount. In this case, the approved amount for that procedure was \$3,000. Therefore after the deductible, the insurer paid 60% of \$2,000, (\$1200) which meant that she owed the difference of \$800, plus the amount not paid by the insurer (\$1,000), for a total of \$1800 out-of-pocket. Note: Even though the out-of-pocket under her policy was \$1500, this does not normally apply when an out-of-network Provider is used.

RESTORATION OF BENEFITS

The restoration of benefits may be offered, in various forms, and on only certain policy forms. The provisions here are provided only as an example of one type only.

The benefits you have used can be restored. If you receive more than \$1,000 in benefits during a Calendar Year, we will automatically restore your lifetime maximum by \$1,000 on the next January 1st.

At any time \$1,000 or more in benefits has been paid during a Calendar Year, you can restore the full lifetime maximum by sending proof of your good health to us. If we accept your proof, your lifetime maximum will be restored.

Note: *Restoration of Benefits does not apply to Alcohol and Drug Dependency, and mental and Nervous Disorders lifetime maximums.*

C.A.

The Horizons Insurance Co. markets a Major Medical plan which includes a Restoration of Benefits provision. The plan has a lifetime maximum of \$1,000,000, and the provision states that if more than \$5,000 in approved benefits is received in any one calendar year, the benefits will be restored by \$5,000.

If a policyholder had medical bills which totaled \$12,000, and \$2,500 was paid by the insured by deductibles and coinsurance, \$9,500 would be received in benefits. This would reduce the lifetime maximum to \$990,500. The first of the next year this amount would be increased by \$5,000 and the total lifetime maximum would then be \$995,500.

MEDICALLY NECESSITY

This Contract does not provide benefits for any service rendered or any supply furnished by a Hospital, Physician, or other Provider which, in the opinion of YOUR INSURANCE COMPANY, is not Medically Necessary, as defined in the general terms section of this Contract. Examples of hospitalization and other health care services and supplies that are not medically necessary include, but are not limited to:

- *Newborn circumcision.*
- *Continued hospitalization of the mother because the newborn cannot be discharged, or vice versa.*
- *Continued hospitalization because arrangements for discharge have not been completed.*
- *Use of laboratory, x-ray, or other diagnostic testing that has no clear indication, or is not expected to alter the management plan.*
- *Hospitalization because care in the home is unavailable or unsuitable; or hospitalization for any service which could have been provided safely and adequately in an alternate setting; e.g., a Physician's office or Hospital Outpatient department.*
- *Hospitalization or admission to a Skilled Nursing Facility for the purpose of custodial care, convalescent care, or any other service primarily for the convenience of the patient and/or his/her family members.*

YOUR INSURANCE COMPANY makes the decision whether hospitalization or other health care services or supplies are/were medically necessary, and therefore eligible for payment under the terms of your Contract. In some instances, this decision is made by YOUR INSURANCE COMPANY after you have been hospitalized or have received other health care services or supplies and after a claim for payment has been submitted.

In some cases, it is usual for a policy to state a disclaimer which informs the policyholder that if a Doctor or other medical Provider states that certain treatment is “medically necessary” does not automatically make it covered under the policy. Wording may be similar to : ***The fact that a Provider may prescribe, recommend, approve, or furnish a service or supply does***

not, of itself, make it Medically Necessary or a covered service; nor does it make the charge an Allowance under this Contract, even though it is not specifically listed as an exclusion.

C.A.

A young mother insured under a Major Medical plan with maternity benefits, delivered her first child prematurely. Although the baby appeared normal in all respects, because it only weighed 4 pounds at birth, the doctor felt that it should stay in an incubator for a brief period of time and until it gained at least 6 more ounces.

The mother was going to breast feed the baby, and became very agitated when she was told that she could be discharged without her baby. Since the attending physician was the family doctor, he kept her in the hospital for an additional 4 days, and at which time both mother and baby were discharged.

The insurance company refused to pay for the hospital charges for the mother's 4-day stay as it was not medically necessary.

PROVIDER ALTERNATIVES

(This section pertains only to PPO policies and would not be present in a typical Fee-for-Service plan.)

YOUR INSURANCE COMPANY's payment program for covered services varies depending on the health care Provider that the Insured selects to provide the service or supply, as set forth in this section. The level of benefits YOUR INSURANCE COMPANY provides is set forth on the Schedule of Benefits.

YOUR INSURANCE COMPANY does not provide or arrange for the provision of health care services or supplies. It is the Insured's responsibility to select the health care Provider. YOUR INSURANCE COMPANY is not liable for any damages or costs arising from the actions or lack of actions of any health care Provider or such Provider's staff.

IN SERVICE AREA (PPO PLANS ONLY)

Eligible PPO Providers

Eligible PPO Providers are those health care Providers that have entered into an agreement with YOUR INSURANCE COMPANY to participate in YOUR INSURANCE COMPANY's PPO Provider network and were participating in the network at the time the service or supply was provided. An Eligible PPO provider will file claims with YOUR INSURANCE COMPANY, on behalf of the Insured. YOUR INSURANCE COMPANY's payment for covered services rendered by a PPO Provider, if any, will always be made directly to the eligible PPO Provider.

YOUR INSURANCE COMPANY's payment for covered services rendered by an eligible PPO Provider will be at the higher Coinsurance percentage of the PPO Schedule amount, as set forth

in the Schedule of Benefits. Eligible PPO Providers have agreed to accept the PPO Schedule amount as payment in full for covered services, therefore, the Insured's financial responsibility does not include payment of charges in excess of the PPO Schedule amount. The Insured's financial responsibility includes the Deductible(s) and Coinsurance amounts, the payment of charges for non-covered services, the payment of charges in excess of any maximum benefit limitations, and payment of any benefit reduction. The Insured's Coinsurance responsibility for covered services rendered by an eligible PPO Provider will be based upon the PPO Schedule amount or the eligible PPO Provider's charges, whichever is lower.

A list of the type of Providers that are currently eligible to participate in YOUR INSURANCE COMPANY's PPO Provider network is provided at the back of this document. To determine if a particular health care Provider entered into an agreement with YOUR INSURANCE COMPANY to participate in YOUR INSURANCE COMPANY's PPO Provider network, review the most recent PPO Provider Directory. It is the Insured's responsibility, however, to verify that a health care Provider is a PPO Provider at the time the service or supply is rendered. To verify a Provider's participation status, the Insured may contact the local YOUR INSURANCE COMPANY office or the Provider's office.

C.A.

A PPO schedule is the maximum amount that the insurer will pay for certain medical treatments. Some of the larger insurers are noted for being tough negotiators on the amount. The question arises infrequently as to whether the insured should know the amount that is paid for their treatment. Most patients just don't care, as long as they are satisfied with the treatment. However, an insured may feel that if the insurer doesn't pay the Providers the "going rate", then the quality or amount of treatment they receive may be lessened. This has been resolved in different jurisdiction, in different ways. As a practical matter, if the patient is friendly with the doctor's staff, they may be able to informally find out, but in some cases the doctors office will not reveal the amount as it is considered confidential and the doctor could have legal headaches if the patient would sue for any reason.

Eligible Non-PPO Providers

Eligible Non-PPO Providers are those health care Providers that have not entered into an agreement with YOUR INSURANCE COMPANY to participate in the PPO Provider network or were not participating in the network at the time the service or supply was provided. YOUR INSURANCE COMPANY's payment for covered services rendered by an eligible Non-PPO Provider, if any, will be at the lower Coinsurance percentage of the PPO Schedule amount, as set forth in the Schedule of Benefits.

The Insured is responsible for filing claims for services and supplies rendered by eligible Non-PPO Providers. YOUR INSURANCE COMPANY's payment, if any, for covered services rendered by an eligible Non-PPO Provider will always is made directly to the Insured.

Typically, on a PPO policy, the payments of medical benefits cannot be assigned to a health Provider that is not an Approved Provider. The insured does not have the contractual or

legal authority to have any benefit assignments made to non-Providers. An example of wording in a PPO policy is as follows.

YOUR INSURANCE COMPANY will not honor any assignment to an eligible Non-PPO Provider, including without limitation, any of the following assignments:

- *an assignment of the benefits due under this Contract;*
- *an assignment of the right to receive payments due under this Contract; or*
- *An assignment of a claim for damages resulting from a breach, or an alleged breach, of this Contract.*

The provision explaining the amount for which the applicant is responsible is important to the policyholder and should be explained completely and fully by the agent at the time the application is taken. It was mentioned earlier that if a non-approved Provider is used, the “60%” {used for illustrative purposes} of expenses payable by the insurer {as opposed to the 80% for approved Providers} may actually be substantially more than 60% of the total medical bill. This is explained in more detail in this provision.

Eligible Non-PPO Providers have not agreed to accept YOUR INSURANCE COMPANY's PPO Schedule amount as payment in full for covered services, therefore the Insured is responsible for the difference between YOUR INSURANCE COMPANY's PPO Schedule amount and the eligible Non-PPO Provider's charge, if any, in addition to the Insured's responsibility for the Deductible(s) and Coinsurance amounts, the payment of charges for non-covered services, the payment of charges in excess of any maximum benefit limitations, and payment of any benefit reduction. The Insured's Coinsurance responsibility for covered services rendered by a Non-PPO Provider will be based upon the PPO Schedule amount.

C.A.

George Benson was insured under a PPO plan. He developed cancer of the throat and underwent serious surgery. George was aware of the restrictions of the PPO plan, and was careful to use doctors that were Providers, and the hospital that was a Provider. The hospital, Central Hospital, was considered the best cancer hospital in the area.

George had to have a nurse come to his home for several days to administer medication and to change bandages, etc. These services were covered under his policy. When informed that he would have to have a visiting nurse, his wife asked (George was unable to contribute at this point) what home health care firm to use. The hospital recommended the Central Home Health Care Agency and George's wife made the arrangements with this agency.

After George was at home and after the home health care nurses stopped coming to his house, George started getting small checks from his insurer. They did not know where they came from, and they were small, so they were deposited and forgotten about. About a month later, George received a bill from the Central HHC Agency for \$2500. They submitted this bill to the insurer, but they continued to get bills from Central HHC. After getting a call from a collection agency, they contacted the claims department of their insurer.

They were informed that even though the Central HHC agency had the same name as the hospital (Central) they were, in fact, not related. Furthermore, Central HHC Agency was not an

(Continued from previous page) approved Provider for the insurance company. Therefore, they had been receiving checks for 60% of the approved amount, which was much less than that billed by Central HHC, in the form of the small checks they had been depositing.

When appealed, the insurer pointed out that it is the responsibility of the insured to verify that the Provider used for any medical procedure, is a company approved Provider.

OUTSIDE SERVICE AREA

Hospitals located outside of the Service area which have entered into an agreement with YOUR INSURANCE COMPANY in that state will be deemed to be participating Hospitals and benefits will be paid directly to that Hospital. If the Insured receives covered services in an out of state Hospital, the Insured will be responsible for the payment of any difference between YOUR INSURANCE COMPANY's payment and the Hospital's charge.

C.A.

There are certain hospitals that specialize in a particular medical field and may be referred to a "Centers of Excellence" who contract with insurers outside of their geographical area. In Tampa, Florida, the Moffitt Center is a regional center for cancer treatment. An insurance company in Georgia may have the hospital as a preferred Provider. Therefore, even though the hospital is outside of the service area, it is available for insured's covered under their PPO plan.

C.A.

Bob Bailey purchased a Major Medical PPO policy from his lifelong friend and insurance agent. The agent had offered various types of plans, but Bailey appreciated the advantages of the PPO.

The disadvantages were that he must use the medical Providers approved by the insurer in order to receive the maximum coinsurance allowance. The other principal disadvantage is that when Bailey travels outside of the state, where there are no participating Providers, he cannot use those doctors except for medical emergencies, and receive the maximum coinsurance allowance. Also, when non-PPO Providers are used, the out-of-pocket provision in his policy does not apply. This means that if he is visiting relatives in a state where no approved Providers are available, and he does not feel well, if he goes to a doctor for a checkup, the insurer will only pay 60% of the amount that they normally would pay for the service (not what the doctor charged). Further, if he should become quite ill and was hospitalized, his \$2,000 out-of-pocket limitation would not apply. This could amount to thousands of dollars that he may have to pay.

The advantages are that since his family doctor is an approved Provider, he really didn't have to change doctors. The doctor will file all claims for him, eliminating the name for frustrating paperwork. One of the big advantages also is that the doctors have all contracted for their services, and he does not have to worry about what is "usual and customary" and then be accosted with a big bill because the doctor bills more than the insurer is willing to pay.

(Continued from previous page) He will receive full benefits of the policy by using approved Providers, but perhaps the deciding reason to purchase a PPO plan is that the premium is considerably lower than any other type of comprehensive plan.

MEDICAL EMERGENCY/ACCIDENT

As stated earlier, the Medical Emergency and Accident provision states that all benefits will be paid to the Provider or reimbursed on the same basis as those medical services provided by Network Providers. This is applicable only for PPO type policies. Many policies provide for an exception that provides that if an insured receives medical services while traveling outside of the Service area, and if the insured cannot reasonably be expected to return to the Service area, benefits will be provided as if they were a medical emergency or an accident and the higher benefits would be provided.

Payment for a Medical Emergency/Accident is made in accordance with the status of the Provider as follows:

Reimbursement for covered services provided by an eligible PPO Provider will be made at the higher Coinsurance percentage of the PPO Schedule amount as set forth in the Schedule of Benefits.

Reimbursement for covered services provided by an eligible Non-PPO Provider will be made at the higher Coinsurance percentage of the Allowance as set forth in the Schedule of Benefits.

C.A.

Bill Armstrong was insured under a PPO plan whose network was only in his state of residence. While on vacation he suffered severe pains in his side and was rushed to the local hospital emergency room.

The hospital billed his insurance company who, according to the terms of the policy, paid 80% of the charges, even though the hospital and ER doctor were not on the PPO list.

C.A.

The Johnson's were traveling to the Grand Canyon on vacation. They were insured under a PPO Major Medical plan. En route, Henry suffered severe chest pains and was rushed to the nearest hospital, a small hospital in rural Arizona. Henry's father died of a heart attack, and his mother had also suffered a heart attack recently, so he was keenly aware of the symptoms. He was diagnosed as having Acute Pericarditis caused by a viral infection. While symptoms of a heart attack were present, with some medication and 2 days rest at a Motel, they were able to continue their trip.

His policy agreed to cover a policyholder who required immediate medical attention and if the insured cannot be reasonably expected to return to his own service area. Therefore, his policy would cover his illness, even though it was not a heart attack.

COVERAGE PROVIDED BY OTHER HEALTH CARE PROFESSIONALS

With the growing specialization in the medical field, a provision is common to provide for certain medical services otherwise not covered by the policy. While the CRNA is perhaps the most common, specialists in the psychological and psychiatric fields are growing and perform important functions.

Anesthesia services rendered by a Certified Registered Nurse: Anesthetist (CRNA) may be covered services, subject to the applicable CRNA Allowance. In those instances where the CRNA is actively directed by a Physician other than the Physician who performed the surgical procedure, YOUR INSURANCE COMPANY's payment for covered services, if any, will be made for both the CRNA and the Physician services at the lower directed-services Allowance in accordance with YOUR INSURANCE COMPANY's payment program then in effect.

YOUR INSURANCE COMPANY's reimbursement for covered services rendered at a participating PPO Substance Abuse or Psychiatric Specialty Facility by Physicians, Psychologists, and other Medical Professionals who are employees, independent contractors, or consultants of such Facility who are paid by the Facility to directly perform patient care services, is included in the Allowance for such Facilities.

COVERED INSTITUTIONAL BENEFITS

This section describes benefits for covered services received in a Hospital, Outpatient department of a Hospital, Ambulatory Surgical Center, Skilled Nursing Facility, or the insured's residence when the insurance company determines that such services are Medically Necessary – note that it is the insurer's determination solely. If the policy is a PPO type of plan, the schedule of allowances will apply. The Deductible, Coinsurance and other limitations and exclusions apply to these benefits as well as for other covered medical services.

HOSPITAL EXPENSE BENEFITS

These benefits will vary by company and policy form, but a typical section covering expenses related to a hospital, would be as shown. With some policies, for instance, outpatient care must be covered under a separate rider. Some policies also have limitations on intensive care, etc.

Covered Hospital services include the following:

- *room and board (typically a private room will be covered only when isolation is required); intensive care units (including cardiac, progressive care and neonatal care units); use of operating and recovery rooms, including Outpatient surgery; use of emergency room;*
- *drugs and medicines for your use in a Hospital; intravenous solutions;*
- *dressings, including ordinary casts;*
- *anesthetics and their administration by a regularly salaried Hospital employee; respiratory therapy, (example, oxygen);*
- *transfusion supplies and equipment;*
- *diagnostic X-rays, ultrasound, and computerized tomography (Cat Scan);*
- *chemotherapy treatments for proven malignant disease, illness, or Condition if the disease, illness or Condition for which the drug or biological product is being administered is an indication for which the drug or biological product has received approval from the Federal Food and Drug Administration;*
- *laboratory and pathology services;*
- *Other approved machine testing, (i.e., electrocardiograms (EKG), electroencephalograms (EEG), echocardiography, mammography, etc.);*
- *Physical Therapy (in connection with a covered Condition); and*
- *X-ray, cobalt and other acceptable forms of radiation therapy for treatment of proven malignant disease.*

C.A.

Adam was admitted to the hospital for prostate surgery. He was put into a semi-private room with a patient who was (in Adams estimation) unusually profane and complaining. Adam is rather religious and modest, and did not appreciate the stream of invectives coming from the other side of the curtain. When his wife came to visit, he was doubly embarrassed, and asked to be transferred to another room. However, the hospital was full as there was a local flu epidemic and even the halls were full. But there was a private room available, which Adam took immediately.

Unfortunately, his insurance policy had a typical clause which stated that a private room in a hospital would only be paid for by the insurer, when isolation is required. Since isolation is not required for prostate surgery, he was responsible for the difference between the semi-private, and the private room rate.

SKILLED NURSING FACILITIES

A Skilled Nursing Facility (SNF) is a facility as described in definitions. It is important to note that generally a Skilled Nursing Facilities requires a Registered Nurse (RN), Licensed Practical Nurse (LPN), or Registered Physical Therapist (RPT) to be on duty 24 hours a day and

a Medical Doctor to be on call 24 hours a day. {Some policies require a RN to be on duty 24 hours a day, a typical requirement for Long Term Care policies} One should note that “Custodial Care” as defined in the policy, does not qualify under this policy as Skilled Nursing Facilities. It should also be noted that some policies may not cover SNF’s, so particular attention must be paid before representing such to any applicant.)

Before you enter a Skilled Nursing Facility, your Physician must submit acceptable documentation (a written treatment plan) to YOUR INSURANCE COMPANY which establishes the Medical Necessity for Skilled Nursing Facility services. (This is a cost-containment feature very common in modern Major Medical plans)

If you are admitted to a Skilled Nursing Facility, and the treatment plan has been received and approved by us, benefits will be provided for the services and supplies shown below, up to the Contract maximum number of days specified on the Schedule of Benefits. Covered services include:

- *room and board;*
- *drugs and medicines for your use while in the Skilled Nursing Facility; intravenous solutions;*
- *dressings, including ordinary casts;*
- *respiratory therapy, (example, oxygen);*
- *transfusion supplies and equipment;*
- *diagnostic x-rays;*
- *laboratory and pathology services;*
- *Electrocardiograms (EKG) and electroencephalograms (EEG); and Physical Therapy.*

Services must be provided or supervised by a licensed RN, LPN, or RPT under the general direction of a Physician.

*When a plan of treatment has not been received and approved by us (again, note that the plan must be approved by the insurer), benefits will be **denied** for Skilled Nursing Facility services. In the event such documentation is provided and the services are found to be medically necessary, benefits will be provided.*

HOME HEALTH CARE

Some policies have more restrictions on home health care than the one used here as an example. The key point in providing home health care is home confinement in many policies. For example, if a person goes to the grocery store, home health care may be excluded. There usually is consideration given for a person going to a doctor or for other medical treatment.

If you are confined at home and require Home Health Care benefits, we will cover Home Health service when provided by a Home Health Agency. This coverage is limited to the maximum reimbursement specified on the Schedule of Benefits.

For Home Health Services to be covered, each of the following conditions must be met:

- *your Physician must send us a home health care plan of treatment; and*
- *we must approve the plan of treatment; and*
- *You must be confined to home and be unable to carry out the basic activities of daily living.*

We will review your Condition to determine the Medical Necessity of your Home Health Services. If your Condition does not warrant the services provided by a Home Health Agency, benefits will be denied. However, at such time documentation is provided and the services are found to be medically necessary, benefits will be extended.

HOME HEALTH SERVICES INCLUDE:

- *part-time or intermittent nursing care, by an RN or LPN; the purchase price of drugs and biologicals; Physical Therapy, by a Registered Physical Therapist-, Occupational Therapy, by an Occupational Therapist; Speech Therapy, by a Speech Therapist;*
- *Home Health Aid Services;*
- *medical social services;*
- *nutritional guidance;*
- *medical supplies; and*
- *The use of medical appliances.*

HOME HEALTH SERVICES DO NOT INCLUDE:

- *homemaker services;*
- *domestic maid services;*
- *sitter services;*
- *companion services; services rendered in adult congregate living facilities;*
- *services rendered in adult foster homes by a person providing general supervision or assistance to three or fewer non-relatives placed in their home by the Department of Health and Rehabilitative Services;*
- *items or services furnished to an individual by a hospice (i.e. medically coordinated program providing a continuum of home Outpatient and home-like Inpatient care for a terminally ill patient and the patient's family);*
- *Services rendered at an adult day care center; and services rendered by and at a nursing home Facility.*

C.A.

Agnes suffered a stroke and upon release from the hospital, was required to take certain medications and a daily evaluation was required by a RN or LPN. She lived alone so a visiting nurse from a home health agency was assigned. Soon afterwards, a physical therapist would be necessary for her to resume the use of her right leg that was the most affected by the stroke.

Agnes' Major Medical policy provided for home health services, which included services of a RN or LPN, and a Physical Therapist. She was totally confined to her home so she qualified in that respect. As time progressed, the RN would do evaluations and if her services were found to be medically necessary, the stated policy benefits would be extended.

MEDICAL AND SURGICAL BENEFITS

Similar to the Hospital services section above, this section describes the benefits for services covered under this plan, those that are medically necessary, and those provided by a Physician or Medical Professional. All of these benefits are subject to the deductible and coinsurance allowances, and benefit allowances if this is a PPO type plan.

SERVICES PROVIDED OUT OF THE HOSPITAL

A typical provision allows benefits to be paid for such services as those provided by an Ambulatory Surgical Center, when used as an alternative to hospitalization.

This Contract provides benefits for Medically Necessary covered services rendered by a Provider, including an Ambulatory Surgical Center, outside of a Hospital when the service is provided as an alternative to Inpatient treatment in a Hospital.

INPATIENT MEDICAL VISITS

The benefits for medical visits by an attending physician and other physicians are considered separately in this provision. This is not for surgical services.

When you are confined in the Hospital, this Contract covers your attending Physician's charges for care, including critical care.

Benefits are provided for up to one Physician's Visit each day only.

Coverage for Physicians' Visits will not be paid in addition to benefits paid for electroshock therapy. Coverage for all Physicians' Visits is excluded when in connection with surgical

procedures. The Physician's fee for a Hospital Visit in connection with his/her surgical procedure is included in his/her fee for the surgical procedure.

C.A.

Daryl was admitted to the hospital for surgery. His family doctor was his attending physician, and knew that Daryl was an “early bird”, so he scheduled his visits with Daryl as his first stop at the hospital. Since his hospital rounds would usually end in early afternoon, he would stop by and see Daryl on his way out. When the bill was submitted to the insurer, the insurer would only pay for one visit a day by a doctor, which is typical of most Major Medical policies.

ADDITIONAL PHYSICIAN BENEFITS IN HOSPITAL

The coverage's provided for physicians other than the attending physician, while the insured is in the hospital, may be separated out as in this illustration, or can be included in one benefits section of the policy. The treatment of other physicians as shown is typical.

During an Inpatient Hospital stay, you may receive services by more than one Physician. We will provide benefit payment to more than one Physician only if your Condition:

- *involves more than one body system; and*
- *is so severe or complex that one Physician cannot provide your care unassisted; and In addition, the Physician must:*
- *Have different specialties or have the same specialty with different sub-specialties; and actively participate in your treatment.*

SURGICAL SERVICES

Some policies cover all surgical services and procedures in one provision. It should be noted that if complications arise, under this illustrated provision, there would be no separate reimbursement. Sort of “You broke it, you fix it” type of provision.

This Contract covers surgery needed to diagnose or treat a Condition, when performed by a Physician acting within the scope of his or her license. Complications, if they occur within 72 hours of the surgical procedure, are not separately reimbursed.

SIMULTANEOUS SURGICAL PROCEDURES

When more than one surgical procedure is performed, most policies treat them as shown in the following provision.

Multiple Surgical Procedures

Multiple surgical procedures are more than one surgical procedure performed on different areas of the body **during the same operative session** by the same Physician. When the attending surgeon performs more than one procedure during a single operative session, benefits will be provided at the PPO Schedule or Allowance (whichever is applicable), for the primary surgical procedure. Additional procedures will be reimbursed at 50% of the PPO Schedule or Allowance (whichever is applicable).

INCIDENTAL SURGICAL PROCEDURES

Some policies include this provision and the one proceeding into one provision. The difference is that the Incidental Surgery is performed through the same incision.

*Incidental surgical procedures are multiple (more than one) surgical procedures **which are performed through the same incision**. If the surgical procedures are not clearly identified or do not add significant time or complexity to the surgical session, these procedures are considered to be incidental to the major surgical procedure. Incidental surgical procedures are covered services but no separate reimbursement will be made for these procedures. The Allowance for an incidental procedure will be included in the PPO Schedule or Allowance (whichever is applicable) for the major surgical procedure.*

C.A.

An example of an incidental surgical procedure is the removal of an appendix during the same operative session in which a hysterectomy is performed. The Allowance for the removal of the appendix is included in the PPO Schedule or Allowance (whichever is applicable) for the hysterectomy. No additional benefit will be extended for the removal of the appendix.

PHYSICIAN SURGICAL ASSISTANT

Benefits for surgical assistants are usually a percentage of the surgical allowance (if PPO) or of the amount paid to the surgeon under the “Usual and Customary”, etc., provision. The following provision is a PPO situation, as are most of the provisions as explained earlier.

This Contract provides benefits for the services of a Physician who acts as a surgical assistant provided:

- *the assistance is Medically Necessary; and*
- *No intern, resident, or other staff Physician is available.*

The reimbursement level for such surgical assistant is 20% of the Physician's surgical Allowance. Benefits will be paid at the percentage of the PPO Schedule, or Allowance (whichever is applicable), specified on the Schedule of Benefits.

ANESTHESIA

Typically, the policy provides for anesthesia to be administered by a physician. Policies may provide for anesthesia to be administered by a CRNA (nurse anesthetist). Please note that this provision may appear conflicting with the previous section on the administration of anesthesia while in the hospital, but actually there is no conflict as this section concerns only Physicians services.

This Contract provides benefits for general anesthesia services when administered by a Physician, other than the operating Physician or his or her partner or associate, for covered surgical procedures.

C.A.

When Ann was undergoing at hysterectomy, she used the hospitals Anesthesiologist. Her Major Medical policy covers benefits for general anesthesia when administered by a physician other than the operating physician

CONSULTATIONS

Second opinions are used in most cases where applicable because not only of the need for additional assistance, but also because of the fear of malpractice suits. Most policies do pay for the second opinion but under certain conditions, similar to those contained in the following example.

Your Physician may request an Inpatient or Outpatient consultation concerning your Condition.

This Contract provides benefits for consultation services only if:

- *your attending Physician requests the consultation; and*
- *The consulting Physician includes a written report in your Hospital record or provides your Physician with a written report.*

Only one consultation from one consulting Physician will be covered per Condition.

C.A.

Maurie was always a pessimist, and when he was diagnosed as requiring immediate surgery, he demanded a second opinion after he was admitted to the hospital. The doctor considered his symptoms as “classic” and could not see the need for a second opinion as the surgery, while important, was relatively simple and one that he had performed hundreds of times without problems.

Maurie then personally called another doctor that was recommended by his brother-in-law, who confirmed the original doctor’s diagnosis and advised Maurie to have the surgery.

Since the attending physician had not requested a second opinion, the insurance company would not pay for a second doctor.

OUTPATIENT VISITS

This is a provision that seems to state the obvious but is legally necessary. It is included in other provisions in many types of policies.

This Contract covers your Physician's or Medical Professional's Medically Necessary services for Outpatient Visits in connection with a Condition or covered Well Child Services.

DIAGNOSTIC SERVICES

Diagnostic services are frequently treated separately as coverage's of these services vary by policy and by company. They can also become quite expensive if a limit is not placed on these services.

This Contract provides benefits for the following diagnostic services, when performed by a Physician, to diagnose or treat a Condition.

- *x-rays, ultrasound, and computerized tomography (CAT Scan);*
- *laboratory;*
- *pathology;*
- *approved machine testing, (i.e., electrocardiograms (EKG), electroencephalograms (EEG); and*
- *Allergy testing, by any method. Our Allowance for allergy testing is based on the type and number of tests performed by the same Physician.*

THERAPEUTIC SERVICES

This Contract provides benefits for the following therapeutic services when medically Necessary.

- *Physical Therapy (in connection with a covered Condition)*
- *Chemotherapy treatments for proven malignant disease, illness, or Condition if the disease, illness or Condition for which the drug or biological product is being administered is an indication for which the drug or biological product has received approval from the Federal Food and Drug Administration.*
- *X-ray, cobalt and other acceptable forms of radiation therapy for treatment of proven malignant disease.*
- *Electroshock therapy services will be provided when rendered by a Physician. Payment of benefits for electroshock therapy is made in lieu of payment for any other medical services rendered on the same day electroshock therapy treatments are given by the Physician providing the medical services.*

- *Allergy therapy is the treatment of allergies by the administration of antigens. Our Allowance of the antigens is based on the type and number of doses per vial.*

MAMMOGRAM SCREENING SERVICES

As discussed elsewhere, mammogram screening varies by state and by type of policy. The following is a typical mammogram screening provision.

Mammogram Screening Services

The following mammogram-screening services are covered services when furnished to an Insured and will not be subject to the Calendar Year Deductible and Coinsurance requirements of the Contract.

- 1. A baseline mammogram for any woman who is 35 years of age or older, but younger than 40 years of age;*
- 2. A mammogram every two years for any woman who is 40 years of age or older, but younger than 50 years of age, or more frequently based upon a Physician's recommendation;*
- 3. A mammogram every year for any woman who is 50 years of age or older; or*
- 4. One or more mammograms a year, based upon a Physician's recommendation, for any woman who is at risk for breast cancer because of a personal or family history of breast cancer, because of having a history of biopsy-proven benign breast disease, because of having a mother, sister, or daughter who has had breast cancer, or because a woman has not given birth before age 30.*

Except for mammograms done more frequently than every two years for women 40 years of age or older, but younger than 50 years of age, benefits are payable when, with or without a prescription from a Physician, the Insured obtains a mammogram in a medical office, medical treatment facility or through a health testing service that uses radiological equipment registered with the Department of Health and Rehabilitative Services for breast-cancer screening.

C.A.

Many Major Medical policies now cover mammograms for females over age 35 and increasing by age, the number of mammograms approved each year. However many states now allow mammograms when ordered by a physician, regardless of age. Some policies make mammograms subject to deductibles and coinsurance, some waive the deductibles, and some policies waive both the deductible and the coinsurance.

OTHER COVERED BENEFITS

For illustrative services, additional benefits are covered under a separate provision. These additional benefits are those that do not fit into one of the above categories, for instance, services and supplies which combine benefits from institutional and medical/surgical benefit, but are medically necessary. They are all subject to the usual deductibles, coinsurance allowances, PPO schedules, etc. Since these are repetitive, they are not listed but include Medical Emergency, Accident Care, Mental and Nervous Disorders, and Alcohol and Drug Dependency treatments.

COMPLICATIONS OF PREGNANCY

Complications of pregnancy and maternity benefits have been discussed earlier. The coverage's are, in almost all cases, shown separately as there have been many misunderstandings on this provision, and it can be an extremely costly provision. On those plans that provide maternity benefits, there may or may not be a provision specifically addressing complications of pregnancy. The following example provision assumes that there is no maternity coverage provided under the policy.

This Contract provides benefits for all Insured's for Complications of Pregnancy on the same basis as for any other Condition.

By Complications of Pregnancy, we mean a Condition diagnosed as separate from the pregnancy. Complications include, but are not limited to, the following:

- *acute nephritis;*
- *nephrosis;*
- *cardiac decompensation;*
- *missed abortion;*
- *therapeutic abortion;*
- *non-elective Cesarean section;*
- *tubal pregnancy which is terminated;*
- *miscarriages; or*
- *Medical and surgical Conditions of similar severity.*

Complications of Pregnancy do not include:

- *false labor;*
- *occasional spotting;*
- *bed rest prescribed by a Physician;*
- *morning sickness;*
- *uncontrolled vomiting;*
- *convulsions and high blood pressure; or*
- *Similar conditions associated with a difficult pregnancy.*

NOTE: This Contract does not provide maternity benefits for a normal delivery.

C.A.

Melissa is covered under a Major Medical plan that does not cover maternity benefits for a normal delivery.

When she became pregnant with her first child, she had a rather difficult time as she was bothered by occasional spotting and morning sickness. Her doctor made her stay in bed for the last 3 weeks of pregnancy. At the time of delivery, it was determined that she must have a Cesarean section to deliver the baby.

When the claims were filed with the insurance company for the problems of pregnancy, such as spotting and morning sickness, and her ultimate bed rest, were denied. However, the services for the Cesarean section were paid under the policy, and are considered as complications of pregnancy.

STERILIZATION

This provision may be included with other coverage's in some policies, but for illustrative purposes the following provision is shown.

This Contract provides benefits for tubal legations, when performed independently of any other surgical procedure, and vasectomies.

NEWBORN CARE AND TRANSPORTATION

Provisions for the care and treatment of newborn children are addressed separately to avoid misunderstanding, and again because of its potential cost.

This Contract provides benefits for the newborn of an Insured from the moment of birth for any Condition. This coverage includes, but is not limited to, the following:

- *congenital defects;*
- *birth abnormalities; and*
- *Prematurity.*

This Contract provides benefits for the transportation of a covered Newborn Insured to the nearest Hospital appropriately staffed and equipped to treat the child's Condition. The attending Physician as needed to protect the child's health and safety must certify the need for transportation.

NOTE: A child born to a covered family member, other than the Contract Holder or the Contract Holder's spouse, is covered from the moment of birth for any Condition and Well Child Care Services up through 18 months only. The length of time may vary by company, policy or jurisdiction.

C.A.

Even though the birth may be normal and there are no complications of pregnancy, if the baby suffers abnormalities at birth, the baby is covered and the resulting medical costs will be covered under most Major Medical policies.

In addition, even though the policy does not cover normal delivery, if the baby is born prematurely and must spend time in the nursery incubator, they are covered from birth and most policies will cover the medical care.

WELL CHILD CARE

Well-child care, also known as Well-baby care, varies by policy and company, but in many states, is standardized and closely follows the following illustration.

Health care services and supplies furnished to an Insured who is a dependent child which are Physician-delivered or Physician-supervised may be covered services. Such services include:

- *Newborn's first examination in the Hospital. The examination must be provided and billed by a Physician other than the delivering obstetrician or anesthesiologist.*
- *periodic examinations, which include a history, physical examinations, developmental assessment and anticipatory guidance necessary to monitor the normal growth and development of a child;*
- *Oral and/or in actionable immunizations; and laboratory tests normally performed for a well child.*

These services must conform to prevailing medical standards and will be limited to 18 Visits during a 16 year period at the following age intervals:

<i>Birth</i>	<i>15 months</i>	<i>6 years</i>
<i>2 months</i>	<i>18 months</i>	<i>8 years</i>
<i>4 months</i>	<i>2 years</i>	<i>10 years</i>
<i>6 months</i>	<i>3 years</i>	<i>12 years</i>
<i>9 months</i>	<i>4 years</i>	<i>14 years</i>
<i>12 months</i>	<i>5 years</i>	<i>16 years</i>

These benefits will be limited to one visit per age interval and will not be subject to the Calendar Year Deductible, but will be paid at the Coinsurance percentage of the allowed amount specified in the Schedule of Benefits. Additionally, the Calendar Year Deductible will not apply to the Newborn's initial Hospital admission. To be eligible for payment of benefits, the services must be received within 90 days prior to or after the date the child reaches the age interval specified.

NOTE: A child born to a covered family member other than the Contract Holder or the Contract Holder's spouse is covered from the moment of birth for any Well Child Care Services, up through 18 months only.

C.A.

Roy's family Major Medical policy provides well-child benefits. His unmarried dependent daughter, age 19, delivers a healthy baby. The initial checkup at the hospital by the family pediatrician would be covered, but not if performed by the obstetrician. Well-child checkups and shots would continue according to a schedule until the baby is typically 18 months old, at which time these services cease since the mother is not the insured under the policy. This provision is typical of many Major Medical plans, but in some policies and in some jurisdictions this does not appear and the baby would get full well-child benefits.

Typically, the well-child benefits are the waiving of the deductibles, but in most cases, the mother is still responsible for the coinsurance percentage.

AMBULANCE SERVICES

Ambulance service is covered similarly to that shown below, in most policies and in most states.

This Contract provides benefits for Medically Necessary Ambulance service when needed to transport you from:

- *a Hospital to the nearest Hospital or Skilled Nursing Facility that can provide proper care; or*
- *a Hospital to your nearest home only when Ambulance service is Medically Necessary; or*
- *Your home or place of a Medical Emergency/Accident to the nearest Hospital that can provide proper care.*

Transportation by water, airplane or helicopter will be paid at the PPO Schedule for a ground vehicle unless:

- *the pick-up point is inaccessible by a land vehicle; or additional speed is critical; or*
- *The distance involved in getting the patient to the nearest Hospital with appropriate facilities is too far for medical safety, as determined by YOUR INSURANCE COMPANY.*

C.A.

Sam was in a severe auto accident 35 miles from the nearest hospital. Para-medics were summoned and it was determined that it was imperative that Sam be admitted to the hospital immediately. They radioed for the hospital helicopter ambulance, who took Sam to the hospital. It was conceded that this action probably saved Sam from paralysis and possibly death. The policy provisions of his Major Medical plan allowed benefits if speed was critical, which was the situation here.

PRESCRIPTION DRUGS

Prescription drugs are usually covered while in the hospital, and in many states, for diabetics. The limitations shown below are typical of these provisions.

Prescription Drugs prescribed for an Insured by a Physician and dispensed by a Pharmacist may be covered services. The benefits for Prescription Drugs are subject to, in addition to all of the other provisions of this Contract, the following limitations:

- *a maximum quantity of a 31-day supply or 100 dosage units, whichever is greater, per Prescription;*
- *authorized refills must be filled within one year from the original Prescription date;*
- *insulin is limited to a two vial (10 ml. each) supply, per Prescription; and*
- *Disposable syringes when prescribed with a supply of insulin, limited to a one month supply or 100 units, whichever is greater, per Prescription.*

PROSTHETIC DEVICES

The following provisions provide coverage for prosthetic devices, orthotic devices, and durable medical equipment. These provisions are quite typical.

This Contract provides benefits to purchase, fit, adjust, repair or replace Prosthetic Devices, including the initial prosthetic device following a covered mastectomy.

This Contract does not provide benefits for dental appliances or for the replacement of cataract lenses. However, we will provide the replacement of cataract lenses if a prescription change is medically necessary.

C.A.

Myrtle's right leg was amputated as the result of an accident. Her Major Medical policy covered Medically Necessary Prosthetic Devices, so she was fitted for an artificial leg and went through rehabilitation. Later, another operation on the leg was necessary making it necessary to change the artificial leg.

Myrtle was a young single lady, and her appearance was very important to her. She discovered that she could get one of the newest engineered artificial legs that would look much more normal than the one she had before. However, the more realistic model cost over \$500 more than one similar to what she had before, and that worked perfectly well.

Unfortunately the policy had a limitation which stated they would cover the most cost-effective device which would do the job. Therefore, Myrtle would be responsible for the purchase of the more expensive leg, or the difference in cost if the prosthetic company would work with her.

ORTHOTIC DEVICES

This Contract provides benefits to purchase, fit, adjust, repair or replace Orthotic Devices. This benefit does not include coverage for arch supplies or orthopedic shoes.

DURABLE MEDICAL EQUIPMENT

Durable Medical Equipment includes wheelchairs, crutches, hospital-type beds, and oxygen equipment, but does not include special devices for the operation or utilization of a motor vehicle (i.e., lift), hot tubs or Jacuzzis.

This Contract provides benefits for Durable Medical Equipment, when each of the following conditions is met:

- *the equipment must be prescribed by a Physician; and*
- *the item is not useful to the patient in the absence of a Condition; and*
- *The equipment does not, in whole or in part, serve as a comfort or convenience item.*

Our Allowance for Durable Medical Equipment is based on the lowest of the following:

- *the purchase price; or*
- *the lease/purchase price; or*
- *The rental rate. The total amount of rent must not exceed the total purchase price.*

Also, we cover the repair or replacement of parts needed for the effective operation of the equipment if you own or are purchasing the equipment.

C.A.

Joseph was injured in an auto accident and after release from the hospital, was confined to a wheelchair. Joseph will probably spend the majority of the coming year in the wheelchair. His insurance company determined that it was less expensive to purchase the wheelchair than to lease it. This fully met the requirements of durable medical equipment as provided under his policy.

Joseph purchased a van so that he could travel more comfortably. He is a large man, so it was difficult for him to propel himself into the van, and it was impossible for his wife to push him into the van. Therefore, he had a special wheelchair lift installed on the side of the van so that he could enter the van in his wheelchair. His policy contained a typical provision that excluded any special devices for the operation or utilization of a motor vehicle. They would not pay for the wheelchair lift device.

SERVICES OUTSIDE OF THE UNITED STATES

Policies should be carefully studied as to whether any medical services received outside of the United States are covered, and if so, under what circumstances.

This Contract provides for Medically Necessary covered services you receive while you are traveling outside the United States. Services received outside the United States which are Experimental or Investigational, in the opinion of YOUR INSURANCE COMPANY, will not be covered.

TRANSPLANT SERVICES AND SUPPLIES

These illustrative provisions are specific as to transplant services and supplies. These may vary widely by policy, company and state regulations.

Transplant includes pre-transplant, transplant and post-discharge services, and treatment of complications after transplantation. YOUR INSURANCE COMPANY will pay benefits only for services, care and treatment received or in connection with a:

- 1. Bone Marrow Transplant, as defined herein, and which may be specifically listed in the appropriate state regulations or insurance codes, or which may be covered by Medicare as described by publications by the Health Care Financing Administration (also see the Definition of a Bone Marrow Transplant as shown in GENERAL TERMS);*
- 2. Corneal transplant;*
- 3. Heart transplant;*
- 4. heart-lung combination transplant;*
- 5. Liver transplant;*
- 6. Kidney transplant;*
- 7. Pancreas transplant performed simultaneously with a kidney transplant; and*
- 8. lung-whole single or whole bilateral transplant.*

In order to ensure that a proposed transplant is covered the Insured or the Insured's physician should notify YOUR INSURANCE COMPANY in advance of the Insured's initial evaluation for the procedure. Corneal transplants do not require prior benefit determination.

YOUR INSURANCE COMPANY's Medical Affairs Department will make a prior benefit determination concerning the proposed transplant, however, YOUR INSURANCE COMPANY must be given the opportunity to evaluate the clinical results of the Insured's initial evaluation for the transplant as well as any applicable protocols. If YOUR INSURANCE COMPANY is not

given an opportunity to make the prior benefit determination, the transplant may be subject to a reduction in payment in accordance with the rules set forth in the Admission Certification section, if applicable. Once coverage for the transplant is predetermined, YOUR INSURANCE COMPANY's Medical Affairs Department will advise the Insured or the Insured's Physician of the coverage decision.

For covered transplants, and all related complications, YOUR INSURANCE COMPANY will cover:

- 1. Hospital expenses and Physician's expenses provided that such services will be paid in accordance with the same terms and conditions for care and treatment of any other covered Condition.*
- 2. Organ acquisition and donor costs. Donor costs are not payable if they are covered in whole or in part by any other insurance carrier, organization or person other than the donor's family or estate.*

No benefit is payable for or in connection with a transplant if:

- 1. The transplant is excluded.*
- 2. The expense relates to the transplantation of any non-human organ or tissue.*
- 3. The expense relates to the donation or acquisition of an organ or tissue to a recipient who is not covered by YOUR INSURANCE COMPANY.*

The following services/supplies/expenses are also not covered: Artificial heart devices used as a bridge to transplant.

Insured's may call the Customer Service Assistance toll free number indicated on their identification card in order to determine which Bone Marrow Transplants are covered under this Endorsement.

C.A.

Paul went to the hospital for kidney stone surgery. Pre-surgery tests indicated that there was mass on one of his kidneys, which tests proved to be cancerous. Later tests indicated that the other kidney had also been so affected. The doctors determined that he must either have kidney transplant, or spend a lifetime as a kidney dialysis patient. Paul was only 45 years old, in otherwise excellent health, with no apparent mental or physical disorders. He was considered as an excellent candidate for a kidney transplant.

Paul's brother was found to be a perfect match for a replacement and agreed to the transplant. However, his brother had been out of work for some time and had lost his health insurance.

Typically, Paul's Major Medical policy will cover the cost of the transplant, including reasonable costs for the acquisition from a donor, so his brother should occur no, or very small, medical costs.

COST CONTAINMENT PROGRAMS

“Cost Containment” programs, as used in this provision cited here, are a form of Managed Care, and are very prevalent in the health insurance industry today. There is so much misunderstanding of Managed Care and how it operates, that a provision such as this is very much in order. Some policies may not have these types of programs, or may not address them separately. For those that do, the following wording is typical.

Any and all decisions made by YOUR INSURANCE COMPANY in administering these programs are made only to determine the benefits, if any, for covered services under this Contract. Any and all decisions that pertain to the medical care provided to an Insured or the setting in which the medical care is provided, are made solely by the Insured and the Insured's health care Provider in accordance with the normal patient/health care Provider relationship. YOUR INSURANCE COMPANY in no way participates in or overrides such medical decisions, but merely determines the level of payment, if any, for the medical care under this Contract.

All requests for forms, certifications, and certification reviews must be directed to the Utilization Management Department of YOUR INSURANCE COMPANY.

NOTE: Notwithstanding the cost containment programs described herein, YOUR INSURANCE COMPANY reserves the right to deny claims for services and supplies at any time during the claims review process. Any YOUR INSURANCE COMPANY determination that an admission is certified does not mean that services and supplies rendered during the admission are covered services payable under this Contract, but merely means that the Hospital setting is appropriate for rendering those services and supplies. YOUR INSURANCE COMPANY makes all claims payment decisions retrospectively during the claims review process.

ADMISSION CERTIFICATION

Fee-for-Service plans would treat this subject differently, as the need for PPO hospitals would not be present. Rarely does a major medical policy lack some provision for pre-admittance requirements.

Admission Certification means certification must be received from YOUR INSURANCE COMPANY to receive full Contract benefits for ALL Inpatient Hospital Admissions (i.e., elective, planned, emergency and maternity) to PPO Hospitals.

The Admission Certification program requirements for admissions to PPO Hospitals are the PPO Provider's sole responsibility; therefore, the Insured is not responsible for satisfying such requirements or for any potential benefit reductions when the Insured is admitted to a PPO Hospital.

Once YOUR INSURANCE COMPANY has received the necessary medical information, YOUR INSURANCE COMPANY will review the information and make a certification decision based upon the Admission Certification program's established clinical criteria then in effect.

For Admissions to PPO Hospitals which are not certified, payment to the PPO Hospital will be reduced by the amount specified in that PPO Hospital's Contract with YOUR INSURANCE COMPANY.

Any and all decisions made by YOUR INSURANCE COMPANY in administering this program are made only to determine the appropriateness of care and/or the appropriateness of setting for that care delivered to the Insured for purposes of payment under this Contract.

Certification must be received from YOUR INSURANCE COMPANY to receive full Contract benefits for elective and/or Planned Inpatient Admissions to any Hospital by PPO Physicians.

The Admission Certification program requirements for elective and/or Planned Admissions by PPO Physicians are the PPO Physician's sole responsibility; therefore, the Insured is not responsible for satisfying such requirements or for any potential benefit reductions when the Insured is admitted by a PPO Physician.

C.A.

Sid's Major Medical PPO policy listed Dr. Smith and the Manfield General Hospital as approved Providers. When Sid needed hospitalization, Dr. Smith filled out some preliminary papers for certification to the Manfield General. The Insurer required additional information which was not sent by Dr. Smith. Therefore, the insurer would not pay for all of the medical services provided by the hospital, and such shortages were billed to Sid. The insurance company intervened and stated that according to the contract with the PPO Providers, and according to the policy provisions, any benefit reductions that were caused by the action of the PPO Provider, is not the responsibility of the insured. The doctor and the hospital therefore, worked out an agreement for payment of these expenses.

Assume that Sid's admission request was refused by the insurance company and that the operation was for a hemorrhoidectomy. In many cases this could be performed in the doctor's office. However Sid suffered from a nervous condition that would require him to be under anesthesia for some time after an operation, and which therefore should properly be performed in a hospital. Further, Sid had a pacemaker and was on heart medication, such facts not reported to the insurer. Therefore, an appeal was made to the insurance company. The Insurance Company reviewed the additional information and approved the admission.

Because of Sid's condition, Sid wanted to stay an additional two or three days in the hospital to make sure that his nervous condition or his heart condition, did not cause additional health problems. The Insurance Company was monitoring his condition under the Concurrent Review provisions of his policy, and they notified Sid and his doctor, that if Sid would stay in the hospital, his benefits would be denied for the additional days. However, if he would go to the doctor's office daily, they would cover the doctor's office visits, etc.

APPEALS PROCESS

It is rare that there are conflicts between a physician and the insurance company regarding admission to hospitals, however there must be a provision for appeal in case there are conflicts. A sample of such provision wording appears below.

The Insured and the PPO Provider have the right to appeal the Admission Certification decision. An appeal request must be submitted in writing to YOUR INSURANCE COMPANY within 90 days of receipt of decision notice. A request for review should include any additional information pertinent to the admission and/or medical services in question.

The Utilization Management Department will review the appeal to determine if the admission met the objective criteria. If the criteria were met, the admission will be certified. If there is no additional information which would allow the admission to be certified, the initial decision will be upheld.

INPATIENT CONCURRENT REVIEW

“Concurrent Review” is a Managed Care concept which monitors the appropriateness of an individual remaining in the hospital. These may or may not be implemented and administered at any time that the insured is on an in-patient basis.

Concurrent Review of an Inpatient admission may be initiated by YOUR INSURANCE COMPANY to monitor the appropriateness of continued hospitalization. Using pre-established review criteria, Concurrent Review of the Hospital stay may occur at regular intervals. In those instances where YOUR INSURANCE COMPANY administers the program, YOUR INSURANCE COMPANY will provide the Insured's Physician with notification when YOUR INSURANCE COMPANY's criteria under this program for payment for continued Inpatient care is no longer met. For Hospital days which are not certified, the Insured has two options:

The Insured may continue with the Hospital stay, however, payment will be denied for those days determined by YOUR INSURANCE COMPANY not to be Medically Necessary; or

The Insured may elect Outpatient treatment, in which case, Contract benefits for Medically Necessary Outpatient care will be provided.

The process to appeal a Concurrent Review decision is the same as the Appeal Process for Admission Certification.

DISCHARGE PLANNING

Discharge planning is another Managed Care technique and provides for benefits once a person has been discharged from the hospital. The purpose is to assist in reducing unnecessary hospital stays by planning for treatment when discharged at the earliest possible date.

Discharge Planning is a program which identifies an Insured's potential need for health care treatment following hospitalization. YOUR INSURANCE COMPANY will use established criteria to identify potential need for services or supplies following discharge from the Hospital. When potential discharge planning services or supplies are identified, YOUR INSURANCE COMPANY will contact the Insured, the Physician and the Hospital.

YOUR INSURANCE COMPANY will also assist in the discharge planning process by helping to identify, for the Insured's Physician and Hospital, alternative services available within the Insured's community which provide health care services or supplies following hospitalization. Additionally, if the Insured's Physician or Hospital has questions regarding overall benefit coverage for services after discharge, YOUR INSURANCE COMPANY will provide this information.

CASE MANAGEMENT PROGRAM

Case Management is one of the foundations of Managed Care, but is voluntary, as described below. This is a popular provision on most Major Medical policies.

The Case Management program is a voluntary service which emphasizes individual case attention. It is designed to review Hospital admissions with particular emphasis on catastrophic or chronic illnesses and/or injuries. This review process helps to determine if an alternative setting for recovery may be appropriate or if coordination of services could avert future Medically Necessary admissions.

YOUR INSURANCE COMPANY may elect to offer alternative benefits through its voluntary Individual Benefits Management program for cost-effective services and supplies not otherwise specified as covered under this Contract. Alternative benefits may be made available on a case-by-case basis to individual Insured's. All eligibility decisions will be made solely by YOUR INSURANCE COMPANY. Such alternative benefits, if offered, will be offered in accordance with an alternative treatment plan with which the Insured, or the insured's representative, and the insured's Physician concur in writing.

Offering to provide or the providing of alternative benefits in one instance shall not obligate YOUR INSURANCE COMPANY to provide the same or similar benefits to the Insured, or to any other Insured, in another instance. Nothing herein shall be deemed a waiver of YOUR INSURANCE COMPANY's right to enforce this Contract in strict accordance with its express terms and conditions, and all provisions in this Contract, except those specifically changed under this program, continue to apply.

NOTE: Regardless of the cost containment programs described above, the insurance company still reserves the right to deny claims for services and supplies at any time during the claims review process. Also, the insurance company does not waive its right to enforce the terms of the Contract (e.g., the exclusions) by administering these programs. For example, if an admission is certified under the Admission Certification program, the insurance company will deny claims for non-medically necessary services or supplies rendered during that admission.

STUDY QUESTIONS

1. The total amount that an insured can pay as their share of a coinsurance provision covered under a Major Medical policy, is called
 - A. maximum out-of-pocket coinsurance expense.
 - B. lifetime benefit limit.
 - C. maximum deductible provision.
2. PPO Major Medical policyholder that uses a Provider that is not “approved”
 - A. usually must pay for all of the medical charges.
 - B. typically will have a higher coinsurance percentage of claims to pay.
 - C. will always be covered as if the Provider were approved.
 - D. will have the deductible increased by 100%
3. A typical PPO Major Medical plan treats a medical emergency outside of the service area
 - A. by paying the claim and increasing the deductible.
 - B. as outside the parameters of the policy and the claim will be denied.
 - C. by imposing higher coinsurance limits on the insured.
 - D. as if it were inside the service area and treated by an approved Provider
4. Under a typical Major Medical policy, “Incidental Surgical Procedures” refers to multiple surgeries that are
 - A. performed by the same surgeon.
 - B. performed on the same day.
 - C. performed through the same incision.
 - D. performed at the same surgical center.
5. Under a typical Major Medical insurance policy, a second medical opinion is
 - A. usually paid for by the insurance company.
 - B. never paid for by the insurance company.
 - C. must be paid for by the attending physician.
 - D. is never required.

6. A typical Major Medical policy provides for a schedule of immunizations and routine checkups for children. This provision is called
 - A. Well Child Care, or Well-Baby provision.
 - B. Subrogation provision.
 - C. Dependent coverage.
 - D. Children's Supplement.

7. A policyholder of a typical Major Medical policy suffers a heart attack and is rushed to the hospital. The policy will pay for the ambulance charge
 - A. to the nearest hospital of any kind.
 - B. to the hospital of the insured's choice.
 - C. only if the nearest Fire Department cannot provide transportation.
 - D. to the nearest hospital that can provide proper care

8. A typical Major Medical policy bases an allowance for durable medical equipment on
 - A. purchase, lease or rental price.
 - B. replacement cost.
 - C. the age of the insured.
 - D. the going rate for used equipment.

9. Under a PPO Major Medical policy, an approved physician Provider sends the insured to an approved PPO hospital. However, the hospital charges more than the insurance company has contracted to pay. Therefore,
 - A. the Doctor must pay the extra amount billed.
 - B. the Insurance company must pay what the hospital billed.
 - C. the insured is not responsible for any amount billed.
 - D. the insured must pay the difference.

10. Examples of "Cost Containment" are
 - A. Discharge Planning, Concurrent Review and Benefits Management
 - B. Coordination of Benefits, Sales Review Material & Limitations
 - C. HMO's, Fee-for-Service plans and Hospital Administered plans
 - D. lowering of commissions for agents.

ANSWERS TO STUDY QUESTIONS

1A 2B 3D 4C 5A 6A 7D 8A 9C 10A



CHAPTER FOUR - GENERAL LIMITATIONS, EXCLUSIONS & PROVISIONS

COORDINATION OF BENEFITS

Coordination of Benefits ("COB") limits the benefits for services under a Major Medical policy because of duplication or possible duplication of benefits by another insurer. These provisions may vary by state, company and policy, but in most cases is standardized in providing coverage.

Coordination of Benefits applies when an Insured is covered under other plans, programs, or policies providing benefits for health care services and supplies which contain a COB provision or are required by law to contain a COB provision. Such other plans, programs, or policies may include, but are not limited to:

- *Any group or individual insurance, group self-insurance, Health Maintenance Organization, or other plan, program, or policy; or*
- *Any group or individual plan, program, or policy underwritten or administered by YOUR INSURANCE COMPANY;*

YOUR INSURANCE COMPANY's payment for covered services depends on whether YOUR INSURANCE COMPANY is the primary payor, as determined in accordance with the provisions set forth below. In the event YOUR INSURANCE COMPANY is the primary payor, YOUR INSURANCE COMPANY's payment for covered services, if any, will not be reduced due to the existence of other coverage and will be made without regard to the Insured's other plans, programs, or policies.

In those instances where COB applies and YOUR INSURANCE COMPANY is not the primary payor, services, if any, will be reduced to that when such payment is combined with Insured's other health care plans, programs, or policies, the total payment will be "reasonable expenses" actually incurred by the Insured. In the event an Insured is treated by a PPO or a Participating Provider, "total reasonable expenses" shall equal the pay to the Provider pursuant to the applicable agreement YOUR INSURANCE COMPANY has with such YOUR INSURANCE COMPANY's shall not exceed 100% of the "total received" covered services from the amount YOUR INSURANCE COMPANY is obligated to provide.

The following rules shall be used by YOUR INSURANCE COMPANY to determine if YOUR INSURANCE COMPANY is the primary payor:

- (a) *The benefits of a policy, plan, or program which covers the person as an employee, member, or Insured, other than as a dependent, are determined before those of the policy, plan, or program which covers the person as a dependent.*

However, if the person is also a Medicare beneficiary, and if the rule established under the Social Security Act of 1965, as amended, makes Medicare secondary to the plan covering the person as a dependent of an active employee, the order of benefit determination is:

- 1. First, benefits of a plan covering persons as an employee, member, or subscriber*
- 2. Second, benefits of a plan of an active worker covering persons as a dependent.*
- 3. Third, Medicare benefits.*

(b) Except as stated in paragraph (c), when two or more policies, plans, or programs cover the same child as a dependent of different parents:

- 1. The benefits of the policy, plan, or program of the parent whose birthday, excluding the year of birth, falls earlier in a year are determined before those of the policy, plan, or program of the parent whose birthday, excluding year of birth, falls later in that year; but*
- 2. If both parents have the same birthday, the benefits of the policy, plan, or program which covered the parent for a longer period of time are determined before those of the policy, plan, or program which covered the parent for a shorter period of time.*

However, if a policy, plan, or program subject to the rule based on the birthday of the parents, as stated above, coordinates with an out-of-state policy, plan, or program which contains provisions under which the benefits of a policy, plan, or program covers a person as a dependent of a male are determined before those of a policy, plan, or program which covers the person as a dependent of a female and if, as a result, the policies, plans, or programs do not agree on the order of benefits, the provisions of the other policy, plan, or program shall determine the order of benefits.

(Note: In some jurisdictions, the dependents of the male is primary)

(c) If two or more policies, plans, or programs cover a dependent child of divorced or separated parents, benefits for the child are determined in this order:

- 1. First, the policy, plan, or program of the parent with custody of the child;*
- 2. Second, the policy, plan, or program of the spouse of the parent with custody of the child; and*
- 3. Third, the policy, plan, or program of the parent not having custody of the child*

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child and if the entity obliged to pay or provide the benefits of the policy, plan, or program of that parent has actual knowledge of those terms, the benefits of that policy, plan, or program are determined first. This does not apply with

respect to any claim determination period or plan, policy, or program year during which any benefits are actually paid or provided before that entity has the actual knowledge.

- (d) The benefits of a policy, plan, or program which covers a person as an employee who is neither laid off nor retired, or as that employee's dependent, are determined before those of a policy, plan, or program which covers that person as a laid off or retired employee or as that employee's dependent. If the other policy, plan, or program is not subject to this rule, and it, as a result, the policies, plans, or programs do not agree on the order of benefits, this paragraph shall not apply.*
- (e) If none of the rules in paragraph (a), paragraph (b), paragraph (c), or paragraph (d) determine the order of benefits, the benefits of the policy, plan, or program which covered an employee, member, or Insured for a longer period of time are determined before those of the policy, plan, or program which covered that person for the shorter period of time. (In effect, if all fails, the one who has a policy that has been in force the longest will be designated as primary).*

If an individual is covered under a COBRA continuation plan as a result of the purchase of coverage as provided under the Consolidated Omnibus Budget Reconciliation Act of 1985 as amended, and also under another group plan, the following order of benefits applies:

- 1. First, the plan covering the person as an employee, or as the employee's dependent*
- 2. Second, the coverage purchased under the plan covering the person as a former employee, or as the former employee's dependent provided according to the provisions of COBRA.*

Coordination of Benefits shall not be permitted against an indemnity-type policy, an excess insurance policy with coverage limited to specified illnesses, (such as Cancer, Accident only, etc.), or accidents, or a Medicare supplement policy.

C.A.

Dwayne was self-employed, and purchased an individual major medical insurance policy which he kept for several years. He has worked for the Tensteel Corporation for the past two years, and after 90 days, became eligible for their employee benefit package, which includes a Major Medical plan. Since the employer pays for the majority of the premiums, Dwayne decided to keep it also so that his deductible and coinsurance could be covered under his individual plan.

When Dwayne became ill, he filed claims under both insurers. Since the benefits were nearly the same with both policies, according to the provisions of his individual plan, the plan that he has had the longest period of time will be determined to be the primary insurer and the benefits will be paid from the individual policy first. Thereafter, the employee benefit plan insurer will pay for its remaining part of any medical bill.

Another example of Coordination of Benefits may arise where a child may be covered under the mother's employee health insurance plan, and also under the fathers plan with a different

employer. In those cases, coordination of benefits is frequently determined by either (1) the parent whose birthday falls earlier in the year, e.g. the mother's birthday in April 2, or the Fathers birthday is June 30. In this case, the mothers insurance would be primary (2) in some jurisdictions, the fathers policy would always be primary.

SUBROGATION

This “legal-sounding” word simply applies to situations where one insurer pays for medical services even though further investigation or circumstances reveal that another insurer or source of medical service should have been primary. The insurer that has paid has the legal right to look to the primary insurer for payment.

In the event any payment for benefits provided to an Insured under this contract is made to or on behalf of an Insured, on account of a Condition resulting from the negligence or fault of or from a third party, YOUR INSURANCE COMPANY, to the extent of such payment, shall be subrogated to all causes of action and all rights of recovery such Insured has against any person or organization. Such subrogation rights shall extend and apply to any settlement of a claim, irrespective of whether litigation has been initiated. The Insured shall execute and deliver such instruments and papers pertaining to such settlement of claims, settlement negotiations, or litigation as may be requested by YOUR INSURANCE COMPANY, and shall do whatever is necessary to enable us to exercise our rights of subrogation and shall do nothing to prejudice such rights. Further, the Insured or the insured's legal representative shall promptly notify us of any settlement negotiations prior to entering into any settlement agreement, shall disclose to us any amount recovered from any person or organization that may be liable for bodily injuries and shall not make any settlements without our written consent. No waiver, release of liability, or other documents executed by you without such notice to us and cooperation by you, if requested, shall be binding upon YOUR INSURANCE COMPANY.

Any such right of subrogation or reimbursement provided to YOUR INSURANCE COMPANY under this Contract shall not apply or shall be limited to the extent that the State Statutes or the courts of State eliminate or restrict such rights.

C.A.

Sam had been responsible for an automobile accident and the driver of the other car, Brett, suffered injuries and spent several days in the hospital. If Brett's health insurance carrier covered the medical bills, then Brett's health insurance company could look to Sam's automobile insurer for reimbursement of the bills that were Sam's responsibility. This is “subrogation.”

PRE-EXISTING CONDITIONS LIMITATIONS

There are many versions of pre-existing conditions, and it is tightly regulated by various states. For group insurance, the Federal HIPA Act of 1996 creates a severe limitation or abolition of any pre-existing condition. In a few jurisdictions, with certain policies, if an individual has stated a medical condition on the application, and the policy is issued on a basis obviously ignoring such condition, the insurer cannot later consider the condition as “pre-existing.” It is particularly important to note that if wording in the policy is similar to that stated in the below-illustrated provision, prescription drugs are also included in the pre-existing condition limitations.

This Contract does not provide any benefits for the treatment of a Pre-Existing Condition, for any Insured, until the Insured has been continuously covered under this Contract for a 24-month period. Without limitation, this provision applies to any Prescription Drug, which was prescribed for the treatment of a Pre-Existing Condition.

C.A.

Priscilla’s son, Danny, has asthma which is kept under control by medication. This was disclosed to the insurance agent and appeared on the application. The insurer issued the policy on a standard basis with no riders or other notations. Sixty days after the effective date of the policy, Danny needed his prescription refilled. His refills would not be covered if the policy had a (typical) 2-year pre-existing clause, until the policy has been in force for two years.

Note: All newly added family members will be subject to the Pre-Existing Condition Limitation waiting period, which will begin on the Effective Date of their coverage. EXCEPTION: A Newborn child is not subject to the Pre-Existing Condition waiting period if the Contract Holder had dependent coverage in effect prior to the birth of the Newborn.

C.A.

The Pre-Existing Condition provision of the policy always raises interesting questions, such as if an applicant for health insurance has not been to see a doctor for several years, but after receiving a policy, he is treated for a heart condition because he thought the little chest pains he had been having was caused by intestinal gas, or in some cases, by muscle strain as his job was rather strenuous. Policies generally read that if a person had symptoms which would cause a “reasonable” person to seek diagnosis or treatment....” it would be considered a pre-existing condition. In this situation, and many other similar situations, the claims department and the medical department of the insurance company would have to determine the validity of the defense of not knowing of the condition.

LIMITATION OF COVERAGE FOR COVERED SERVICES AND SUPPLIES

There are certain limitations to coverage's because of cost – effectiveness, medically necessary determinations, and which relates to principally prosthetic and orthotic devises and durable medical equipment.

QUALIFIED EXCLUSION FOR AIDS AND ARC

Because of the possible liabilities involved in AIDS and ARC patients, and because of the legal and political problems in restricting medical care for these conditions, they must be addressed separately. Wording may vary considerably depending upon the company, policy and jurisdiction.

If, in the opinion of a Physician, an Insured either first exhibited objective manifestations of Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Syndrome (ARC) which are not attributable to another cause or tested HIV positive, or was diagnosed as having AIDS or ARC, at any time prior to that insured's first Anniversary Date, there is no coverage under this Contract for any expense related, directly or indirectly, to AIDS or ARC. This exclusion is in addition to any other rights we have, including but not limited to, enforcement of the Pre-Existing Condition limitation provision, and rescission or cancellation of this Contract for fraud or Material Misrepresentation.

This exclusion shall not apply:

- *if we fail to assert this provision within the first two years of that insured's coverage under this Contract; or*
- *If we fail to notify the Insured, in writing, of the applicability of this provision within ninety (90) days of our determination that the Insured is subject to this Provision.*

C.A.

Watson was a young single and “swinging” bachelor. He was self-employed and did not have health insurance. He heard a rumor that one of his casual girl friends had tested HIV positive, so he immediately applied for a Major Medical policy in case he had contracted AIDS. He had had a complete physical about 6 months prior, and the insurer accepted the results for their underwriting purposes and the policy was issued on a standard basis with no riders or exclusions.

He did not get any tests to see if he was HIV positive, as he was afraid that if he was, it would become known and his single swinging life would be over. However, after the policy had been in effect for 8 months, he became ill and tests showed that indeed he had AIDS.

His policy had a provision that is common in the industry, that states that if he exhibited any manifestations of AIDS within one year after the effective date of the policy, there would be no coverage for any AIDS or ARC related illnesses, whether the expenses were related directly or indirectly to AIDS or ARC. Further, the insurance company started an investigation into whether

he knew that he had AIDS prior to taking out the policy; however this would not be possible to prove, so this was dropped. But since Watson's purpose in taking out the policy was to cover any AIDS expenses, he dropped the policy after they refused to pay for the medical costs already borne.

GENERAL EXCLUSIONS

All policies have exclusions and are listed in separate sections. Logically, and because of tight regulations, these exclusions must be carefully constructed, worded and presented. The following exclusions are worded well for those who are not technically educated in insurance, and most wording now follows this pattern.

This Contract does not provide benefits for:

- *services or supplies which are, in our opinion, not Medically Necessary; services and supplies not specifically covered by this Contract; services and supplies which are, in our opinion, Experimental or Investigational in nature;*
- *services or supplies provided to you as either an Inpatient or Outpatient in a Hospital or free standing facility, primarily to provide Rehabilitative Services;*
- *training and educational programs primarily for pain management or vocational rehabilitation; Speech Therapy -- except as provided under Home Health Care Services;*
- *services rendered or supplies furnished, either prior to the Effective Date, or subsequent to the termination date;*
- *Occupational Therapy -- except as provided under Home Health Care; admissions to a Hospital primarily for Physical Therapy; services for which there is no charge;*
- *personal comfort articles such as beauty and barber services, radio, television; services by a Physician or other professional related to you by blood or marriage;*
- *Services and supplies to diagnose or treat any Condition arising out of or in the course of employment or self-employment. Benefits will not be provided under this Contract to an individual who elects exemption from the Workers Compensation coverage or who waives entitlement to Workers Compensation coverage for which he may be eligible;*

Note: This particular section may or may not appear in a policy, as some policies have “24-hour” coverage, others are tightly regulated because of Workers Compensation.

C.A.

Ben is a partner with his brother in a cabinet making and installation company. His sister-in-law works for a large law firm that has excellent benefits and her husband is covered under her policy. Therefore, Ben purchases a Major Medical policy for him and his family.

According to the laws of the state where Ben lives and works, it is permissible for a partner in a 2-man operation to claim exemption from Workers Compensation laws until they have at least two other employees. They do not purchase Workers Compensation for their firm.

Ben is injured on the job when overhead cabinet fell on him, breaking an arm and injuring his back. He was hospitalized and a claim was made by the hospital to his insurer. Ben's policy had a clause that is used frequently in individual Major Medical policies that states that if a person could get Workers Compensation insurance, and elected not to do so, who requires medical services that would otherwise be covered by Workers Compensation.

In some jurisdictions, policies are available that offer "24-hour" coverage and they would provide benefits for on-the-job injuries. In addition, some insurers allow a rider to be added to the policy at an additional cost, that covers 24-hour injuries and illnesses, whether job-related or not.

- *treatment and/or drugs received in a Veterans Hospital or government facility due to a service connected disability;*

C.A.

Bill is a member of the National Guard. While on duty, he contracted Lyme Disease and was admitted to the Army Hospital at Fort Bragg, the closest hospital to where he was on maneuvers. When he was discharged from the hospital, he returned home but had a relapse and entered his regular hospital at home. Bill thought that maybe the insurer would pay for his time in the Army Hospital, in addition to his regular hospital. However, the policy does not cover any treatment in a government hospital and they paid for only treatment in his local hospital.

- *a condition resulting from war or an act of war, whether declared or not;*
- *a Condition resulting from your participation in a felony, riot, or rebellion;*
- *a Condition resulting from your engaging in an illegal occupation;*
- *a Condition resulting from your service in the armed forces;*
- *intentionally self-inflicted injuries, suicide or attempted suicide, whether sane or insane;*
- *a Condition resulting from you being drunk or under the influence of any narcotic unless taken on the advice of a Physician;*
- *services associated with autopsy or postmortem examination, including the autopsy;*
- *blood and blood plasma;*
- *Cosmetic Surgery -- defined as surgery primarily to improve the appearance of the individual but not to restore bodily function or to correct deformity. However, we do pay for the surgery needed to restore or correct a part of the body that has been altered by injury, disease, or surgery that occurred while you were covered under this Contract;*
- *bypass procedures performed for morbid obesity -- except if Medically Necessary;*
- *nicotine withdrawal programs, facilities and supplies;*

- *Custodial care such as that provided at health resorts, rest homes, nursing homes, and health spas. Custodial Care is care comprised of services and supplies, including room and board and other institutional or home services, which are provided to an individual, whether disabled or not, primarily to assist him or her in the activities of daily living;*

C.A.

Sarah had a stroke and was hospitalized. It was determined that she would eventually recover the facilities that were lost due to the stroke. Since she could not care for herself and was bed-bound she went to a skilled nursing facility for 2 weeks, and then upon the advice of the doctor and the concurrence of the insurer, she went into a rehabilitation hospital. Upon release from the rehabilitation hospital, she felt that she needed help with preparing food, cleaning, dressing on occasion, and transportation. She was not home-bound, and she could move around slowly, but she felt that she would recover better in a special facility since she had no family or relatives to help her, so she went to the Sunny view Nursing Home where she would receive assistance as needed.

While she was in the hospital and in rehabilitation, her Major Medical policy covered the medical expenses. However, the policy specifically excluded custodial care and they would not pay for her stay at Sunny view Nursing Home.

- *Diagnostic Admissions -- meaning admissions that are not Medically Necessary because the diagnostic service could have been provided in a Physician's office, the Outpatient department of a Hospital, or some other setting without adversely affecting the Insured's condition or the quality of medical care.*
- *If a Hospital admission is primarily for observation, evaluation or diagnostic studies; we will only cover the charges for laboratory, x-ray and supplies. Room and board and Inpatient Physician care will be excluded.*
- *biofeedback and other forms of self-care or self-help training and any related diagnostic testing;*
- *private duty nursing by an RN or LPN whether in an Inpatient Hospital setting or Skilled Nursing Facility;*
- *Human Organ Transplant services for which the cost is covered/funded by governmental, foundation or charitable grants. This includes services performed on potential or actual living donors, recipients and cadavers;*
- *any organs or combination of organs other than those specifically listed as covered; any organ or tissue which is sold rather than donated to the Insured;*
- *any surgical procedure, including, but not limited to, Radial Keratotomy, performed primarily to correct or improve myopia or other refractive disorders not a consequence of trauma or prior ophthalmic surgery;*
- *partial hospitalization for Mental and Nervous Disorders (partial hospitalization is a concept of psychiatric treatment where the patient receives institutional care during the daytime or the night-time and returns home during the portion of the 24 hour period when treatment is not scheduled. A Hospital shall not be considered a "home" for the purposes of this definition);*
- *all services and supplies in connection with hospice care, treatment, or programs;*

- *eye glasses, contact lens, hearing aids, or examinations for their Prescription or fitting;*
- *eye exercise, visual training or orthoptics;*
- *dental care -- unless needed to repair an accidental injury as determined by YOUR INSURANCE COMPANY to natural (not artificial) teeth and jaws, mouth or face which was initiated within 90 days of the accidental injury or unless needed for medical conditions caused by temporomandibular joint dysfunction (TMJ);*
- *dental appliances;*
- *foot care not related to the diagnosis or treatment of a Condition; therapeutic devices or appliances, regardless of the intended use (i.e., arch supports, orthopedic shoes, or support hose);*
- *all obstetrical benefits in connection with or as the result of a normal delivery, except as specified in the section "Complications of Pregnancy"; (unless maternity benefits are covered, and then these restrictions would not apply)*
- *birth control pills when used as contraception;*
- *contraceptive devices or appliances;*
- *all services and supplies in connection with infertility, including but not limited to artificial insemination or in-vitro fertilization;*
- *elective abortions;*
- *reversal procedures of previous sterilization to allow fertilization; services or supplies related to sexual reassignment (sex transformations) or modifications; immunizations (injections to prevent contagious disease) - except as those covered for Well Child Care;*
- *non-Prescription drugs;*
- *vitamins, mineral supplements, fluoride drugs or appetite suppressants;*
- *exercise programs of any kind;*
- *Transplant -- Any services or supplies in connection with any transplant, other than those transplants listed herein are excluded. This exclusion applies to:*
 - a. Any service or supply in connection with the implant of an artificial organ, including the implant of the artificial organ;*
 - b. Any organ, tissue, marrow or stem cells which is sold rather than donated to the Insured;*
 - c. Any Bone Marrow Transplant, as defined herein, which is not specifically listed in State Administrative Code, or covered by Medicare pursuant to a national coverage decision made by the Health Care Financing Administration as evidenced in the most recently published Medicare Coverage Issues Manual;*
 - d. Any service or supply in connection with identification of a donor from a local, state or national listing;*
 - e. Transportation costs for the Insured to and from the approved facility; and*
 - f. Direct, non-medical costs for immediate family for (a) transportation to and from the approved facility; and (b) temporary lodging.*
- *travel expenses -- even if prescribed by your Physician; physical examinations (annual or routine), not related to a diagnosis or treatment of a Condition; except for Well Child Care;*
- *services associated with home health aid (sitter), home maker or domestic maid; and*
- *services or supplies rendered by any mental health professional in connection with or as a result of any Mental and Nervous Disorders, including but not limited to a psychiatric social worker, mental health technician, psychiatric nurse, or Occupational Therapist.*

CONDITIONS EXCLUDED BY RIDER

A Rider is a statement attached to a policy that eliminates treatment for certain stated conditions or diseases. The provision that the Rider may be reviewed after a period of time differs by policy, company and jurisdiction.

You will not be eligible to receive benefits for treatment of any Condition that we excluded from coverage by a Rider when you accepted coverage under this Contract.

After two (2) years following the Effective Date of your coverage, you may request that we remove the Rider(s) limiting your coverage. If we approve your request, we will advise you when the Rider(s) will no longer be in effect.

C.A.

Mike slipped on ice on his driveway and injured his back. It was diagnosed as muscle sprain, but a later x-ray indicated that there may be damage to a disc also, but not serious enough to require surgery. Other than that, Mike was in excellent health. He applied for a Major Medical policy and after the company had completed the underwriting, they offered a standard policy to Mike that excluded any medical expense arising from his back strain, and excluding any treatment that could be related to that injury. This company allowed a review after the policy had been in force for two years. Mike accepted the policy, as his agent had informed him that most insurance companies won't accept anyone with any kind of a back problem.

Two years after the effective date of the policy Mike requested that the rider be removed. He presented medical evidence that showed that he had not had any back problems or medical expenses related to his back condition. He also produced a recent x-ray which showed that there was no damage to the disc as feared previously. The rider was removed from the policy.

TERMINATION AND REINSTATEMENT

Obviously provisions must be made for termination of the policy and for reinstatement. These provisions may vary somewhat, but are rather standard among Major Medical policies.

Your Contract will be terminated if:

- *you fail to pay your Premium within the stated thirty-one (31) day Grace Period; or we cancel all Contracts with this same form number; or*
- *On the first day of the month in which you or your spouse attains sixty-five (65) years of age. Your spouse, if under sixty-five (65) years of age, may request separate coverage;*

C.A.

Ron, age 63 and Brenda, age 60, are insured under a Major Medical policy. Ron reaches age 65 and his policy automatically terminates for his coverage. Some companies allow Brenda to continue coverage by simply changing the insured and by contract there is no evidence of insurability required.

On a rare occasion, a company may require evidence of insurability on the remaining spouse. This is important if either spouse develops a medical condition that may make them uninsurable, such as high blood pressure or diabetes. There have been so many complaints about this that few, if any companies, still have this restriction.

Or,

- *in applying for any benefits under this Contract, there is fraud or Material Misrepresentation provided to us by you; or*
- *You are Eligible under any other state or federal law for benefits similar to those provided by this Contract.*

Also, coverage will terminate:

- *for your Covered Dependents if your Contract is terminated for any reason; or*
- *for your Eligible dependents when they obtain the limiting age, as specified in this Contract; or*
- *For your spouse, in the case of divorce or legal separation.*

Cancellation provisions vary by the type of policy, whether non-cancelable, guaranteed renewable, renewable at the option of the company, or non-cancelable & guaranteed renewable. In most cases, the policy may be cancelled for fraud or misstatement, as shown above, or they may be cancelled if all policies of the same type within a state are cancelled simultaneously, and appropriate notice is given. Premiums may be modified if necessary, but this would require approval of the Department of Insurance in most cases. Premium adjustments and cancellation may vary also with those policies issued by out-of-state trusts (ERISA trusts).

YOUR INSURANCE COMPANY may cancel, or not renew the Contract, or modify rates at any time without the consent of any Insured or any other person upon giving at least forty-five (45) days advance written notice to the Contract Holder. If we fail to provide the Contract Holder with such notice, the coverage shall remain in effect at the existing rates until forty-five (45) days after the notice has been given. However, notwithstanding the above, if the reason for termination is non-payment of Premium, the Contract may be canceled following ten (10) days written notice. If we do cancel your Contract in this manner, you will still be entitled to benefits for any claim for covered services which were rendered before the cancellation date. We will not cancel your Contract in any event solely because of the amount of claims paid under your individual Contract.

C.A.

Manny purchased a Major Medical policy containing the usual cancellation clause. Manny paid his premiums when due and was happy with the policy until the insurance company notified all of its Major Medical policyholders, that it was going to cancel all of its Major Medical Policies in the state because of claims experience. The notice also stated that all policies would be canceled at the end of 45 days after receiving the notice.

Manny was very upset as he had been diagnosed as a diabetic and could not get any other insurance. He had not made any claims except for the recent checkup, which led to the diabetes diagnosis. However, according to the provisions of the policy, the insurer could terminate coverage by giving 45 days notice.

In accordance with State Statutes, if the renewal Premium is not paid before the Grace Period ends, this Contract will lapse. Later acceptance of the Premium by YOUR INSURANCE COMPANY, or by an Agent authorized to accept payment, without requiring an application for reinstatement, will reinstate this Contract.

When YOUR INSURANCE COMPANY or its Agent requires an application, you will be given a Conditional Receipt for the Premium. If the application is approved and Premium is paid, the Contract will be reinstated as of the approval date. Lacking such approval, the Contract will be reinstated on the 45th day after the date of the Conditional Receipt unless YOUR INSURANCE COMPANY has previously written and advised you of its disapproval. The reinstated Contract will cover only loss that results from an accidental injury sustained after the date of reinstatement or a Condition that starts more than 10 days after such date

(Note the difference – if losses are caused by accident, there is no waiting period, if caused by sickness, there is a 10 day waiting period).

In all other respects, your rights and our rights remain the same, subject to any provisions noted on or attached to the reinstated Contract. Any Premiums YOUR INSURANCE COMPANY accepts for reinstatement will be applied to a period for which Premiums have not been paid. No Premiums will be applied to any period more than 60 days before the reinstatement date.

EXTENSION OF BENEFITS

Extending payment of claims vary by policy, company and state regulations. This is usually tightly regulated by the Department of Insurance.

The termination of this Contract by us shall be without prejudice to any continuous loss which commenced while this Contract was in force, but the extension of benefits beyond the period this Contract was in force will be predicated upon the continuous Total Disability of the Insured person, and the extension of benefits is limited to a maximum period of 90 days, beginning on the termination date. This extension of benefits is only for the Condition which caused the disability for that Insured. YOUR INSURANCE COMPANY will determine Total Disability.

Written documentation from your Physician regarding the extent of your disability will be required.

C.A.

According to the definition of Total Disability under a Major Medical policy, if Bruce, who is a student at UCLA and covered under his parents family policy, suffers a spinal injury playing pick-up football with friends, and cannot continue his education or his normal activities, would nevertheless be Totally Disabled. He would not be entitled to coverage under a Disability Income policy, as he had no income.

C.A.

Pam was covered under her father's Major Medical policy while attending college. Upon graduation she was no longer eligible for coverage under his policy, so she applied for her own coverage. The policy contained a popular provision that would offer her a continuation contract without asking for evidence of insurability. However the premiums were rather substantial and she felt that she could not afford them. She was in good health, so she applied for a new policy that would be underwritten, but which would be much lower in premium.

Note: In some states, legislation has been introduced which would allow a person who becomes ineligible for continuation of coverage, to be issued a similar policy at underwritten rates.

CONVERSION

Conversion privileges vary by company, and by regulation. The following closely follows the NAIC Model.

If coverage ceases because of termination of eligibility prior to becoming eligible for Medicare or Medicaid, you shall be entitled to a Contract without evidence of insurability, provided that application is made and Premiums are paid within thirty-one (31) days after termination. There will be continuous coverage during the thirty-one (31) day period, if such coverage is selected and the Premiums are paid.

GENERAL PROVISIONS

The General Provisions as shown, are basically for a PPO organization, however much of the administration procedure is typical of any Major Medical policy. The big difference is as stated before, is that a PPO Provider will handle all claims in most cases, and the insured is not liable for any extra costs covered under the plan, other than the usual deductible and coinsurance provisions.

HOW TO FILE A CLAIM

In all cases, the Preferred Patient Provider will file the necessary claim for you. You will only be responsible for any Deductible, Coinsurance amount and non-covered charges when you use a Preferred Patient Care Provider. Our payment for eligible services will go directly to the Provider. They will bill you directly for any balance.

In most cases, the Non-Preferred Patient Hospital will file claims on your behalf for both Inpatient and Outpatient services. Simply present your identification card at the time of service. Our payment for eligible services will be made directly to the Hospital. The Hospital will bill you directly for any balance.

If you elect to use a Non-Preferred Patient physician, present your identification card at the time of service and ask if the Physician's office will file a claim for you. If the Physician's office will not file the claim for you, ask for an itemized statement which should include the following information: the date, the description of service, the amount charged for each service, the patient's name. Attach the itemized statement to a completed claim form and send both to our home office.

WRITTEN NOTICE OF CLAIM

Written notice of a claim for benefits must be given to us within twenty (20) days after the service has been rendered to you, or as soon after that as is reasonably possible. Notice to us at our Home Office, or to any of our authorized agents, along with enough information to enable us to identify you (the name and Contract number of the Insured), is sufficient. Presentation to a participating Hospital or participating Physician of the identification card we have issued to you is sufficient notice of a claim.

CLAIM FORMS

In many instances, your health care Provider will file your claim for you. When we receive the notice of claim, we will send you the claim forms for filing proof of loss. If these forms are not given to you within 15 days, you must meet the proof of loss requirement by giving us a written

statement of the nature and extent of the loss within the time stated in the "Proof of Claim" Section.

PROOF OF CLAIM

State laws and regulations closely regulate the time elements between the time a claim is filed and the time it is paid and reviewed if necessary. The time limits contained in this provision example applies to one particular state, but is rather typical of most states. These time limits should be carefully noted when marketing these plans and the insured should be aware of these provisions.

The complete claim for benefits (a proof of claim) must be returned to us at our Home Office within ninety (90) days of the date services were rendered.

An admission and billing notice from a Hospital and/or health claim form from a Physician for services rendered to an Insured will be sufficient to serve as proof of claim.

If you fail to file a proof of claim within 90 days after the date services were rendered, you will not be eligible for benefits, unless it was not reasonably possible to give us proof of claim within that time period. You must still furnish YOUR INSURANCE COMPANY, with proof of your claim as soon as reasonably possible, and under no circumstances later than fifteen (15) months after the service was rendered to you, unless you are unable to do so by reason of legal incompetence.

TIME OF PAYMENT OF CLAIMS

(Again, this is regulated by the various states. Check your policies)

YOUR INSURANCE COMPANY shall process all claims for which we have all of the necessary information, as determined by YOUR INSURANCE COMPANY, within forty-five (45) days of receipt of a complete claim for benefits (proof of claim). In the event YOUR INSURANCE COMPANY contests or denies the claim or a portion of the claim, or needs additional information, YOUR INSURANCE COMPANY shall so notify you, or your assignee, if an assignment of benefits is required to be honored by YOUR INSURANCE COMPANY under this Contract, within forty-five (45) days of receipt of the initial proof of claim. The notice will identify the contested or denied portion of the claim and the reason(s) for contesting or denying the claim or portion of the claim. YOUR INSURANCE COMPANY will then complete processing of the claim within sixty (60) days of receipt of the necessary additional information. YOUR INSURANCE COMPANY will either pay or deny the claim or portion of the claim no later than one hundred twenty (120) days after receiving the claim. Consequently, it is the Insured's responsibility to ensure that YOUR INSURANCE COMPANY receives all necessary information required to properly adjudicate claims submitted for processing. If YOUR INSURANCE COMPANY does not receive all necessary information, a claim or portion of a

claim may be denied. Any claims payment not made by YOUR INSURANCE COMPANY within the applicable time frame is subject to the payment of simple interest at the rate of ten percent (10%) per annum. Claims payments are deemed to have been made as of the date placed in the United States Mail by YOUR INSURANCE COMPANY.

C.A.

Ron and Brenda went on a trip and while out of state, Ron suffered a mild heart attack and was admitted to the local hospital in a small town in Arizona. They are insured under a PPO Major Medical plan, and there are no preferred Providers outside of their home state.

When Ron was seen by a doctor at the doctor's office, he gave his Major Medical card to the office manager but was informed that they do not participate with their insurer, and they must file the claim.

Ron asked for an itemized statement which was later furnished to them. They also asked for their credit card so that it could be billed for the doctor's charges.

When we was admitted to the hospital, the hospital agreed to accept their insurance card, but again asked for their credit card so that it could be billed for any services not covered by the insurance company.

After a brief stay at the hotel, Ron and Brenda continued their vacation, but at a much slower pace. They returned to their home 2 weeks after the heart attack, and called their agent. The agent promptly notified the insurance company so that they had received notice within the required 20 days. The agent did not have the necessary claims forms, so he requested that the forms be sent directly to Ron. Upon receipt of the forms, Ron had to contact the doctor in Arizona for information required by the insurer. The doctor was on vacation and his office was closed. Therefore, Ron was not able to file the claims forms within the time required in the policy. They notified the agent, who notified the claims department, who then asked for a written statement of exactly what the nature and extent of the illness was.

The policy also stated that the Proof of Claim must be submitted within 90 days after the date the services were rendered. Even though the doctor in Arizona was in no hurry to send the necessary papers, by staying in continual contact with the claims department of the insurance company, the insurance company extended the time and the claim was eventually paid. It had already been paid when the credit card bill was received, so the amount was payable to the insured.

PAYMENT OF CLAIMS

Any benefit(s) unpaid at the death of the Insured will be paid at our option, either to the Insured's beneficiary or estate.

PHYSICAL EXAMINATION AND AUTOPSY

We reserve the right, at our expense, to have you submit to a physical examination, as often as is reasonably necessary while a claim is pending. We also reserve the right, if the law permits, to make an autopsy in case of death.

LEGAL ACTION

No action may be brought to recover on this Contract within 60 days after written statute of proof of loss has been given as required under this Contract. No such action may be brought after the expiration of the applicable limitations from the time written proof of loss is required to be given. All provisions in this Contract will be interpreted according to the laws of the State. Any legal dispute involving this Contract shall be brought to court in the State of domicile of the insurance company.

SURVIVOR RIGHTS

In the event the Contract Holder dies, the covered family members may continue the Contract by timely payment of Premiums, or any of the Contract Holder's surviving Covered Dependent(s) can purchase a new Contract. The Eligible Dependent(s) should contact us with thirty-one (31) days after the death of the Contract Holder.

TIME LIMIT ON CERTAIN DEFENSES

We will not void your Contract or deny a claim for benefits for a Condition which occurs after two (2) years from the Effective Date of your Contract, solely on account of misstatements on your application for coverage. If those misstatements were fraudulent, however, we may raise that defense at any time. In addition, after two (2) years from the Effective Date of this contract, we will not deny a claim for benefits for any covered service rendered to you for a Condition that existed before you became covered under this Contract. This does not apply, however, to any Condition that we specifically identified and excluded from coverage at the time your coverage took effect.

C.A.

Martin applied for a Major Medical policy that contained a 2-year Pre-existing clause. On the application Martin had forgotten to mention that he had been to a doctor 18 months previously for excess stomach gas pains, but he believed at that time that it was not important and it “slipped his mind.”

3 years after the effective date of the policy, he suffered another similar attack, and his doctor told him that he needed surgery for a perforated ulcer, and then berated him because he had not treated his ulcer over the past 4 years. The original doctor was the present doctor’s former partner, and noted in Martin’s file was a notation to the effect that the doctor had deliberately not told Martin that he had an ulcer under the belief that Martin would worry about it and would make it worse. He had told Martin to see a doctor if he had any more intestinal distress.

The insurer questioned the medical records in anticipation of raising a defense of fraudulent misstatements, even though after 2 years the policy was incontestable. However, their legal department felt that since Martin had not been told directly that he had an ulcer, it would be too difficult to try to prove fraudulent misstatements.

NOTICE

Any notice which is required or permitted by this Contract shall be deemed given if hand-delivered or if mailed by United States Mail, postage prepaid, and addressed as indicated in our files. Such notice shall be deemed given and effective as of the date delivered or so deposited in the mail to the Contract Holder.

FRAUDULENT SUBMISSION OF CLAIMS

If, in the opinion of YOUR INSURANCE COMPANY, any Insured commits fraud, or misrepresents or omits material information in requesting the receipt of benefits, that Insured's coverage may be canceled or rescinded at any time by YOUR INSURANCE COMPANY. This remedy is available in addition to any other remedies which may be available to YOUR INSURANCE COMPANY.

C.A.

Jerome applies for a Major Medical policy. In completing the application, he told the agent that his income was \$50,000 a year derived from his shoe repair business. In actuality, his income from the shoe repair business was less than \$15,000 a year, but he had a large, but undisclosed, income, from the illegal bookmaking that he ran from the back room of his shop.

13 months after the policy effective date, he was `shot by an irritated gambler. The police report indicated that it was a “mob hit” as a result of his gambling establishment. When this information was relayed to the insurance company, they refused to pay for any of his medical bills as a result of the shooting. Further, the policy was voided (not canceled) as if there had never been any coverage.

THE PROCESSING OF YOUR CLAIM

The section on claims processing is required in most states, but can vary as to procedure. The illustration below is typical of a Major Medical policy issued by a major Provider of health insurance and would suffice in the majority of states.

This section is an explanation of how your claim is handled after it is received at YOUR INSURANCE COMPANY.

Claims Processing

In order to process your claim, we may need information from the Provider that supplied the service. As an Insured accepting this Contract, you agree to authorize the Provider to release any necessary information and records to us. The Provider is authorized to give this information to us even if it is considered confidential.

In addition, we may require you to be examined by a Physician we choose, at our expense. We have the right to require this as often as is reasonably necessary while a claim is pending.

If we need more than the usual maximum of 60 days to decide your claim because of special circumstances, we will send you a notice within 60 days after we receive your claim explaining why we need more time.

After your claim has been processed, we will send you an Explanation of Benefits (EOB) indicating the amount we have paid on your behalf. If you have paid the bill and are seeking reimbursement, payment will be made directly to you.

When a Claim Is Not Paid

If your claim includes charges that we consider not eligible for payment, in whole or in part, because we either need more information or because we consider the charge not payable under this Contract, we will send you an Explanation of Benefits that shows:

- *The reason(s) your claim was not paid,*
- *A description of additional information which may be necessary to make your claim eligible; An explanation of why more information is necessary; and*
- *An explanation of how you may have the claim reviewed if you do not agree with our decision.*

C.A.

Lupe purchased a Major Medical policy and at time of application, signed the release form that was on the application, which authorized any Provider to release any medical records in their possession, to the insurance company. On the application, Lupe provided the name and address of a doctor that had treated him for chest pains. The insurance company sent the release form to the doctor, and in error, did not make a copy of the form.

The doctor revealed that Lupe had been referred by another doctor, and also that the doctor had called in a cardiologist for consultation. The insurance company notified Lupe that they needed another signed release form in order to complete their underwriting. Lupe refused to sign another form, saying that the original doctor worked for a walk-in clinic, and when he discovered that Lupe had seen another doctor years before, he immediately sent him to this doctor. Lupe insisted that since he had never seen the cardiologist, he was not going to sign another release.

As provided in the policy, the insured agrees to cooperate fully with the insurance company in any claims processing, including the signing of any forms that the insurer feels necessary. Because Lupe refused to cooperate, the insurance company canceled the policy, refused to pay the claim, and returned the unearned premium to Lupe.

CLAIMS REVIEW

The following section explains how you may have your claim reviewed if you do not agree with our decision to deny all or part of your claim.

Filing Your Request for a Review

Within 60 days after you receive the Explanation of Benefits notifying you that your claim has been denied, write or come in person to YOUR INSURANCE COMPANY office. At that time, you should be prepared to tell us why you do not agree with our decision not to pay the claim. A Request for Review will then be filed for you.

Your Right to Representation and Document Review

If you prefer, you may designate a representative to act for you in the review procedure. Simply give that person a written statement designating him/her to represent you in review of your claim.

You or your authorized representative will have up to 45 days after we receive your request for review to review pertinent documents at a YOUR INSURANCE COMPANY office during regular office hours. Written releases permitting disclosure of information will be required from both the patient and the particular health care Provider if the information is considered sensitive or confidential.

Review Procedures

You also have 60 days to submit issues and comments and any pertinent, additional medical information.

In unusual situations when you are unable to submit written issues and comments within 60 days, and you advise us within that 60 day period that you need more time, we will grant the request provided we have sufficient time to give you the extension notice that is required by law.

Final Decision

We will provide you with a written decision within 60 days after we receive your request for review. That written decision will indicate the reasons for the decision and refer to the section or sections of your Contract on which the decision was based.

In unusual situations, we may need additional time to make a decision. In that case, before the 60 day period has expired, we will send you a written notice that more time is necessary; extending our time for a written decision to a total of 120 days from the date we received your request for review. We are precluded by law from delaying the decision beyond the 120 day period even at your request.

C.A.

Ben was insured under a Major Medical: PPO policy which had been in force for a year when he suffered a stroke and was admitted to the hospital. After discharge, and after a stay at a rehabilitation center, he was sent home. Ben contacted the Ideal Home Health Service Co., which provided him with excellent care for 2 months, after which he was able to take care of his needs without the home health care nurse. However, the doctor had recommended home health care, but the insurance company felt that it was not needed in this case, and furthermore, the home health care company was not a Provider under the contract.

Ben immediately contested this claims denial by gathering the medical files of his doctor where the doctor had recommended this service and the files from the home health agency which outlined the services that he received and the reasons thereof. Further, he offered documentation that the Ideal Home Health Service was the only home health service within 50 miles of his home, with the exception of Central Home Health, which had recently lost their Medicare certification, so he would not feel comfortable with them. While Central was shown as a Preferred Provider of the insurance company, he was told by Central that they no longer represented his insurer. Ben then took the file to a well-known specialist that served in the local hospital, and requested a written recommendation from him as to whether he needed home health care.

These papers were then taken to Harold Langston & Sons, a local attorney who specialized in mal-practice and cases of this type, who reviewed the file, agreed with the assessments of the doctor, and then sent the file to the insurance company.

The insurance company had 60 days to respond. In 10 days they agreed to compensate Ideal Home Health Care at the full Provider rate and since Ben had met his deductible and out-of-pocket, Ben had no further bills to pay to Ideal.

ENDORSEMENTS

Because of the continual changing and liberalizing of benefits an insurer could submit new policy forms to be approved once [or more] a year, adding to the workload of the Department of Insurance, which would, in turn, create intolerable delays in policy approval. It is much simpler and more cost-effective to use an "Endorsement" on a policy to add or change existing provisions to meet new or changing regulations.

Following are samples of Endorsements that appear in some policies in some states. It is very important that the agent be aware of the Endorsements, as they supersede and replace important policy provisions. Unfortunately, many companies are lax in informing their agents of any changes and Endorsements to their policies. In most jurisdictions, when there is a change in regulations affecting existing policies, the advertising material that addresses or refers to the provisions changes, must also be changed. Too frequently old and outdated advertising or sales material is used which does not reflect the change in the provisions. It is the responsibility of the agent to use the proper sales and advertising material and severe consequences can result if the agent provides an applicant with incorrect material when the proper information is available to the agent.

ENDORSEMENT - DIABETES

This Endorsement is to be attached to and made a part of your current Contract and any Endorsements or Riders attached thereto. The Contract is hereby amended by adding the following provisions:

Diabetes Outpatient Self-Management

Covered Services include Diabetes Outpatient Self-Management Training and Educational Services and Nutrition Counseling, including all medically appropriate and necessary equipment and supplies, when used to treat diabetes, if the Insured's treating Physician or a Physician who specializes in the treatment of diabetes certifies that such services are necessary. Diabetes outpatient self-management training and educational services must be provided under the direct supervision of a certified Diabetes Educator or a board-certified Physician specializing in endocrinology. In order to be covered under this Contract, nutrition counseling must be provided by a licensed Dietitian.

EXCLUSIONS *Any training or EDUCATION PROGRAMS or materials, including, but not limited to programs or materials for: pain management, the management of diabetes, except as provided in the Diabetes Outpatient Self-Management section; or vocational rehabilitation.*

DEFINITIONS *Diabetes Educator*
A Diabetes Educator is a person who is properly certified pursuant to State law to supervise diabetes outpatient self-management training and educational services.

Dietitian:

A Dietitian is a person who is properly licensed pursuant to State law to provide nutrition counseling for diabetes outpatient self-management services.

ENDORSEMENT - PRESCRIPTION DRUGS

This Endorsement is to be attached to and made a part of your current Contract and any Endorsements or Riders attached thereto. The Contract is hereby amended by amending or revising any applicable provisions:

Prescription and Non-Prescription Enteral Formulas

The Contract is amended by adding the following provision for the coverage of prescription and non-prescription enteral formulas for home use:

Prescription and non-Prescription enteral formulas for home use which are prescribed by a Physician as Medically Necessary for the expenses to treat inherited diseases of amino acid, organic acid, carbohydrate or fat metabolism as well as malabsorption originating from congenital defects present at birth or acquired during the neonatal period. Coverage for expenses to treat inherited diseases of amino acid and organic acids shall include food products modified to be low protein, in an amount not to exceed \$2,500 annually for any Insured, through the age of 24. This section applies to any Insured notwithstanding the existence of any Pre-existing Condition.

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Contract, other than as specifically stated in this Endorsement. In the event of any inconsistencies between the provisions contained in this Endorsement and the provisions contained in your Contract, the provisions contained in this Endorsement shall control to the extent necessary to effectuate the intent of Your Insurance Company, Inc. as expressed herein.

ENDORSEMENT - REGISTERED NURSE FIRST ASSISTANT

This Endorsement is to be attached to and made a part of your current Contract and any Endorsements or Riders attached thereto. The Contract is hereby amended by adding or revising any applicable provisions:

DEFINITIONS	<i>Registered Nurse First Assistant (<u>RNF</u>) A person properly licensed to perform surgical first assisting services pursuant to State Statutes,</i>
Registered Nurse	<i>Surgical services rendered by a Registered Nurse First Assistant (herein RNFA)</i>
First Assistant	<i>when acting as a Surgical Assistant when the assistance is medically necessary may be covered services, subject to the applicable Allowed Amount. YOUR INSURANCE COMPANY's reimbursement level for surgical assistance performed by an RNFA is 20% of the Physician's surgical allowance. YOUR INSURANCE COMPANY's reimbursement for these covered services if any will be made directly to the Insured. However, in the event the Insured properly assigned the benefits to the RNFA, YOUR INSURANCE COMPANY's payment will be made directly to the RNFA.</i>

STUDY QUESTIONS

1. An individual has a Major Medical policy with a typical Coordination of Benefits clause. Which is not covered by this clause?
 - A. A spouse's Major Medical policy.
 - B. A Hospital Indemnification plan paying \$200 a day in hospital.
 - C. An old individual Basic Medical plan.
 - D. A disability income policy.
2. A policyowner has had a typical Major Medical policy for 2 years, but does not cover her husband as he is covered at his place of employment. Her husband loses his job and she wants to add him to the family policy. In respect to a typical pre-existing condition clause of two years,
 - A. The husband is subject to a 30-day pre-existing condition clause.
 - B. The husband is not subject to pre-existing conditions as over 2 years have passed.
 - C. The husband is subject to 1 year of pre-existing conditions.
 - D. The husband is subject to the usual pre-existing condition clause.

3. A policyholder of a typical Major Medical policy a weight increase to where he now weighs over 400 pounds. He would like to have bypass procedures covered under his policy.
 - A. There is no way his insurer will pay for this surgery.
 - B. The insurer would pay if it can be shown to be medically necessary (at 400+ pounds, this could be possible).
 - C. The insurer would pay if his doctor thought it would drastically improve his appearance, which is necessary for his job.
 - D. Bypass procedure will be approved if he can get his weight down to 125% of the initial weight (on the application).

4. Birth control medication for medical purposes other than birth control would not be covered under a typical Major Medical policy.
 - A. This is true.
 - B. This is false, if the medication was for other than contraception.
 - C. This medication is covered after a 2- year waiting period.
 - D. This medication is approved for women over age 45.

5. Typically, a Rider that is added for an existing condition may
 - A. be reviewed for removal after a specified period of time.
 - B. usually never be removed.
 - C. be removed if the insured insists, with no other medical evidence.
 - D. automatically be removed after 2 years.

6. If the insured under a typical Major Medical policy files a claim for medical services because of a deteriorating disease, the company may
 - A. ask for a physical examination every 30 days while under claim.
 - B. cancel the contract covering the ill family member.
 - C. not require an autopsy if the family does not want an autopsy performed.
 - D. restrict payment to a percentage of normal charges.

7. If there are misstatements in a Major Medical application, and a period of two years has elapsed since the effective date of the policy,
 - A. policy will be cancelled “ab initio”, as if it never was issued.
 - B. the insurance company can cancel the policy at any time the misstatements were discovered.
 - C. the policy cannot be cancelled but the insurance company does not have to pay any claims.
 - D. the insurance company cannot cancel the policy if the misstatements were not fraudulent

8. A Major Medical policy can be reinstated, and the reinstated policy will cover only losses that result for an accidental injury sustained after the date of reinstatement. If there is a medical condition that existing during this period,
- A. the benefits would start (typically) 10 days after reinstatement for illnesses.
 - B. it will be covered immediately after reinstatement.
 - C. it will never be covered under a reinstated policy. The insured must apply for a new policy.
 - D. the insured is subject to a 50% pre-existing condition penalty.
9. Jones submitted a claim for benefits under a typical Major Medical PPO plan. The Insurer did not pay because the Provider was not approved due to an administrative error of the insurer. The insured must present the claim
- A. only in person at the company's local office.
 - B. only in writing to the company at their headquarters.
 - C. either in person or in writing to the insurance company.
 - D. to his attorney who will take it court for a ruling.
10. Jones wants an attorney to represent him in the appeal process.
- A. The insurer will not recognize an attorney representing an insured.
 - B. The attorney must have a court order before he can represent Jones.
 - C. Jones can appoint an attorney as his personal representative for this purpose.
 - D. If Jones gets an attorney, the insurance company will refuse to pay.

ANSWERS TO STUDY QUESTIONS

1B 2D 3B 4B 5A 6A 7D 8A 9C 10C



CHAPTER FIVE - GROUP HEALTH INSURANCE PROVISIONS

The Group Policy is a document between the employer and the insurance company, mostly of an administrative nature. The individual employee's coverage's are provided in a Certificate of Coverage and details of coverage, benefits and provisions are provided in the Certificate. For purposes of this text, the provisions of the Certificate will be discussed.

As stated earlier, there are many similarities between the provisions of a Major Medical individual policy and a Group Certificate of Coverage. Therefore, the provisions that are similar will be only mentioned below, with special attention to those provisions that pertain only to Group Insurance.

Since a Group Contract can cover from one (in some states) to several thousand employees, the benefit structure will vary greatly. Most insurers offer coverage for small groups (such as those from 1 or 2 to 10 employees), medium size groups (from 11 to 50 employees) and large groups (51 employees and up). Additionally, the types of groups available include Health Maintenance Organizations (HMO's), Preferred Provider Organizations (PPO's), Point-of-Service Plans (POS), Fee-for-Service Plans (FFS) and a wide variety of Provider organizations and plans offering flexibility between the FFS (highest flexibility) and the HMO (least flexibility). Additionally, there are plans sold under ERISA, administered by Trusts.

For simplicity purposes, a POS plan Certificate of Coverage is used as an illustration. A POS plan has many of the cost-containment features of the PPO with a little more flexibility of the PPO, and is quite popular.

In 1996, H.R. 301, the Kassebaum-Kennedy bill, Health Insurance Portability and Accountability Act (HIPAA) was enacted. Because of this Act, some provisions in Group Insurance will change in respect to coverage for employees who leave their employment and who want to continue with their health insurance coverage. Many details are still in transition, but the bill will be discussed separately at the end of this Section.

Provisions are listed in order as they appear in a typical Certificate of Coverage. However, the arrangement can vary decidedly, therefore the order they are shown is of little consequence.

(Note: As in the previous discussion, Consumer Applications are headed "C.A." and are illustrations as to how a particular provision(s) affect an insured or potential insured.)

SCHEDULE OF BENEFITS

The Schedule of Benefits shown below is used only for illustration purposes, as the amount, percentages and other information on the Schedule can be changed, depending upon the needs of the Employer. Later illustrations may use these benefits as shown below.

INSUREDS' FINANCIAL RESPONSIBILITIES FOR COVERED SERVICES

1. *Calendar Year Deductible:*
 - a. *Individual Deductible \$300*
 - b. *Aggregate Family Deductible \$900*
2. *Hospital per Admission Deductible (Non-PPO) Hospitals Only) \$100*
3. *Coinsurance Percentage Payable by YOUR INSURANCE COMPANY:*
 - a. *PPO Providers 90% of the PPO Schedule Amount.*
 - b. *All other Providers 70% of the Allowance.*
4. *Coinsurance Requirement Limits per Calendar Year:*
 - a. *Individual Coinsurance Requirement Limit \$1,000*
 - b. *Aggregate Family Coinsurance Requirement Limit \$3,000*

NOTE: Coinsurance Requirement Limits do not include the Calendar Year Deductible amount, the Hospital per Admission Deductible amount, any benefit penalty reduction, non-covered charges or any charges in excess of the Allowed Amount.

BENEFIT MAXIMUMS

1. *Lifetime Maximum Benefit per Insured \$1,000,000*
2. *Alcohol And Drug Dependency Benefit Lifetime Maximum per Insured (Inpatient, Outpatient or any combination) \$2,000*
 - a. *Inpatient Care treatment provided in a general, specialty or rehabilitative Hospital.*
 - b. *Outpatient Care limited to 44 Outpatient Visits up to a maximum of \$35.00 per Visit for treatment provided by a Physician or Psychologist.*
3. *Mental and Nervous Disorder Benefit Maximum per Insured per Calendar Year:*
 - a. *31 inpatient days or combination of inpatient and Partial Hospitalization.*
 - b. *outpatient care \$1,000*
4. *Hospice Benefit Lifetime Maximum per Insured \$5,200*
5. *Home Health Care Benefit Maximum per Insured per Calendar Year \$1,000*
6. *Skilled Nursing Facility Days Maximum Per Insured per Calendar Year 60*
7. *Accident Care Benefit Maximum, Not Subject To Deductible and Coinsurance \$500*

C.A.

Consolidated Inc. is the Contract holder of a Group Health Insurance plan. Mike is an employee that has just become eligible for Group Health insurance with Consolidated. Coverage's are as used in the illustration above. He has to pay only for Dependents coverage as the employer pays for the employee's premium. Mike has a wife (Marie) and two children, a son age 17 and daughter age 18.

Marie becomes ill and after 2 weeks and 4 visits to the family physical (approved Provider) she was admitted to a non-approved hospital. She was in the hospital for 4 days and released. Her Doctor and Laboratory bills total \$1,500. The Hospital bill was \$5500, including drugs etc. Mike is concerned as to how much he will have to pay out of his pocket.

Total bills	\$7,000
Deductible	\$300
Non PPO Hospital Deductible	\$100
Total after deductibles	\$6,600
10% of Coinsurance	\$660
Total Deduc. & Coins.	\$1,060
Total paid by insurer	\$5,540

Mike must pay \$1060 for the deductible and 10% of the coinsurance. If the coinsurance percentage (10%) exceeded 10\$, Mike has a limit of \$1,000 and the insurer would pay the excess.

C.A.

Mike was stricken with a kidney disease and when he was released from the (PPO Approved) hospital, was sent to a Skilled Nursing Facility for 45 days, and then was sent home. He required Home Health Care for 3 weeks until he could leave his house and no longer required assistance. In addition to Deductible of \$300, (no approved-hospital deductible), he paid 10% of his hospital bill. He only had to pay up to \$1,000 on his coinsurance, so his total was \$1,300. In addition, his Home Health Care bill was \$75 per day for 21 days, or \$1,575. The coverage only pays \$1,000, so Mike had to pay the \$575, bringing his total to \$1,875.

UTILIZATION MANAGEMENT PROGRAMS WITH POTENTIAL PENALTIES

1. Admission Certification

a. PPO Provider - No penalty for Insured

b. Non-PPO Provider - All admissions must be certified. The Allowed Amount is reduced by 25% for any non-certified admission. The Insured is responsible for the penalty.

2. Second Surgical Opinion

a. PPO Provider - not required

b. Non-PPO Provider - the Allowed Amount will be reduced by 25% if confirming opinion is not received. The Insured is responsible for the penalty.

C.A.

Assume that Mike's doctor wanted a second opinion before sending him to the hospital. If the confirming doctor charged \$1,500 for his services, if he were an approved physician the insurer would pay the entire amount (subject to deductible and coinsurance). If the doctor were non-approved, the insured would have to pay an additional \$375 (25% penalty).

REPRESENTATIONS ON APPLICATION AND ENROLLMENT FORMS

Similar to Individual Major Medical plans, inasmuch as the contract can be voided or cancelled if there is fraud, misrepresentation, omission, concealment of facts, etc., on the Group Application or the individual Enrollment Forms.

ELIGIBILITY FOR COVERAGE

A unique provision of Group insurance is the requirement of eligibility. Most Group insurance is not subject to individual medical conditions so certain provisions such as Eligibility is a method of underwriting.

Please note that some of the eligibility requirements may not apply in some jurisdictions because of recent legislation. The purpose of this provision is to justify the premiums by ensuring that the employee falls within the requirements.

The following individuals only are eligible to apply for coverage under this Contract. YOUR INSURANCE COMPANY may require acceptable documentation that an individual meets and continues to meet the eligibility requirements (e.g., court order naming the Certificate holder as the legal guardian or Adoption documentation).

Bona fide employees of the Contract holder who meet each of the following requirements are eligible to apply for coverage under this Contract:

- 1. The employee's job must fall within a job classification set forth on the Group Application;*
- 2. The employee must be scheduled to work and actually work on a full-time basis at least 25 hours or more each week. Part-time, temporary or substitute employees are not eligible;*
- 3. The employee must be actively at work on the Effective Date of coverage; and*
- 4. The employee must have completed any applicable Waiting Period set forth on the Group Application.*

The Certificate holder eligibility classification may be modified, and may be expanded to include:

- 1. Retired employees;*
- 2. Additional job classifications;*

3. *employees of affiliated or subsidiary companies of the Contract holder, provided such companies and the Contract holder are under common control; and*
4. *Other individuals as determined by YOUR INSURANCE COMPANY (e.g., members of associations or labor unions).*

Any expansion of the Certificate holder eligibility class must be approved in writing by YOUR INSURANCE COMPANY and the Contract holder prior to such expansion, and may be subject to different Rates.

The following individuals are eligible to apply for coverage under this Contract:

1. *The Certificate holder's present lawful spouse; and/or*
2. *the Certificate holder's unmarried natural, newborn, Adopted, Foster, or stepchildren, or a child for whom the Certificate holder has been court appointed as legal guardian or legal custodian, who is under the limiting age.*

C.A.

When Mike first went to work for Ajax, he was on a part-time basis, working 20 hours a week. He wanted the health insurance benefits, but did not qualify as he did not work 25 hours a week. After 6 months, he was put on full-time and worked 40 hours a week. He reapplied and was accepted as he was full time and had satisfied the 90 day waiting period.

Mike immediately requested coverage for his wife and 2 dependent children. Both children reside with Mike and both are students under the age of 19.

Mike does not hold a hazardous job and since the group consists of over 50 employees, there were no health questions asked. Mike and his family all became insured on the first of the month that Mike became eligible. He is required to pay 75% of the premium for his family (the employer pays Mike's entire premium).

EXTENSION OF ELIGIBILITY FOR DEPENDENT CHILDREN:

Group provisions closely follow those of Major Medical plans.

ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

Whereas individual policies have effective dates affecting only an individual policyowner, Group insurance effective dates for employees depend upon the eligibility rules, date of employment, actively-at-work requirements, etc.

Employees who are eligible to apply for coverage under this Contract may do so by completing an Individual Application for Group Insurance/Membership form and forwarding it to the Contract holder. When the Eligible Employee completes the Individual Application for Group Insurance/Membership form, the Eligible Employee must elect one of the types of coverage available under the Contract holder's program. Such types may include:

- 1. Employee Only Coverage. This type of coverage provides coverage for tile Eligible Employee only.*
 - 2. Employee/Spouse Coverage-- This type of coverage provides coverage for the Eligible Employee and the employee's present lawful spouse only.*
 - 3. Employee/Children Coverage. This type of coverage provides coverage for the Eligible Employee and the employee's eligible children only.*
 - 4. Employee/Family Coverage. This type of coverage provides coverage for the Eligible Employee and the employee's Eligible Dependents.*
- There may be an additional Premium charge for each Dependent based on the coverage selected by the Contract holder.*

Eligible Employees and Eligible Dependents who become covered under this Contract will be referred to as "Insured's". To become an Insured, the employee must:

- 1. Complete and submit, through the Contract holder, a written request for coverage, using enrollment forms approved by YOUR INSURANCE COMPANY;*
- 2. Provide any additional information needed to determine eligibility, if requested by YOUR INSURANCE COMPANY; and*
- 3. Agree to pay his or her portion of the required premium, if required by the Contract holder.*

An employee who is an Eligible Employee must enroll within the Initial Enrollment Period. An Eligible Employee who has been covered under another health benefit plan established and maintained by the Contract holder, and who now wants to change to this Contract, must enroll for such coverage change during an Annual Open Enrollment Period or Special Enrollment Period.

If an Eligible Employee does not enroll for coverage under this Contract during one of the periods described above, and later requests to enroll (, he or she will be considered a Late Enrollee. See the Late Enrollee provision below.

In many policies, there is a lengthy description of the Employee Effective Date. Basically, if an employee meets the eligibility requirements when the policy becomes effective, there is an enrollment period and the effective date can be either the date when the policy become effective or a later prescribed date. These policy provisions (eligibility and effective date) should be discussed in detail at time of placing the policy of the group. The enrollment of a Dependent is discussed below.

A Covered Dependent is an Eligible Dependent of a Certificate holder who becomes an insured under this Contract. For an Eligible Dependent to become an Insured, the Certificate holder must:

- 1. Complete and submit through the Contract holder a written request for such Eligible Dependent's coverage, using enrollment forms approved by YOUR INSURANCE COMPANY;*
- 2. Provide any information needed to determine eligibility, it requested by YOUR INSURANCE COMPANY; and*

3. Agree to pay his or her portion of the appropriate premium, as required by the Contract holder, for the Eligible Dependent's coverage.

To add Eligible Dependents on the Certificate holder's Effective Date, the Certificate holder must enroll his or her Eligible Dependents at the same time he or she initially enrolls during the Initial Enrollment Period.

To add a newborn, an Adopted newborn, or an Adopted child after the Certificate holder's Effective Date, the Certificate holder must enroll the Eligible Dependent within thirty (30) days after eligibility.

To add any other Eligible Dependent including Foster Children or court ordered coverage for a spouse or a minor child after the Certificate holder's Effective Date, the Certificate holder must enroll the Eligible Dependent within thirty (30) days after eligibility begins or thirty (30) days after the court order is issued.

The Effective Date of an Eligible Dependent's coverage under this Contract, excluding Late Enrollees, depends on when the Eligible Dependent is enrolled:

- 1. If the Eligible Dependent is eligible for coverage on the Effective Date of this Contract, coverage will become effective on the Contract Effective Date if the Certificate holder enrolls the Eligible Dependent for coverage at the same time he or she enrolls during the Initial Enrollment Period.*
- 2. If the Certificate holder through whom the Eligible Dependent is eligible first becomes eligible after the Contract Effective Date and the Certificate holder enrolls himself or herself and his or her Eligible Dependents. During the Initial Enrollment Period, coverage for the Eligible Dependents will be effective on the same date that the Certificate holder's coverage becomes effective.*
- 3. If the Eligible Dependent is first becomes eligible after the Certificate holder's Effective Date, and the Certificate holder enrolls the Eligible Dependent within thirty (30) days after eligibility, that Eligible Dependent's coverage will become effective on the date the enrollment form is received by YOUR INSURANCE COMPANY.*

A standard provision covering Adopted and Foster children frequently is part of this contract. Generally, Adopted and Foster children are accepted on the first billing date that they are legally the responsibility of the insured employee. Interestingly, some group policies waive pre-existing conditions for Adopted children, but not on Foster children. This may change in some jurisdictions because of recent legislation.

In the event the Certificate holder wishes to delete a Dependent from coverage, a Member Status Change Request form should be forwarded to YOUR INSURANCE COMPANY. That Dependent's coverage will terminate on the first billing date following YOUR INSURANCE COMPANY's receipt of such form.

An Eligible Employee or Eligible Dependent who does not enroll under this Contract during the Initial Enrollment Period and who does not qualify for the Special Enrollment Period (see the Special Enrollment Period provision) is a Late Enrollee. Being considered a Late Enrollee has two important consequences:

1. *The Effective Date of the enrollee's coverage may be delayed, as described in the Late Enrollee Enrollment, Effective Dates and Pre-existing Conditions Limitations provision; or*
2. *The period during which Pre-existing Conditions will not be covered may be extended, as described in the Late Enrollee Enrollment, Effective Dates and Pre-existing Conditions Limitations provision.*

An Eligible Employee or Eligible Dependent requesting to enroll under this Contract outside of the Initial Enrollment and Annual Open Enrollment Period will not be considered a Late Enrollee if:

1. *The individual was covered under another employer-provided health benefit plan as an employee or Dependent at the time he or she was initially eligible to enroll for coverage under this Contract;*
 - *When offered coverage under this Contract at the time of initial eligibility, states, in writing, that coverage under another employer provided health plan was the reason for declining enrollment;*
 - *Demonstrates that he/she has lost coverage under another employer health benefit plan within the past thirty (30) days as a result of the termination of employment, divorce, a change in employment status that impacts benefits, the termination of the other plan's coverage, or the death of a spouse; and Requests enrollment within thirty (30) days after the termination of coverage under another employer health benefit plan.*
2. *A court has ordered coverage to be provided for a spouse or minor child under the covered employee's plan and a request for enrollment is made within thirty (30) days after issuance of the court order.*

When coverage is requested in accordance with paragraphs 1 or 2 above, enrollment will be allowed outside of the Initial and Annual Open Enrollment Periods, with coverage becoming effective on the date the enrollment request is received by YOUR INSURANCE COMPANY.

If enrollment is not completed in accordance with paragraphs 1 or 2 above: that individual will be considered a late Enrollee and subject to the Late Enrollee Enrollment, Effective Dates and Pre-existing Conditions Limitations provision.

C.A.

Mike's 18 year-old daughter recently graduated from high school. She decided to work for a living and was planning on being insured under her employer's group plan. Therefore, Mike did not list her as a dependent when he became eligible for group insurance. After 3 months of working, his daughter changed her mind and decided to attend the local Junior College full time.

Since it was more than 30 days after Mike became eligible for coverage, Mike had to complete enrollment forms for his daughter. Her enrollment date then became the first of the month after the insurance company received the application. There were no pre-existing condition provisions under the group plan, but if there had been, she would have been subject to the pre-existing clause.

ENROLLMENT RECORDS

Because of the importance of timely and accurate records, Group policies contain specific and detailed instructions as to the establishment and maintenance of employee insurance records. These are spelled out in detail and vary by company. When the Group policy is delivered, this section should be reviewed in detail so it is important that the agent be familiar with the particular policy delivered.

The following other provisions regarding the enrollment and effective dates of coverage are unique to Group Health insurance.

1. Rehired Employees

Individuals who are rehired as employees of the Contract holder are considered newly hired employees for purposes of this Contract. The provisions of this Contract which are applicable to newly hired Eligible Employees and their Eligible Dependents (e.g., enrollment, Effective Dates of coverage, Pre-existing Conditions limitation, and Waiting Period) are applicable to rehired Eligible Employees and their Eligible Dependents.

2. Premium Payments

In those instances where an individual is added to coverage under this Contract (e.g., a new Eligible Employee or a new Eligible Dependent, including a newborn or Adopted child), that individual's coverage shall be effective, as set forth in this Section, provided YOUR INSURANCE COMPANY receives the applicable additional Premium payment within 30 days of the date YOUR INSURANCE COMPANY notified the Contract holder of such amount. In no event shall an individual be covered under this Contract if YOUR INSURANCE COMPANY does not receive the applicable Premium payment within such time period.

3. Prior Coverage under an Extension of Benefits

The Contract holder's prior carrier may be required to provide certain benefits to the Insured under an extension of benefits provision. In no event shall YOUR INSURANCE COMPANY pay any claims for services or supplies which are covered under any provision in the prior carrier's plan relating to extension of benefits after plan termination.

C.A.

When Mike applied for dependent coverage on his daughter, he paid the premium to cover her at time of application for coverage. The Human Resources Department of Consolidated completed the necessary forms and notified the insurer immediately. His daughter met all requirements for dependent's coverage.

Mike's foreman, Bill, left the employ of Consolidated and moved to Georgia and a new job. His wife did not like Georgia and wanted to return home. After 8 months, Bill applied for his old job at Consolidated and was rehired in a similar position. He applied for health insurance benefits but had to wait for 90 days before he became eligible for coverage. However, in the state where Consolidated is located, a "key man" exception is allowed, whereby if the employer can attest to the fact that the employee is a "key man" the insurer may waive the waiting period. In this case, Bill held 2 engineering degrees and Consolidated showed how they had not been able to fully replace Bill when he left, even with the hiring of 3 persons. The insurer would probably allow a waiver of the waiting period in actual practice.

PAYMENT OF PREMIUMS

YOUR INSURANCE COMPANY requires the regular and timely payment of Premiums on a prospective basis. The first payment must be received by YOUR INSURANCE COMPANY before YOUR INSURANCE COMPANY issues this Contract. After such first payment, Premiums are due on the 1st day of each month, unless YOUR INSURANCE COMPANY and the Contract holder agree to have the 15th day of each month as the Premium due date. The Contract holder is solely responsible for the timely payment of Premiums. In the event this Contract terminates for any reason, the Contract holder is responsible for all due and unpaid Premiums. Other than as specifically set forth in this Contract, YOUR INSURANCE COMPANY is not obligated to provide any coverage for any individual(s) for whom Premiums have not been received by YOUR INSURANCE COMPANY in advance, or to refund Premiums paid on behalf of any individual(s) who was listed on YOUR INSURANCE COMPANY's Enrollment Records as an Insured.

C.A.

Consolidated pays their premiums on the 1st of each month and their customers usually pay their bills towards the middle of the month in order to take advantage of any discounts. However, Consolidated's suppliers generally require payment by the first of the month. With the expansion of Consolidated and the additional new employees becoming eligible for benefits, the payment gap causes a strain on the finances of Consolidated. They requested that their billing date be moved to the 15th of the month.

GRACE PERIOD

Note the abbreviated Grace Period [compared to Individual plans] and the difference in the payment of premiums provision, due to the premiums being submitted by the employer.

YOUR INSURANCE COMPANY allows a 10 day Grace Period for the payment of Premiums. Any Premium which is not paid by the applicable due date may be paid within the 10 day period immediately following such due date. In the event the Premium payment is received by YOUR INSURANCE COMPANY within the Grace Period, this Contract will remain in force. In the event the Premium payment is not received by YOUR INSURANCE COMPANY within the Grace Period, this Contract will terminate as of the due date and the Contract holder shall be liable to YOUR INSURANCE COMPANY for any claim payments made by YOUR INSURANCE COMPANY for services or supplies rendered subsequent to such due date.

C.A.

After Consolidated and the insurer agreed to the 15th of the month as billing date, the following month the corporate comptroller forgot that the due date had been changed, and waited until the 5th of the following month to submit the premiums. Since the new billing date was the 15th, and there was a 10-day Grace Period, the policy had lapsed as of the 25th of the month. The insurer did not receive the premium payment until the 5th of the next month. Technically, this policy lapsed and the insurer had no liabilities. However, as a matter of practice and to conserve the business, the insurer will work with the Contract holder, and with payment of back premium, would in nearly all cases, reinstate the policy. They would probably bill Consolidated for an additional 2 weeks of premium. Of course, if for some reason, the insurer is not interested in continuing the group coverage of Consolidated (high claims ratio, for instance), they are within their right to terminate the group policy and refuse to reinstate.

OTHER PREMIUM PAYMENT REQUIREMENTS

1. *YOUR INSURANCE COMPANY reserves the right to suspend claims payments for claims incurred after the applicable due date in the event YOUR INSURANCE COMPANY does not receive the payment prior to the applicable due date.*
2. *YOUR INSURANCE COMPANY shall not be required to retroactively terminate this Contract or coverage for any Insured under this Contract.*

INSUREDS' FINANCIAL RESPONSIBILITIES

1 Individual Calendar Year Deductible requirement

The Individual Calendar Year Deductible requirement is set forth on the Schedule of Benefits. This requirement must be satisfied by each insured each Calendar Year, as determined by YOUR INSURANCE COMPANY, before any payment will be made by YOUR INSURANCE COMPANY for any claim. Only those charges indicated on claims received by YOUR INSURANCE COMPANY for Covered Services will be credited by YOUR INSURANCE COMPANY towards the Individual Calendar Year Deductible requirement, and only up to the applicable Allowed Amount.

2. Aggregate Family Calendar Year Deductible Requirement Limit

The Aggregate Family Calendar Year Deductible requirement limit is set forth on the Schedule of Benefits. Once the Certificate holder's family has reached such limit, no Insured in that family will have any additional Deductible responsibility for the remainder of that Calendar Year. The maximum amount that any Insured in the family can contribute to the Aggregate Family Calendar Year Deductible requirement is the Individual Calendar Year Deductible amount.

3. Annual Carryover

Any charges credited by YOUR INSURANCE COMPANY towards the Calendar Year Deductible requirements during the last three months of the prior Calendar Year will be carried over to reduce the Calendar Year Deductible requirement for the next Calendar Year.

4. Prior Coverage Credit

Any charges credited by the Contract holder's prior insurer towards an Insured's Deductible requirement during the 90 days prior to the Effective Date of this Contract, under a policy which was replaced by this Contract, shall be credited to that Insured's Calendar Year Deductible requirement for the initial Calendar Year of coverage under this Contract, but only to the extent those charges were for Covered Services. Prior coverage credit only applies at the initial enrollment of the group. The Contract holder and/or Insured is responsible for providing YOUR INSURANCE COMPANY with the information necessary for YOUR INSURANCE COMPANY to apply this prior coverage credit.

The Hospital per Admission Deductible requirement is set forth on the Schedule of Benefits. The Hospital Per Admission Deductible requirement must be satisfied by each Insured, as determined by YOUR INSURANCE COMPANY, before any payment will be made by YOUR INSURANCE COMPANY for any claim for services or supplies rendered by or at a Hospital. The Hospital per Admission Deductible requirement applies regardless of the reason for the admission and is in addition to the Calendar Year Deductible requirement.

COINSURANCE REQUIREMENT

The wording very closely resembles that of the similar provision on Major Medical Plans.

C.A.

Consolidated received a notice of premium increase from their Group Health Insurance carrier, which they felt was exorbitant. Therefore, they changed carriers effective August 1st. The plan benefits remained the same.

Mike had been to the doctor for the Asian flu that raged through his community, and he had accumulated \$200 towards his deductible (\$300). His wife also was sick and had accumulated \$150 towards the deductible. On September 15th, Mike contracted a skin disease that required treatment and the total bill was \$300.

Under the Prior Coverage Credit provision of the policy, the amounts that Mike and Marie had spent (during the calendar year and while they were under the prior carrier), was waived. In effect Mike's deductible was satisfied and his new carrier would pick up its coinsurance share of \$200 (\$180). If Marie receives medical services, after \$150 is billed, her deductible would also have been satisfied.

C.A.

Mike resides in a suburban area served by a Regional Hospital, located approximately 1 mile from his home. He noted that under the new PPO group insurance policy, the Regional Hospital was not an approved hospital. However, the City Hospital was 12 miles from his residence, and City is an approved hospital.

If Mike needs to be hospitalized, if he uses Regional, he will have to pay \$100 deductible for each admission. This deductible will not need to be paid if he uses City. However (explained later in the text) if he needs immediate hospitalization &/or Emergency Room care, he can use Regional if time is of the essence.

RESTORATION OF BENEFITS

The wording very closely resembles that of the similar provision on Major Medical Plans.

HEALTH CARE PROVIDERS

Wording regarding the PPO Providers (when applicable) are the same as with individual Major Medical plans. As a rule, Provider-type plans are established the same for Group and Individual plans. Note the illustrated Schedule of Benefits on the first page shows a difference in approved and non-approved Providers in coinsurance percentages. Since some groups are multi-state, there can be special consideration given if there are employees in an area not served by participating Providers. Some plans allow a choice with higher co-payments or some other added cost if approved Providers are not used. Again, because the size of the group determines the type of plan and the benefits provided, there are more alternatives to this and other similar provisions than could be outlined in a text of this size and type.

COVERED SERVICES

Hospital Care, Physician Care, Ambulatory Surgical Center Care, Accident Care, Accident Dental Care, Prescription Drugs, Complications of Pregnancy, Sterilization, Newborn Child and Well-Child Care, Organ Transplant, Mental-Nervous Disorder treatment, Alcohol-Drug Dependency treatment, Therapeutic Services, Mammogram, Skilled Nursing Care, Home Health Care, Ambulance Services, Prosthetic & Orthotic Devices & Durable Medical Equipment, are all comparable to the provisions and terminology of the individual Major Medical plans. The only two sections of interest that are not defined under Major Medical provisions are Maternity and Hospice Care. (See below)

MATERNITY CARE

Maternity Health care services and supplies, including prenatal care, delivery and postnatal care, provided to an Insured other than the Certificate holder's child, by a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Hospital, Birth Center, midwife or Certified Nurse Midwife may be Covered Services.

Maternity benefits are provided for a Certificate holder's Dependent daughter only when: 1) the Certificate holder has employee/children or employee/family type coverage; 2) the Contract holder has purchased the optional Dependent daughter maternity benefits Rider from YOUR INSURANCE COMPANY; and 3) the Dependent daughter was covered under such Rider for at least 30 days prior to the date of conception of such Dependent's pregnancy, as determined by a Physician.

Complications of Pregnancy: *Health care services and supplies provided to an Insured for the treatment of complications of pregnancy may be Covered Services. Coverage for complications of pregnancy are limited to Covered Services to treat the Condition covered by the complication, and does not include maternity coverage.*

Additionally, coverage for complications of pregnancy is subject to any Pre-existing Condition limitations. For purposes of this Section, the phrase complications of pregnancy" means a Condition which is diagnosed as a separate Condition from the pregnancy.

Complications of Pregnancy definitions and limitations closely follow those outlined in the Major Medical policy.

C.A.

Mike's daughter had been "going steady" with her high school sweetheart for 2 years. When Mike and Marie discovered that the daughter and her boyfriend were having intimate relations, they became concerned. They were afraid that their daughter might become pregnant, even though they attempted to stop such irresponsible behavior.

Marie had a friend whose husband also worked for Consolidated, and had a similar situation arise, but when the daughter became pregnant, they discovered that they had had to purchase a special Maternity Rider before a dependent would be covered. Mike took immediate action and purchased the Rider. The action was correct as soon afterwards, their daughter informed them that she was pregnant. She and her parents decided that she should continue in college and when the baby was born, Marie would keep her while her daughter continued her education.

It was determined that the daughter had become pregnant about 45 days before the Maternity Rider was purchased (if it had been less than 30 days, she would not have been covered under Consolidated's group plan). She elected to have her baby at a birth center near their home and to use the services of a Certified Nurse Midwife as she felt more comfortable with these people (as they were approved Providers, the plan would cover those expenses). However, she started having pains prior to her due date, and as a precaution she was sent to Regional Hospital, close to her home (not-approved, so there would be an additional \$100 deductible), and brought in the services of an obstetrician (approved Provider). It was determined that a Cesarean should be performed. The surgery was performed, and the daughter gave birth to an 8-pound baby girl.

Since the Cesarean was necessary, the Maternity provision would not apply, however, the Complications of Pregnancy provision would apply and her expenses would be covered. She would be responsible for the \$300 deductible, plus the \$100 Hospital Deductible, plus 10% of the remaining bills up to a maximum of \$1,000, for a total cost of \$1,400.

HOSPICE CARE

(Typically, hospice care is not covered under individual Major Medical policies)

Health care services and supplies provided to an Insured in connection with a Hospital treatment program may be Covered Services provided the Hospice treatment program is approved by the Insured's Physician who advises that the Insured is not expected to live more than one year. Benefits for Covered Services for Hospice are limited as indicated in the Schedule of Benefits.

C.A.

Mike's Brother-in-law, Sam, also works for Consolidated and is covered under their Group Insurance Plan. Sam was a very heavy smoker, and had a lingering, hacking cough. He went to his doctor for a checkup, and was diagnosed as having lung cancer, requiring immediate surgery.

During the operation, it was discovered that the cancer had spread throughout his body. After surgery and a week in the hospital, the doctors sent him home, as there was nothing more they could do for him. They gave him less than a month to live.

Sam's doctor recommended Hospice service, and set up a planned treatment program. The Hospice installed a hospital bed in his home and spent time with the family, instructing them on how to treat him during his last hours. The "Do Not Resuscitate" sign was posted in his room. He very soon could not eat solid foods, and had to have a special diet of Ensure. The surgery left a hole in his chest for drainage, and the bandages had to be changed 2 or 3 times a day. He passed away 4 weeks after hospital discharge.

The Hospice expenses would be covered under the group insurance plan.

SECOND SURGICAL OPINION

In general, Second Opinions are more closely regulated under Group insurance coverage than with individual Major Medical policies. This will vary by company, policy form and jurisdiction; however the following illustrated wording is typical for many plans.

Under this program, each Insured is required to obtain a confirming surgical opinion from a Physician who is participating in this program when a Non-PPO Physician intends to perform any Procedures of the Planned (i.e., surgery that is not all emergency or urgent) surgical procedures listed below. There is no Coinsurance or Deductible responsibility for insured's when receiving covered consultations under this Program. In the, event an Insured does not obtain such confirming opinion, the Allowed Amount will be reduced by 25%. This penalty is the Insured's responsibility and is in addition to all applicable obligations and limitations under this Contract. The benefit reduction amount will not be applied towards the Coinsurance requirement limits (for example, the individual Coinsurance requirement limit).

1. Planned Surgical Procedures Requiring a Confirming Opinion

Insured's must obtain a confirming opinion for the following planned surgical procedures when they are to be performed by a Non-PPO Physician:

- *arthroplasty - plastic operation on a joint or the formation of an artificial joint when performed on the knee or hip;*
- *arthroscopy - internal examination performed by the use of a scope, when performed on the knee;*
- *bunionectomy - surgical removal of a bunion;*
- *cataract removal - removal of the opacity of the crystalline lens of the eye;*
- *cholecystectomy - removal of the gall bladder;*
- *coronary bypass and pacemaker insertion;*
- *D&C - dilation and curettage;*
- *subcutaneous mastectomy - excision of cyst, tumor, or lesion of the breast;*
- *hemorrhoidectomy - removal of a mass of swollen varicose veins in the rectal mucous membrane*
- *hysterectomy - removal of the uterus by excision;*
- *laminectomy or laminotomy - removal of or incision into a disk*
- *prostatectomy (including transurethral resection) - excision of the prostate gland;*
- *submucous resection/rhinoplasty - surgical correction of deviated septum, plastic surgery on the nose; and*
- *tonsillectomy/adenoidectomy - removal of the tonsils and adenoids*

2. How to Obtain a Second Opinion

The Insured must obtain the confirming opinion from a Physician who is participating in YOUR INSURANCE COMPANY's Second Surgical Opinion program in order to avoid the 25% penalty. Insured's may obtain a list of such participating Physicians by contacting YOUR INSURANCE COMPANY. Additionally, upon request YOUR INSURANCE COMPANY will provide the insured with a Medical Records Release Authorization form which will allow the insured's Physician to transfer records to the consulting Physician.

In the event the consulting Physician does not confirm the need for the planned surgery, the Insured may seek a third opinion from a Physician participating in YOUR INSURANCE COMPANY's Second Surgical Opinion program.

C.A.

Mike suffered from hemorrhoids and since he had to sit nearly all day at his job, they became intolerable. Mike went to a local clinic and was checked by a non-approved physician, who wanted to perform a hemorrhoidectomy in the Regional Hospital. However, he needed a second opinion, preferably from an approved Physician to avoid a 25% penalty. The doctor that gave the second opinion felt that the operation was not needed at this time. Mike's original doctor then asked for a third opinion (again, approved Physician) and the third opinion agreed. Mike then entered the hospital and had a hemorrhoidectomy. Note: At the Regional hospital, he still would have to pay an additional \$100.

MEDICAL NECESSITY

The wording under Group policies and Individual Major Medical are approximately the same – primarily the decision as to whether a procedure is medically necessary is the decision of the insurance company.

PRE-EXISTING CONDITIONS

Pre-existing conditions differ considerably between Group insurance and Individual Major Medical insurance, however because of liberalization of provisions due to politics-driven regulations, the difference is narrowing and in particular with respects to the HIPA Act as discussed later in this text.

Except as otherwise provided in this Contract, if the Insured enrolled for coverage under this Contract during the Initial Enrollment Period or during an Annual Open Enrollment Period, the period during which coverage for Pre-Existing existing will be limited depends on whether or not the Insured had Qualifying Previous Coverage.

Except as otherwise provided in this Contract, insured's who had employer-based group health Qualifying Previous Coverage will be given credit for the partial satisfaction of a Pre-existing Condition limitation waiting period if that person was subject to a Pre-existing Condition limitation under the previous coverage and had not satisfied a 12 month Pre-existing Condition waiting period:

- 1. If the Insured employee is newly hired by the Contract holder and enrolls himself or herself and his or her Eligible Dependents within 30 days before the Effective Date of his or her new coverage under this plan, exclusive of any waiting period, or;*
- 2. If the Insured employee, and his or her Eligible Dependents, were covered under another health benefit plan established and maintained by the Contract holder and maintained that coverage under that plan up to the beginning date of the Annual Open Enrollment Period, and now desires to change to this Contract during an Annual Open Enrollment Period.*

An insured who had employer-based group health Qualifying Previous Coverage will not be subject to Pre-existing Condition Limitation waiting period if they were covered continuous to a date not more than thirty (30) days prior to the Effective Date of coverage, exclusive of any waiting period.

An insured who had individual Qualifying Previous Coverage that was in effect for 12 months or longer will not be subject to a Pre-existing Condition limitation waiting period if they were covered continuously under the Qualifying Previous Coverage continually to a date 30 days before the Effective Date of this Contract, exclusive of any waiting period.

If the Insured's (not including Late Enrollees) did not have Qualifying Previous Coverage, the following rules apply:

- 1. If the Contract holder has 3 or more employees, Pre-Existing Conditions which manifested themselves, or for which medical advice or treatment was received, within the 6 month period immediately preceding the Insured's Effective Date will be considered pre-existing and will not be covered until the insured has been covered under this Contract for 12 consecutive months.*
- 2. If the Contract holder has less than 3 employees, Pre-existing Conditions which manifested themselves, or for which medical advice or treatment was received, within the 24 month period immediately preceding the Effective Date will be considered pre-existing and will not be covered until the insured has been covered under this Contract for 24 months.*

Late Enrollees

A Late Enrollee can enroll for coverage under this Contract in one of the, following ways.

- 1. If the Late Enrollee waits until the next Annual Open Enrollment Period to enroll, Pre-existing Conditions Limitations which had manifested themselves or for which there was medical advice or treatment:
 - within the 6 month period immediately preceding the Insured's Effective Date will not be covered under this Contract until the Insured has been covered under this Contract for 12 consecutive months for an employee of a Small Employer with 3 or more employees, or;*
 - within the 24 month period immediately preceding the Insured's Effective Date will not be covered under this Contract until the Insured has been covered under this Contract for 24 consecutive months for an employee of a Small Employer with less than 3 employees.**
- 2. YOUR INSURANCE COMPANY will allow a Late Enrollee who wants to apply prior to the next Annual Open Enrollment Period to apply at any time, however, he/she will be required to submit a Medical Statement Application and will be subject to the following rules:*

If the Late Enrollee's Medical Statement Application is acceptable to YOUR INSURANCE COMPANY:

Coverage will become effective on the date YOUR INSURANCE COMPANY accepts the Late Enrollee for coverage but

- For individuals whose coverage is provided by a Small Employer who has 3 to 50 employees:
 - Pre-existing Conditions, which manifested themselves, or for which treatment or advice was received, 6 months prior to the individual's Effective Date, will not be covered for a period of 12 months following the individual's Effective Date (with proper credit for Qualifying Previous Coverage, if any).**
- For individuals whose coverage is provided by a Small Employer who has 1 or 2 employees: Pre-existing Conditions, which manifested themselves, or for which treatment or advice was received, 24 months prior to the individual's Effective Date, will not be covered for a period of 24 months following the individual's Effective Date of coverage (with proper credit for Qualifying Previous Coverage, if any).*

If the Late Enrollee's Medical Statement Application is not acceptable to YOUR INSURANCE COMPANY, then the Late Enrollee will be required to reapply at the next Annual Open Enrollment Period. Once the Late Enrollee reapplies:

- *For those individuals whose coverage is provided by an employer and who has 3 to 50 employees and who did not have Qualifying Previous Coverage*

Pre-existing Conditions which manifested themselves, or for which treatment or advice was received, 18 months prior to the individual's first (original) date of application will not be covered for a period of 18 months following the individual's Effective Date of coverage, with credit for the number of months for which he/she was totally excluded from coverage, i.e., the number of months between the original date of the individual's application and the individual's Effective Date of coverage.

- *For those individuals whose coverage is provided by an employer who has 1 or 2 employees and who did not have Qualifying Previous Coverage.*

Pre-existing Conditions which manifested themselves, or for which treatment or advice was received 24 months prior to the individual's first (original) date of application will not be covered for a period of 24 months following the individual's Effective Date of coverage, with credit for the number of months for which he/she was totally excluded from coverage, i.e., the number of months between the original date of the individual's application and the individual's Effective Date of coverage.

YOUR INSURANCE COMPANY reserves the right to collect from the Insured the cost of any service or supply paid as benefits by YOUR INSURANCE COMPANY for a Pre-existing Condition in error.

C.A.

One of Consolidator's suppliers, Widget One Corporation, provided their 8 employees with health insurance, with benefits the same as Consolidated as most of their employees had formerly worked for Consolidated and wanted the same benefits when possible. The principal difference between the plans was that as a smaller group, the employees were subject to a pre-existing condition clause.

Widget One hired Donald, who had formerly worked for Consolidated. Donald enrolled in the Widget One health benefits program. Because he had enrolled directly from one plan to another, the pre-existing conditions provision was waived as Donald had been with Consolidated for several years.

However, new employee Harold, came from another small company, and had only had coverage for 6 months prior to coming to work for Widget One. Therefore, he would have a 6-month pre-existing condition provision.

Harold's previous company only had 2 employees (Harold and the owner), so their group plan had a 24 month pre-existing clause. By joining a larger group, he reduces his pre-existing condition clause to 18 months.

Prior to joining Consolidated, Harold had suffered severe chest pains on 3 separate occasions. At first he thought it was simply gas pains, took some Tums, and the pain left. Later he became concerned, but since he knew he was going to Consolidated who had a better health plan in respect to pre-existing conditions. Soon after joining Consolidated, he again suffered chest pains and his wife rushed him to the hospital, where it was determined that he had suffered a heart attack.

Harold insisted that this was not a “pre-existing condition” as he had not gone to a doctor. However, during his physical examination and chest x-rays, it became obvious that he had had at least 3 myocardial infarctions as there were spots of injured muscle on his heart. The insurance company referred to their definition of pre-existing “which manifested themselves, or for which medical advice or treatment was received during this period”, particularly to the “condition which manifested itself” during this period. (Some policy provisions further specify that “any condition that would cause a reasonable person to seek medical care” is considered pre-existing if it falls within the appropriate time period).

BENEFIT LIMITATIONS

Restrictions and limitations such as those for various devices and equipment limited to the most cost effective; Multiple Surgical Procedures; Incidental Surgical Procedures; Allowance For Surgical Assistant; Allergy Testing; Physician In-Hospital Visits; Limitation For Physical Therapy, etc., are outlined in a group contract and closely resemble the wording and provisions of an individual Major Medical policy.

EXCLUSIONS

Not surprisingly, the Exclusions under a Group policy closely resemble the Exclusions under a Major Medical program, except for noted exceptions, such as Maternity and Hospice coverage.

COORDINATION OF BENEFITS

Coordination of Benefits provisions in individual policies vary from those used in group policies primarily because group policies are subject to COBRA [described later in this text] and approach the problem of duplicate coverage from a different [group & employer furnished benefits] perspective.

Coordination of Benefits is a limitation of benefits for Covered Services under this Contract and is designed to avoid the duplication of payment for health care services and supplies.

Coordination of Benefits applies when an Insured is covered under other plans, programs, or policies providing benefits for health care services and supplies which contain a COB provision or are required by law to contain a COB provision. Such other plans, programs, or policies may include, but are not limited to:

- 1. Any group or individual insurance (including automobile PIP and/or medical payments), group self-insurance, health maintenance organization, or other plan, program, or policy; or*
- 2. Any group or individual plan, program, or policy underwritten or administered by YOUR INSURANCE COMPANY*

YOUR INSURANCE COMPANY's payment for Covered Services depends on whether YOUR INSURANCE COMPANY is the primary payer, as determined in accordance with the provisions set forth below. In the event YOUR INSURANCE COMPANY is the primary payer, YOUR INSURANCE COMPANY's payment for Covered Services, if any, will not be reduced due to the existence of other coverage and will be made without regard to the Insured's other plans, programs, or policies.

In those instances where COB applies and YOUR INSURANCE COMPANY is not the primary payer, YOUR INSURANCE COMPANY's payment for Covered Services, if any, will be reduced so that when such payment is combined with the payments made under the Insured's other health care plans, programs, or policies, the total payment will not exceed 100% of the "total reasonable expenses" actually incurred by the Insured. In the event an Insured receives Covered Services from a PPO or a Participating Provider, "total reasonable expenses" shall equal the amount YOUR INSURANCE COMPANY is obligated to pay to the Provider pursuant to the applicable agreement YOUR INSURANCE COMPANY has with such Provider.

The following rules shall be used by YOUR INSURANCE COMPANY to determine if YOUR INSURANCE COMPANY is the primary payer:

- 1. The benefits of a policy, plan, or program which covers the person as all employee, member, or Insured, other than as a Dependent, are determined before those of the policy, plan, or program which covers the person as a Dependent.
However, if the person is also a Medicare beneficiary, and if the rule established under the Social Security Act of 1965, as amended, makes Medicare secondary to the plan covering the person as a Dependent of an active employee, the order of benefit determination is:
 - a. First, benefits of a plan covering persons as an employee, member, or subscriber.*
 - b. Second, benefits of a plan of an active worker covering persons as a Dependent.*
 - c. Third, Medicare benefits,**
- 2. except as stated in paragraph 3, when two or more policies, plans, or programs cover the same child as a Dependent of different parents:
 - a. The benefits of the policy, plan, or program of the parent whose birthday, excluding the year of birth, falls earlier in a year are determined before those of the policy, plan, or program of the parent whose birthday, excluding year of birth, falls later in the year; but*
 - b. if both parents have the same birthday, the benefits of the policy, plan, or program which covered the parent for a longer period of time are determined before those of the policy, plan, or program which covered the parent for a shorter period of time.*
However, if a policy, plan, or program subject to the rule based on the birthday of the parents as stated above coordinates with an out-of-state policy, plan, or program which contains provisions under which the benefit of a policy, plan, or program covers a person as a Dependent of a male are determined before those of a policy, plan, or program which covers the person as a Dependent of a female and if, as a result, the policies, plans, or programs do not agree on the order of benefits, the provisions of the other policy, plan, or program shall determine the order of benefits.*
- 3. If two or more policies, plans, or programs cover a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - a. First, the policy, plan, or program of the parent with custody of the child;**

b. Second, the policy, plan, or program of the spouse of the parent with custody of the child; and

C. Third, the policy, plan, or program of the parent not having custody of the child

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and if tile entity obliged to pay or provide the benefits of the policy, plan, or program of that parent has actual knowledge of those terms, the benefits of that policy, plan, or program are determined first. This does not apply with respect to any claim determination period or plan, policy, or program year during which any benefits are actually paid or provided before that entity has the actual knowledge.

4. The benefits of a policy, plan, or program which covers a person as an employee who is neither laid off nor retired, or as that employee's Dependent, are determined before those of a policy, plan, or program which covers that person as a laid off or retired employee or as that employee's Dependent. If the other policy, plan, or program is not subject to this rule, and if, as a result, the policies, plans, or programs do not agree on the order of benefits, this paragraph shall not apply.

5. If none of the rules in paragraph 1, paragraph 2, paragraph 3, or paragraph 4 determine the order of benefits, the benefits of the policy, plan, or program which covered an employee, member, or Insured for a longer period of time are determined before those of the policy, plan, or program which covered that person for the shorter period of time.

If an individual is covered under a COBRA continuation plan as a result of the purchase of coverage as provided under the Consolidation Omnibus Budget Reconciliation Act of 1985, as amended, and also under another group plan, the following order of benefits applies:

a. First, the plan covering the person as an employee or as the employee's Dependent.

b. Second, the coverage purchased under the plan covering the person as a former employee, or as the former employee's Dependent provided according to the provisions of COBRA.

Coordination of benefits shall not be permitted against an indemnity-type policy, an excess insurance policy as defined in State Statutes, a policy with coverage limited to specified illnesses or accidents, or a Medicare supplement policy.

C.A.

Mike's father-in-law also works for Consolidated. He turned age 65 and was eligible for Medicare. Medicare, by law, is secondary to the group plan of Consolidated. Since Consolidated pays for the employee's insurance, he elected to keep his group coverage.

Bill (also employed at Consolidated) has a son, Reginald, who has been a sickly child and requires considerable medical attention. Bill's wife, Joanne, works for another company and is insured under their health plan as the employer pays all of the premiums. Because of Reginald's health, both parents carry Reginald as a dependent on their insurance. Until recently, Reginald's medical costs had been a series of small doctor's bills, but recently he has had rather costly CAT Scans and MRI's, plus new expensive medical treatment.

In determining which plan would be primary, it was first determined whether Bill or Joanne had the earliest birthday, and by coincidence (they never forget each other's birthdays) they both were born on March 4. Therefore, the policy then called for the one that had had coverage the longest. Since Bill had returned from Georgia and went back to his old job, Joanne had only recently gone to work. Therefore, Bill's insurance would be primary. (Continued on next page)

Interestingly, in some states, with the same birthdays, the coverage of the male (Bill) would be primary anyway. In some other jurisdictions Bill's coverage would be primary regardless of the incidence of birthdays.

SUBROGATION

The wording very closely resembles that of the similar provision on Major Medical Plans

TERMINATION OF THE GROUP CONTRACT

Termination provisions of a Group Contract differ from those of an individual plan because the policyholder is actually the employer. Therefore, provisions must be made for cancellation by the employer and termination of coverage for individual employees. A provision in the renewability section allows the insurer to cancel a group contract if continued exposure could injure the insurer financially, with the Department of Insurance's permission. It is conceivable that a company may have a very large group that could have so many claims the insurer would be financially injured if they kept it on the books, a situation that obviously would not arise in an individual policy.

This Contract shall remain in effect until terminated by either party in a manner consistent with this Contract.

The Contract holder may terminate this Contract at any time without cause upon at least 45 days prior written notice to YOUR INSURANCE COMPANY.

This Contract is renewable at the option of the Contract holder except that YOUR INSURANCE COMPANY may terminate or not renew this Contract for any of the following reasons:

- Non-payment of required premiums;*
- Fraud or misrepresentation of the Contract holder;*
- Non-compliance with required Contract provisions;*
- Non-compliance with YOUR INSURANCE COMPANY's minimum participation requirements;*
- Non-compliance with YOUR INSURANCE COMPANY's Contract holder contribution requirements*
- The Contract holder's termination of the business in which it was engaged on the Effective Date of this Contract;*
- the Department of insurance determines that continuation of coverage is not in the best interest of the Contract holder or Insured's or will impair YOUR INSURANCE COMPANY's ability to meet its contractual obligations. In such instances, the Contract holder may seek assistance from the Department of Insurance in finding replacement coverage.*

This Contract will automatically terminate as of the applicable Premium due date in the event YOUR INSURANCE COMPANY does not receive the applicable Premium payment prior to the end of the Grace Period. In no event will such termination relieve the Contract holder of its obligation for claims payments made by YOUR INSURANCE COMPANY for services or supplies rendered subsequent to such due date. YOUR INSURANCE COMPANY shall provide to the Contract holder written notification of any termination by YOUR INSURANCE

COMPANY. Upon receipt of such notification, the Contract holder shall immediately notify each Certificate holder of the termination.

C.A.

Consolidated does not have a participation problem inasmuch as they pay the premium for their employees; therefore, there is no logical reason for an employee not to accept the health insurance. If they are covered under their spouse's health insurance with other groups, they are not considered "eligible", so it will not affect the ratio.

If Consolidated only paid for 50% of the employee's premium, many employees would feel that they could not afford the 50% premium from their paycheck and would not accept the insurance when they became eligible. This would create problems as traditionally, the younger and healthier individuals are the ones who feel that they can't afford health insurance, and since they are healthy, they feel they don't need it. Therefore, the ones remaining in the group (if there are enough eligible employees to maintain the participation requirements) are the least healthy; those who suffer from poorer health, or are older and more susceptible to ill health. This creates an anti-selection problem, as claims would increase which would increase the overall premium for the group. As the premium increases, more healthy employees will refuse or drop out of group health coverage as they feel they cannot afford it – and again they will be the healthy ones. The cycle could continue. It may be more cost-efficient for the employee to pay for all of the premiums on the employees.

COBRA CONTINUATION OF COVERAGE

A provision unique to Group insurance is the COBRA provision. In effect, this allows employees who have been insured under a Group insurance policy, that leaves the group, to remain covered under the same policy for a period of time (normally 18 months, except if disability is involved - see below). This provision was legislated by the Federal Government, with the result that very detailed explanation of this benefit is required and is strenuously enforced. COBRA is mandated for all Groups of 20 or more employees, but some states have enacted a similar provision for smaller groups – usually groups 5 to 20 employees. The principal features of the COBRA provision is that benefits extend for 18 months, maximum 36 if disability is involved as outlined below; and that it affects groups of 20 or more employees. It is the employers responsibility to notify the ex-employee of his/her COBRA benefits, however in at least one state that has a State COBRA – like law for smaller groups, the responsibility is that of the insurance company).

*Federal continuation of coverage requirements of the **Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)**, as amended, also known as Section 4980B of the Internal Revenue Code of 1986, may apply to the Contract holder. If COBRA applies to the Contract holder, an Insured may be entitled to continue his or her group health coverage for a limited period of time, if the Insured meets the applicable requirements, makes a timely election, and pays the proper Premiums.*

An Insured must contact the Contract holder to determine if he/she is entitled to COBRA continuation of coverage. The Contract holder is solely responsible for meeting all of the obligations under COBRA, including the obligation to notify all covered employees and Dependents of their rights under COBRA. If the Contract holder or the Insured fails to meet its obligations under COBRA and this Contract, YOUR INSURANCE COMPANY shall not be liable for any claims incurred by the Insured after his/her termination of coverage.

Solely for the convenience of the Contract holder, a summary of the COBRA rights of an Insured and the general conditions for an Insured's qualification for COBRA continuation coverage is provided below. This summary is not meant as a representation that any of the COBRA obligations of the Contract holder are met by the purchase of this Contract; the duty to meet such obligations remains with the Contract holder.

Insured's may elect, if COBRA applies to the Contract holder and the Insured is eligible for such coverage, to continue their group health insurance if they qualify fewer than one of the following circumstances:

- 1. If coverage would otherwise be lost due to the death of a covered active or retired employee of the Contract holder, the surviving spouse and Dependent children may qualify to elect to continue their group health coverage for a period of time not to exceed 36 months from the date of death.*
- 2. A spouse who would otherwise lose coverage due to a divorce or legal separation from a covered active or retired employee of the Contract holder, and Dependent children who would otherwise lose coverage due to the divorce or legal separation, may qualify to elect to continue their group health coverage for a period of time not to exceed 36 months from the date of divorce or legal separation.*
- 3. A spouse or Dependent child of a covered active or retired employee who would otherwise lose coverage due to the employee's (or retired employee's) entitlement to Medicare, may qualify to elect to continue their group health coverage for a period not to exceed 36 months from the date the employee or covered retiree first becomes entitled to Medicare.*
- 4. Children of a covered active or retired employee, who would otherwise lose coverage due to a failure to meet the group health plan's eligibility requirements (e.g., exceeding the limiting age), may qualify to elect to continue group health coverage for a period not to exceed 36 months from the date the child ceased to meet such eligibility requirements.*
- 5. a. Covered employees, their covered spouse and Dependent children may qualify to elect to continue their group health coverage if coverage would otherwise be lost due to termination of employment with the Contract holder (other than for reasons of gross misconduct), or due to a reduction in hours of employment with the Contract holder. This continuation of coverage may continue for a period not to exceed 18 months from the (late of termination or reduction in hours.*
 - b. If, at the time of the employee's termination or reduction in hours, an Insured is totally disabled (as defined by the Social Security Administration) and all notification and eligibility requirements are met, an extension of coverage of up to 11 additional months may be available (29 months total). Extension of coverage will not be provided if the Insured fails to inform the Contract holder in writing of the disability before the continuation of coverage expires and within the time periods required by COBRA.*

6. *If an Insured is receiving continuation coverage under paragraph 5, such coverage may continue for a period longer than the time stipulated in that paragraph if an event that would otherwise have entitled the Insured to COBRA continuation coverage (e.g., divorce, legal separation, or death) later occurs. But in no case will the Insured receive coverage beyond 36 months from the event that originally made him or her eligible for coverage.*
7. *If a bankruptcy or other proceeding under Title 11 of the United States Code commences with respect to the Contract holder, continuation rights shall be provided to the Insured to the extent required under COBRA.*

In order for the group health coverage to continue pursuant to COBRA, under this Contract, the following conditions must be met:

1. a. *If coverage would be lost due to a reduction in hours or termination of employment (for reasons other than gross misconduct), the Contract holder must notify the employee and Dependents of their continuation of coverage rights under COBRA within 14 days of the termination of employment or reduction in hours causing loss of coverage.*
 - b. *If coverage would be lost due to Medicare entitlement, divorce, legal separation, or the failure of a covered Dependent child to meet eligibility requirements, the employee or Dependent must notify the Contract holder, in writing, within 60 days of any of these events. The Contract holder must notify the Dependents of their continuation of coverage rights within 14 days of receipt of such notice from the employee or Dependent.*
2. *the qualified Insured must elect to continue, the group health insurance within 60 days of the later of the date that the coverage terminates or the date the notification of continuation of coverage rights is sent by Contract holder.*
3. *The qualified Insured who elects continuation coverage must not be covered under any other group health insurance plan. However, COBRA coverage may continue if the new group health insurance plan contains exclusions or limitations due to a Pre-existing Condition that would affect the continuant's coverage.*
4. *The qualified Insured who elects continuation of coverage must not become after electing, entitled to Medicare.*
5. *A Totally Disabled Insured who is eligible to extend and who elects to extend his or her continuation of coverage after 18 months may not continue such coverage more than 30 days after a determination by the Social Security Administration that the Insured is no longer disabled. The Insured must inform the Contract holder of the Social Security determination within 30 days of such determination. For purposes of this Section, a Totally Disabled Insured is an Insured who is determined to be disabled under the Social Security Acts (Title 11, OASDI or Title XVII, SSI).*
6. *the qualified Insured electing continuation of coverage, must meet all Premium payment requirements, and all other eligibility requirements set forth in COBRA, and, to the extent not inconsistent with COBRA, in this Contract.*
7. *The Contract holder must continue to provide group health coverage to its employees through YOUR INSURANCE COMPANY.*

An election by an employee or spouse shall be deemed to be an election for any other qualified beneficiary related to that employee or spouse, unless otherwise specified in the election form.

The Insured does not need to show insurability to receive COBRA continuation of coverage. However, the Insured must pay the applicable Premiums charged by the Contract holder and this Contract.

In the case of a qualified Insured whose maximum period of continuation of coverage expires, the Contract holder must, during the 180 days period prior to such expiration date, provide the qualified Insured the option of enrolling in an individual conversion policy made available to the Insured's of the Contract holder by YOUR INSURANCE COMPANY.

NOTE: This Section of this Contract shall not be interpreted to grant to any Insured any continuation rights in excess of those required by COBRA and/or Section 4980B of the Internal Revenue Code. Additionally, this Contract shall be deemed to have been modified, and shall be interpreted, so as to comply with COBRA and changes to COBRA that are mandatory with respect to the Contract holder.

C.A.

Assume that Mike leaves Consolidated and decides to go into business for himself as a consultant. He is qualified for COBRA coverage. Mike continues coverage for himself and his family on the same basis as he had when he was working for Consolidated. However, his premium jumped considerably as Consolidated had paid for his insurance coverage so he had to pay the premiums previously paid by Consolidated.

Mike and his family are in relatively good health, but if a Mike or a dependent became disabled, the COBRA period would extend from 18 months to 24 months.

If Mike finds that the premium is excessive, he should investigate individual Major Medical coverage as an alternative. Since individual policies are underwritten, if they qualify for coverage, the premium should be less. The principal feature that they would lose would be Maternity, however since they are over childbearing age, except for their daughter so arrangements will have to be made for her. Perhaps she could qualify for an individual policy with a maternity rider.

If Mike elects to continue with the COBRA coverage, after the COBRA plan has been in existence for 18 months he must then either accept the conversion policy or at that time, apply for an individual policy. Since he has exhausted COBRA, he qualifies for a conversion policy under the provisions of HIPAA (See details later in text). HIPAA requires that insurers offer 2 of their most popular plans to those qualifying for the conversion plan, but if there is no regulations requiring competitive pricing, the premiums for the conversion policies may be quite expensive. If this situation continues, Mike would probably be better off with individual policies, providing he and his family can meet the underwriting and health requirements at the end of the COBRA period.

CONVERSION TO AN INDIVIDUAL POLICY

A conversion policy must be offered to an ex-employee covered under the plan as stated below, is entitled to a conversion policy, i.e. an individual policy under certain situations, as listed below. Because of the HIPAA legislation, and subsequent legislation relating to portability

of insurance, regulations are in effect in most jurisdictions to specify the policies that may be offered, in addition to those provisions provided under HIPAA.

Any Insured who has been continuously covered for three (3) months under this Contract, or under any group policy providing similar benefits that this Contract immediately replaced and whose coverage has been terminated for any reason, including discontinuance of this Contract in its entirety and termination of continued coverage under COBRA, is entitled to apply for a YOUR INSURANCE COMPANY individual conversion policy. YOUR INSURANCE COMPANY must receive the completed conversion application and the applicable Premium payment within the 30-day period beginning on the date the coverage under this Contract terminated.

In the event YOUR INSURANCE COMPANY does not receive the conversion application and the initial Premium payment within such 30-day period, the Insured's conversion application will be denied and the Insured is not entitled to a conversion policy.

Additionally, an Insured is not entitled to a conversion policy if:

- 1. The Insured is eligible for or covered under the Medicare program;*
- 2. The Insured's coverage under this Contract terminated because the Insured's Certificate holder failed to make any Premium contribution payment on a timely basis;*
- 3. this group Contract was replaced by any group policy, contract, plan, or program, including a Self-insured plan or program, that provides benefits similar to the benefit provided under this Contract; or*
- 4. a. the Insured is covered under any Hospital, surgical, medical or major medical policy or contract or under a prepayment plan or under any other plan or program that provides benefits which are similar to the benefits provided under this Contract;*
 - b. the Insured is eligible, whether or not covered, under any arrangement of coverage for individuals in a group, whether as an insured, uninsured, or partially insured basis, for benefits similar to those provided under this Contract; or*
 - c. benefits similar to the benefits provided under this Contract are provided for or are available to the Insured pursuant to or in accordance with the requirements of any state or federal law (e.g., COBRA, Medicaid); and*
 - d. the benefits provided under the sources referred to in paragraph 4a or the benefits provided or available under the source referred to in paragraph 4b and c above, together with the benefits provided by YOUR INSURANCE COMPANY's conversion policy would result in over insurance in accordance with YOUR INSURANCE COMPANY's over insurance standards, as determined by YOUR INSURANCE COMPANY.*

It is the sole responsibility of the Insured to exercise this conversion privilege by submitting a YOUR INSURANCE COMPANY conversion application and the initial Premium payment to YOUR INSURANCE COMPANY on a timely basis. The conversion policy may be issued without evidence of insurability and shall be effective the date the individual's coverage under this contract terminates.

MEDICARE SECONDARY PAYER PROVISIONS

If an employee becomes eligible for Medicare, and continues to be eligible to be covered under the contract, the benefits of the Group policy are primary and Medicare is secondary. The

person insured can elect Medicare as primary, in which case the Group policy becomes secondary. For larger groups, there are provisions for employees who are covered under Medicare disability, and for those working employees who have end stage renal disease. For disabled employees, Medicare will become primary and the Group becomes primary. If a covered employee who has (will be undergoing) renal dialysis, or have (will) receive a kidney transplant, group coverage will continue primary for 12 months after the start of dialysis, or a month after which the individual has a kidney transplant, or a combination of 2 months after hospital admission if the individual enters the hospital up to 2 months prior to a transplant.

STUDY QUESTIONS

1. A Lifetime Maximum Benefit on a Group COC is
 - A. the amount that the company will pay for any one illness during a lifetime.
 - B. the lifetime maximum amount of benefits that will be paid to the insured employee.
 - C. the amount payable in case of death of the insured employee.
 - D. the maximum hospital charge and the maximum physician's charge, expressed independently, payable over the life of the insured.
2. Normally, the following classes of employees are not eligible for coverage:
 - A. Part-time, temporary or substitute employees.
 - B. A Foster child of the Certificate holder.
 - C. An employee whose job falls within a job classification reported to the insurance company.
 - D. Contract employees.
3. For an employee to be covered under a group health insurance plan,
 - A. the employee must meet all waiting period and full-time employee requirements.
 - B. the employer's Human Resources Department must telephone the insurance company.
 - C. the employee is not required to complete an application.
 - D. the employee must be in excellent health and under age 45.
4. Typically, an Adopted or Foster child may be accepted on the Certificate holder's coverage
 - A. on the first billing date that they are totally the responsibility of the insured.
 - B. on the date of adoption or placement.
 - C. only as an exception with the Employer or Contract holder's approval.
 - D. only by Endorsement with reduced benefits.
5. The Insurance Companies require group premium payments to be on a
 - A. prospective basis.
 - B. retrospective basis.
 - C. cumulative basis.
 - D. preliminary basis.

6. In a typical PPO or POS Group Health plan, before the insurer pays benefits, the Certificate holder must pay
 - A. another monthly premium in advance.
 - B. a deductible every time they go to the doctor.
 - C. only a coinsurance percentage.
 - D. a surcharge billed by the physician.

7. If the Group Health Plan has a Hospital per Admission Deductible, this deductible
 - A. is in addition to the Calendar Year deductible.
 - B. replaces the Calendar Year deductible for hospital admissions.
 - C. also applies for Doctor's office visits.
 - D. is waived after the first hospital admission.

8. Typically, under a Group Insurance Plan, if a late enrollee had employer-based group health coverage from his previous employer,
 - A. the employee cannot be covered for group insurance.
 - B. the insured will have a 12 month pre-existing condition clause on his present (new) insurance.
 - C. the insured will have a 6 month pre-existing condition clause on his present (new) insurance.
 - D. the pre-existing condition will be waived.

9. If a group insured Certificate holder has duplicate insurance under another insurer, the determination of liability is called
 - A. Subrogation.
 - B. Coordination of Benefits.
 - C. Duplication of Effort.
 - D. Duplicate Coverage.

10. If COBRA applies to the Contract holder, an insured may be entitled to continue group health coverage for a limited period of time,
 - A. if the insured meets the requirements, makes a timely election, and pays the proper premiums.
 - B. if the employer pays the proper premiums.
 - C. if the insured elects COBRA within 120 days after separation from the employer.
 - D. for a period not to exceed 90 days.

ANSWERS TO STUDY QUESTIONS

1D 2A 3A 4A 5A 6B 7A 8B 9B 10A



CHAPTER SIX – FEDERAL REGULATIONS OF INTEREST

(HIPAA) HEALTH INSURANCE PORTABILITY ACT OF 1996

H.R. 3103 - Kassebaum/Kennedy

OVERVIEW

The provisions of the Group Health policy illustrated above, does not take into consideration much of the HIPAA legislation. At the time of this text construction, many companies had not affected many of the required changes, and there were questions that had not been answered by the Federal Government. Therefore, provisions as such are not presented in this text, but a review of the Act will demonstrate the changes and additions in benefits as the result of this legislation.

In addition to the effects on Group Insurance, the legislation also addresses portability of individual policies, the introduction of Medical Savings Accounts (MSA), Medicare and Medicaid Fraud, and Administrative simplification of health insurance products. For this purposes of this discussion, references will be made to the role of individual insurance and MSA's (which are individual health insurance products) only.

The following is a summary of this Act's provisions.

Purpose

The purpose of this legislation is "to provide portability and continuity of health insurance coverage in the group and individual markets, to combat waste, fraud and abuse in health insurance and health care delivery, to promote the use of medical savings accounts, to improve access to long-term care services and coverage, to simplify the administration of health insurance."

Portability of Coverage

Group Market

Groups are defined as two or more participants (employees generally). The prime reason for the legislation is portability, which is achieved through limitation on pre-existing condition exclusions. Such limitations are applicable to all group plans and are defined as follows:

- The pre-existing condition must be diagnosed or treated within 6 months of the enrollment date in a plan.
- Exclusion of coverage for the pre-existing condition cannot be for more than 12 months, or 18 months in the case of a late enrollee.
- The time accrued under the pre-existing condition exclusion must be carried from one plan to another (the portability feature), as long as there is not a break in coverage of more than 62 days. The previous coverage can be virtually any coverage, including individual coverage, dependent coverage, *etc.*; a waiting period does not count as a break in coverage.

- Pre-existing condition exclusions may not apply in the case of pregnancies, or for newborns and adopted children who are covered by insurance 30 days from the date of birth or adoption.

Individual Market

GUARANTEED ACCESS AND RENEWABILITY

Group Market

- Insurers who offer coverage in the small group market (2 to 50 employees) in a state cannot exclude a small employer or any of the employer's eligible employees from coverage on the basis of health status. There are certain exceptions, such as lack of financial reserves that causes the insurer not to write any new policies.
- No group health plan, regardless of size, may exclude an employee or other qualified person or dependents from enrollment in the plan on the basis of any of the following health-related factors: health status, medical condition (physical or mental), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability.
- An individual in a group plan cannot be charged, on the basis of any health factor, a premium greater than that charged for a similarly situated individual in the plan. This requirement does not restrict the amount an employer may be charged for coverage under a group plan.
- All group coverage, "large" market or "small" must be renewed. The following exceptions apply: nonpayment of premiums, fraud, violation of participation or contributions rules, discontinuation of market coverage by the insurer, movement outside the service area, or the dropping of association membership.

Individual Market

An insurer providing individual coverage in a state cannot deny coverage to an individual coming off of group coverage. Such an individual, however, must:

- a) Have had previous coverage for at least 18 months;
- b) Not be eligible for other group coverage;
- c) Not have been terminated from previous coverage due to non-payment of premiums, fraud, etc.; and
- d) Not be eligible for or have exhausted, COBRA coverage.

An individual insurer is not required to guarantee issue more than two policies. Those two policies can either be the insurer's two most popular plans, based on premium volume, or a package of lower level and higher level coverage plans based on premium volume, or a package of lower level and higher level coverage plans based on an actuarial average. The latter plans must be covered under a risk adjustment or risk-spreading mechanism.

The guaranteed issue requirement would not apply in a state that has instituted an approved alternative mechanism to provide group-to-individual coverage. Such a mechanism can be, but is not limited to, a risk pool, mandatory group conversion policies, guaranteed issue of one or more individual plans, open enrollment by one or more insurers, or a combination of these or other mechanisms.

The alternative mechanism option can be automatically met through adoption of NAIC models covering high-risk pools, small employers, and/or individual health coverage.

A state will be presumed to have in place an acceptable alternative mechanism as of the July 1, 1997 implementation date H.R. 3103 if the governor notifies the Secretary of Health and Human Services of intent to do so, even though the actual mechanism may not be enacted until January 1, 1998. In other words, there is a grace period that will allow the state additional time for enactment without the guaranteed issue requirement becoming effective.

All individual policies, not just the group-to-individual policies, must be renewed (guaranteed renewability), with the exceptions applicable for group coverage also applicable here.

Overview of HIPAA Mandate Provisions

Pre-Existing Conditions

Effective Date: 7-1-97. Based on date of service, for all fully insured groups in all market segments, and HMOs

Provisions:

- Pregnancy, treatment related to domestic violence, are not subject to pre-existing condition exclusions.
- Use of Genetic information cannot be used in pre-existing condition determinations.
- Can not apply pre-existing condition exclusion period to newborns, if covered within 30 days of birth.
- Can not apply pre-existing condition exclusion period to adopted children, or children placed for adoption, under age 18, if covered within 30 days of the event.

(Following not applicable to individual policies)

- Eliminated “manifested” clauses and only allows for exclusion of pre-existing conditions based on “date treated.”
- Limits the look-back period to 6 months from enrollment date
- Limits pre-existing condition exclusion period “look forward” to 12 months from enrollment date.

Creditable Coverage

Provisions:

Provisions allow for the reduction of the pre-existing condition exclusion period by the creditable coverage under a prior health insurance plan *if there was no break in coverage of more than 62 days.*

Certification of Creditable Coverage

Provisions: (Note: The group may elect to furnish the certificates themselves provided they sign a waiver with their carrier).

Health insurers are required to furnish a certificate of creditable coverage to an individual as follows:

- Certificate provided automatically when individual cancels.
- provide upon the request of an individual at any time while enrolled
- Provide upon the request of an individual within 24 months of losing coverage.
- Offer summary of all members, when whole group cancels.

Anti-Discrimination

Provisions:

- Prohibits establishing rules for eligibility and premium payment based on health status related factors.

Guaranteed Issue

Provisions:

- Requires insurers that offer small group coverage to accept every small employer in the state that applied for coverage. (Consistent with many states current law)

Guaranteed Renewability

Provisions:

- Group insurers must renew policies.
- Individual insurers must renew policies except for coverage made available through associations.
- Exceptions to renewing: Fraud, non-payment, noncompliance with participation requirements, market exit, or service area limitations.

MEDICAL SAVINGS ACCOUNTS

A demonstration program testing the viability of medical savings accounts is provided. Under the program, contributions to an MSA, as well as the interest earned, are tax deductible, but only if a catastrophic health insurance policy is also purchased. The key components and parameters of the demonstration program area as follows:

Those eligible are the self-employed, employers with 50 or fewer employees and their employees (however, if a company expands to up to 200 employees, the company's work force would still be eligible), and those without insurance.

Initial eligibility for MSAs under the demonstration program begins January 1, 1997. A cap of 750,000 is placed on the number of MSA policies or plans that can participate, though the actual number of people covered could be twice that amount or more, depending on the amount of family coverage. In addition, those without insurance coverage or access to coverage through the employer for at least six months would not be counted under the cap, but could not obtain MSAs once the cap is reached.

Catastrophic policies accompanying the savings accounts must have deductibles in the range of \$1500 to \$2250 for individuals, and \$3000 to \$4500 for families. In addition, out-of-pocket expenses could not exceed \$3000 for individuals and \$5500 for families. The policies are typical Major Medical individual insurance policies.

Annual contributions to the MSA will be limited to 65% of the deductible for individuals and 75% for families.

A 15% penalty would be applied to all funds withdrawn from the savings account and used for non-medical purposes. Through age 65, except in cases of death or disability

Those participating in the demonstration will be able to keep their MSAs after the four-year period runs out, but for coverage to extend to the rest of the population, Congress would have to vote to do so.

DEDUCTIBILITY FOR THE SELF-EMPLOYED

Health insurance deductions for the self-employed currently stand at 30%. They will be increased as follows:

1997 - 40%
1998 - 45%
2003 - 50%
2004 - 60%
2005 - 70%
2006 - 80%

C.A.

Mike's decision to leave the employ of Consolidated and acquire his own health insurance, and the effects of HIPAA are illustrated in the C.A. previously. In addition, there are other provisions of interest to Mike.

Now that Mike is self employed and in good health, he may elect to participate in a Medical Savings Account. He would purchase "catastrophe" coverage, defined as a Major Medical Insurance policy with a deductible of \$1500 to \$2250, or combined family deductible of \$3000 to \$4500. (New proposed legislation will reduce the deductible to \$1,000 and combined accordingly). He would set aside 65% of the individual deductible or 75% of the deductible for the family coverage, into a Medical Savings Account. Funds in the MSA that are not used for medical purposes may accumulate tax-free.

In addition, he can deduct 45% of his insurance premium from his taxes as business expense.

MENTAL HEALTH PARITY ACT OF 1996

(Included as Title VII of the VA-HUD Appropriations Bill)

Please refer to provisions regarding group health insurance coverage of mental health above. For groups of 50 or more employees, the Mental Health Parity Act of 1996 was enacted. Many of the large group policies will have Endorsements reflecting this legislation, or will have it as part of their Mental Health Care provisions. Following is a Summary of Final Provisions

- If a group health plan does not have lifetime or annual caps, it cannot impose such caps on mental health benefits.
- If a group health plan includes a Lifetime or annual cap on substantially all medical and surgical benefits, mental health benefits under the plan cannot be subject to a lower cap.
- If different caps are applied to different categories of medical and surgical benefits, the cap applied to mental health benefits must be a weighted average of the aggregate caps.
- The provisions apply only to group plans (ERISA and non-ERISA) for employers with more than 50 employees.
- A plan is not required to offer mental health benefits.
- No standards are imposed on the terms and conditions of mental health coverage, such as the amount, duration, or scope of coverage, the level of cost-sharing, limits on the numbers of visits or days of coverage, or requirements relating to medical necessity.

- Mental health benefits are not defined in this legislation. The definition is left up to the plan. However, the legislation states that mental health does not include treatment of substance abuse or chemical dependency.
- The lifetime or annual cap provisions do not apply if they result in an increase of one percent or more in the cost of the plan.
- The legislation applies to group plans for plan years beginning on or after January 1, 1998. Congress is in essence given a one-year grace period in which to change its mind about the mental health parity requirements or to make modifications.
- The mental health parity requirements sunset after September 30, 2001, for them to continue, Congress would have to pass new legislation.

C.A.

Consolidated's health insurance plan has a limitation on Mental Health benefits (as indicated in prior text). Since their health insurance plan was in force prior to January 1, 1998, this Endorsement would not apply to their plan. However, if they change plans, the new plans must allow Mental Health benefits to be treated the same as any other benefit under the plan, with the exception of alcohol and drug rehabilitation in most jurisdictions.

If, however, by adding this provision to a new health insurance plan, the premium would increase by more than one percent (and it can be actuarially proven), they could resort back to an annual cap.

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996 (NMHPA)

Another Federal Act was enacted in 1996 as a political response to highly publicized early discharges of mothers of newborn children. Signed into law on September 26, 1996, NMHPA provides new protection for mothers and their newborn children with regards to the length of hospital stays following the birth of the child.

This legislation prohibits any insurer/HMO from:

- 1) Denying to a mother or her newborn infant eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the contract for purpose of avoiding the requirements of the NMHPA;
- 2) Providing monetary payments or rebates to a mother to encourage the mother to accept less than the minimum protections available under the law;

- 3) Penalize or otherwise reduce or limit the reimbursement of an attending Provider solely because the attending Provider provided care to an individual participant or beneficiary in accordance with the law;
- 4) Providing incentives, monetary or otherwise, to an attending Provider solely to induce the Provider to provide care to an individual participant or beneficiary in a manner inconsistent with the law; or
- 5) Restricting benefits for any portion of a period within a hospital length of stay required under the law in a manner that is less favorable than the benefits provided for any preceding portion of such stay.

These amendments do not require a mother who is a participant or beneficiary to give birth in a hospital or stay in a hospital for a fixed period of time following the birth of her infant.

STUDY QUESTIONS

1. The primary purpose of the HIPAA legislation is
 - A. to provide portability and continuity of health insurance coverage.
 - B. to shift responsibility for oversight of insurance to the Federal government.
 - C. to add additional taxes to insurance.
 - D. strictly political as it does not accomplish anything.
2. Under HIPAA, time accrued under the pre-existing condition exclusion must be carried from one plan to another
 - A. except in Group to Individual plans.
 - B. if there is a waiting period of 60 days.
 - C. as long as there is not a break in coverage of more than 62 days.
 - D. including Group to Group, Group to Individual, Individual to Group, or Individual to Individual.
3. The same pre-existing condition exclusion provision applicable in the group market is applicable in the individual market,
 - A. provided the group and the individual insurance carriers are the same.
 - B. but only for individuals coming off of group coverage.
 - C. except the individual policy must have a 63 day waiting period.
 - D. except the group must have a 72 day waiting period.
4. An insurer cannot deny coverages to an individual coming off of group coverage, however
 - A. they must meet other requirements, such as exhausting COBRA coverage, etc.
 - B. they can offer any kind of insurance policy that they wish.
 - C. they do not have to offer coverage if the insured is not eligible for other coverage.
 - D. they may increase the premium by any amount that they want and decline female coverage.

5. Under HIPAA, Pregnancy and treatment related to domestic violence
 - A. can be excluded from a conversion policy.
 - B. are subject to pre-existing condition restrictions.
 - C. are not subject to pre-existing condition restrictions.
 - D. must be offered by all policies with full coverage, no deductibles or coinsurance.

6. Under the Mental Health Parity Act of 1996, if a group health insurance policy does not have lifetime or annual limits on benefits for mental health,
 - A. the insurer can impose such limitations in the future.
 - B. it cannot impose any caps on mental health benefits in the future.
 - C. mental health benefits cannot be whatever the insurer determines.
 - D. mental health benefits must be the same as any other benefit.

7. The “Newborns’ and Mothers’ Health Protection Act” provides new protection for mothers and their newborn children with regards to
 - A. Medicare.
 - B. length of hospital stay.
 - C. choice of doctors.
 - D. payment of hospital bills.

8. The Mental Health Parity Act of 1996
 - A. was passed because of the deterioration of the mental health of insurance agents.
 - B. can be sold as a stand alone individual policy.
 - C. requires certain benefits to be included in the plan.
 - D. applies to groups of fifty or more employees.

9. In respect to the Newborn’s and Mother’s Health Protection Act of 1996, which of the following is a true statement:
 - A. This law required that a mother must spend at least 3 days in the hospital following birth.
 - B. An HMO may offer a primary care physician a bonus for each new mother that leaves the hospital within 1 day of birth.
 - C. An insurer may not offer rebates to a mother to encourage her to accept less than the minimum protections available under this law.
 - D. The NMHPA only affects the length of time that a newborn will stay in the hospital.

10. Under Medical Savings Account (MSA) contributions to an MSA
- A. are tax deductible, but not the interest earned.
 - B. and interest earned are tax deductible, provided the individual has purchased a catastrophic health insurance policy.
 - C. are tax deductible, but only in group situations of 25 or more employees.
 - D. are non-taxable.

ANSWERS TO STUDY QUESTIONS

1A 2C 3C 4B 5A 6B 7B 8D 9C 10B

