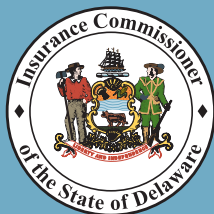


THE INSTANT INSURANCE GUIDE: **HEALTH**



INFORMATION FOR WELL-BEING IN DELAWARE



TRINIDAD NAVARRO
Insurance Commissioner

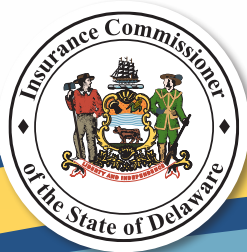
DELAWARE DEPARTMENT OF INSURANCE
302-674-7300 • insurance.delaware.gov

A Message From The Delaware Department of Insurance

The Delaware Department of Insurance has compiled this guide to educate consumers about the different types of health products available, including insurance and non-insurance products. Navigating health plans can be confusing for even the most experienced person. Our goal is to provide concise information about different types of health products, as well as opportunities to access additional resources if needed.

The Affordable Care Act, or ACA, became law in 2010. As a result, changes to health insurance have taken place at both the state and federal level. We will continue to update this guide as often as possible to reflect the latest regulations and guidelines.

The Department of Insurance is here to serve you. If you have questions about health products, or other insurance-related questions not explored in this guide, please contact us.



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302-674-7300



Table of Contents

| | |
|---|----------------|
| Insurance Words and Terms | Page 4 |
| Understanding Types of Plans | Page 5 |
| Changes as a Result of the ACA..... | Page 6 |
| Essential Health Benefits..... | Page 7 |
| Buyer Beware | Page 8 |
| Other Coverage Options..... | Page 9 |
| Ways to Save..... | Page 10 |
| Problems With Claims | Page 11 |
| Keeping Health Coverage | Page 12 |
| Fraud; Self-Funded Plans | Page 13 |
| Need Help? | Page 14 |
| Notes..... | Page 15 |
| Dept. of Insurance Contact Information (Back cover) .. | Page 16 |

Disclaimer: The Delaware Department of Insurance makes every attempt to provide accurate and up-to-date information. If you need further clarification with any health questions we suggest you call your insurance provider or our office. This guide is not a substitute for legal or professional advice. Information may change without notice.

Insurance Words and Terms

Affordable Care Act (ACA): The most common formal name for the health care reform law passed by Congress in 2010. Commonly called Obamacare.

Catastrophic Plan: Plans that have a high deductible. Benefits are paid only after the deductible has been paid by the consumer. In most cases in Delaware, these plans can only be purchased by individuals who are under 30 years old.

Co-insurance: The percentage that the insurance company and consumer pays for covered services after the plan deductible has been met. For example, when a plan has an 80%/20% co-insurance, the insurance carrier will pay 80% of the allowed amount and the consumer will pay 20% of covered expenses. The co-insurance percentage will vary by service and/or plan.

Co-payment: A set dollar amount paid when receiving specific services. Co-pays generally do not apply to deductibles, co-insurance or the out-of-pocket maximum. Not all services require a co-pay.

Deductible: The amount a consumer must pay for health care services covered by the health insurance plan before the insurance company begins to pay. For example, if a deductible is \$1,000 the plan will not pay anything until the consumer has met the \$1,000 deductible for covered health care services. The deductible may not apply to all services.

Out-of-Pocket Costs: Expenses for medical care that include deductibles, co-insurance, and co-payments for covered services.

Out-of-Pocket Limit/Maximum: The maximum amount you may pay for medical services in a calendar year which may or may not include the deductible, depending on your plan. Once a person reaches the out-of-pocket maximum the health plan will pay 100% of charges for all covered services for the remainder of the year. However, the insured may still be required to pay applicable co-pays. The maximum amount of money may vary depending on whether the services you receive are in or out-of-network.

Premium: The amount that must be paid for a health insurance plan. Usually paid monthly, quarterly or yearly.

Understanding Types of Plans

Many medical plans typically cover a comprehensive array of health care needs, including doctors' visits, drugs and hospital care. These benefits can be delivered in several different ways:

Indemnity plan. These medical plans typically have a deductible – the amount you pay before the insurance company begins paying benefits. After your covered expenses exceed the deductible amount, benefits usually are paid as a percentage of actual expenses, often 80 percent. These plans usually provide the most flexibility in choosing where to receive care.

Preferred Provider Organization, or PPO. In these medical plans, the insurance company enters into contracts with selected hospitals and doctors to furnish services at a discounted rate. As a member of a PPO, you may be able to seek care from a doctor or hospital that is not a preferred provider, but you will probably have to pay a higher deductible or co-insurance.

Health Maintenance Organization, or HMO. These medical plans make you choose a primary care physician (PCP) from a list of network providers. Your PCP is responsible for managing all of your health care. If you need care from any network provider other than your PCP, you may have to get a referral from your PCP to see that provider. You must receive care from a network provider in order to have your claim paid through the HMO. Treatment received outside the network is usually not covered, or covered at a significantly reduced level.

Point of Service, or POS. These medical plans are a hybrid of the PPO and HMO models. They are more flexible than HMOs, but do require you to select a primary care physician. Like a PPO, you can go to an out-of-network provider and pay more of the cost. However, if the PCP refers you to an out-of-network doctor, the health plan will pay the cost if the insurance plan has authorized the referral.

Changes as a Result of ACA

The Affordable Care Act (ACA), also known as Obamacare or simply as “federal health reform”, was signed in to law in 2010, provisions included in the ACA are intended to expand access to health insurance, increase consumer protections and coverage, and emphasize prevention and wellness.

Some of the law’s protections went in to force in 2010 but as of January 1, 2014 all new insurance plans will be required to offer the following minimum benefits and protections. For an extensive list of protections see healthcare.gov.

- **For all adults and children, you can no longer be denied coverage by an insurance company for having a pre-existing condition.**
- **Your insurance company can no longer place a lifetime dollar limit on your coverage.**
- **Your insurance company can no longer place low annual dollar limits on your coverage.**
- **You can no longer be dropped from coverage by your insurance company because you get sick.**
- **Children can stay on their parent’s health plan until the age of 26, under certain conditions. Ask your employer or insurer for details.**
- **There are no out-of-pocket costs for key preventive health services and all plans must cover ten essential health benefits (See description of benefits on page 5). Note: You may still be responsible for an office co-payment for the actual visit.**
- **Your insurance company must now spend at least 80% of your premium covering medical services.**
- **Insurers are prohibited from dropping or limiting coverage because an individual chooses to participate in a clinical trial.**
- **Women can no longer be denied coverage due to pregnancy.**

Essential Health Benefits

Essential Health Benefits: The Affordable Care Act sets certain standards that all insurers must meet, and mandates that all health plans offered to those who buy health insurance on their own or in small groups include a set of “essential health benefits,” which are listed below.

- **Emergency services**
- **Hospitalizations**
- **Laboratory services**
- **Maternity care**
- **Mental health and substance abuse treatment**
- **Outpatient, or ambulatory, care**
- **Pediatric care**
- **Prescription drugs**
- **Preventive care**
- **Rehabilitative and habilitative (helping maintain daily functioning) services**
- **Vision and dental care for children (up to age 19)**

Grandfathered Health Plans: A grandfathered health plan isn't required to meet all of the standards of new plans or comply with some of the consumer protections of the Affordable Care Act. If you are covered by a health plan that existed before March 23, 2010 your plan may be considered a “grandfathered” plan. This is true whether you are covered by an individual health insurance policy that you had on that date, or you are covered by a job-based health plan that your employer first established before March 23, 2010. This is true even if you enrolled in that job-based plan after March 23, 2010.

How do I know if I have a grandfathered health plan? The easiest way to find out if you have a grandfathered plan is to call your insurance company or ask your HR department, if you have the insurance through your employer.

Buyer Beware

As a general rule, if an offer seems too good to be true—it probably is.

Discount Plans or Discount Cards: You may see or receive advertisements from plans offering discounts on health care for a monthly fee. These are not health insurance plans, and participants do not have the same protections as under licensed, major medical health insurance.

Some of the discount cards use high-pressure marketing tactics and ask for a large, up-front fee. They are often advertised via spam emails, internet popup ads, on roadside signs or on telephone poles. The Delaware Department of Insurance strongly recommends that you thoroughly investigate any plan promising deep discounts for a “low” monthly fee and weigh the benefits against the costs carefully.

Non-Licensed Risk-Sharing Plans: You may receive offers to join a group or association that will take your monthly payments, put them in a savings account, or trust, with other participants' money, and then help pay some of your health care costs, as needed.

Such arrangements are not insurance and the participants do not have the protections available to purchasers of licensed insurance plans. The Delaware Department of Insurance strongly recommends that you thoroughly investigate such plans before joining.

Supplemental Plans: Limited benefit plans such as those covering only dental or vision and plans that offer discounts on medical services are available but do not provide full health coverage.

Other Coverage Options

Additional coverage options provide added protection should you become disabled, require long-term care or enroll in Medicare:

- **Disability Income** provides for weekly or monthly benefit payments while you are disabled after a covered injury or sickness.
- **Long-Term Care Insurance** usually pays for skilled, intermediate and custodial care in a nursing home as well as care in other settings, such as the home, adult day care center or assisted living facility. The policy usually pays a fixed amount per day while a person is receiving care.
- **Medicare Supplemental Coverage:** The federal Medicare program pays most medical expenses for people 65 or older, or for individuals under 65 receiving Social Security disability benefits. However, Medicare does not pay all expenses. As a result, you may want to buy a Medicare Supplement policy (also known as Medigap) to help pay for certain expenses, including deductibles not covered by Medicare.

Ways to Save

- **Subsidies may be available**, depending on your family size and income, for the health plans that are offered through [healthcare.gov](https://www.healthcare.gov). Individual plans that are not offered through the Health Insurance Marketplace, [healthcare.gov](https://www.healthcare.gov), do not qualify for federal subsidies.
- Check to see if your employer offers a **flexible spending account**. These plans, which allow you to set aside pre-tax dollars for medical expenses and childcare, are a good way to reduce your out-of-pocket medical costs.
- Many plans offer a menu of options. Review your situation regularly, and **adjust your options** to meet changing needs.
- **Stay in your network** as much as possible, making sure to obtain referrals as required.
- Many plans require **pre-certification** for certain tests and procedures. Know your plan, and make sure you comply with these requirements to avoid paying penalties.
- **Hold on to all receipts** for medical services. Even though your intent may be to always stay in-network, you never know when an accident, out-of-town emergency room visit or unexpected illness might cause you to incur out-of-pocket expenses that exceed even a high deductible.
- Finally, consider combining a high-deductible plan with a **Health Savings Account**, or HSA. An HSA is earmarked for medical expenses. Deposits are tax-deductible for the self-employed and can be easily withdrawn by check or debit card to pay routine medical bills with tax-free dollars. Larger medical expenses are covered by the high-deductible health insurance policy.

Problems With Claims

Before you make a claim: Review your summary of benefits and coverage carefully to be sure the service in question is covered. Follow any managed care rules, including pre-certification requirements and use of network providers.

To submit a claim properly: Find out if your provider submits the claim for you or if you need to do it. If you are required to file a claim, review the information to be sure it is complete and correct. Send the claim to the right address and make sure to keep a copy for your reference. Be aware of timely filing requirements.

Time frame for claims: Delaware's "Prompt Payment" regulation basically requires the insurance company to pay a claim, reject it or ask for more information within 30 days. It also requires that a health insurance company only ask for additional information once, rather than repeatedly making requests. The company must send you an explanation of benefits that explains its decision. The prompt payment regulation does not apply to other types of insurance such as dental, vision, or hearing.

If your claim is paid: If you assigned benefits to the provider, the benefit check will be sent directly to the provider. If you did not assign the benefits, the check will come to you and you will need to pay your providers for the entire amount.

If your claim is denied: The reason for denial should be stated on your explanation of benefits. If you disagree with the basis stated for denial, check your summary of benefits and coverage for the company's appeal procedures. The company should be able to answer procedural questions about appeals over the phone. Your appeal should be in writing and may require information from your doctor or health care provider.

If, after going through the company's appeal process, you feel that your claim was unfairly denied, contact the Insurance Commissioner's Office at consumer@delaware.gov or call 1-800-282-8611.

Keeping Health Coverage

There is a way you may keep your health coverage for a period of time when you leave a job. The first step is to figure out if you qualify for "COBRA".

COBRA (which stands for the Consolidated Omnibus Budget Reconciliation Act) is a federal law that allows you to extend your current group health insurance coverage when you leave a job, are fired from a job (for reasons other than fraud or misconduct), are reduced from fulltime to part-time status, or another "qualifying event" occurs. You can extend the coverage—at your cost—for 18 months, and sometimes longer. PPOs, HMOs, indemnity policies and self-insured plans are all subject to COBRA. Employers with 20 or more employees are usually required to offer COBRA coverage and to notify their employees of the availability of such coverage. COBRA applies to plans maintained by private-sector employers and sponsored by most state and local governments.

If you leave a job and use COBRA to continue your health coverage, you will still have the same plan with the same benefits and provisions, but you will pay much more for it. That's because your employer was paying part of your premium before and now you will be responsible for paying all of the premium. Ask your employer's human resources staff if you are eligible for COBRA. Be mindful that this process is time-sensitive.

Mini-COBRA: House Bill 170, the Mini-COBRA Law, was signed in to law by Governor Markell on May 22, 2012. The bill amends Title 18 of the Delaware Insurance Code relating to group health insurance. This bill requires insurers to offer to otherwise ineligible employee's mini-COBRA coverage for small-employer plans. Under this new legislation, individuals who have lost their employment and health insurance may qualify for continuation of health insurance coverage for nine months (as long as the employer is still offering health insurance to their active employees). The Delaware mini-COBRA law applies to insured plans of employers that normally employed between 1 and 19 full-time employees on a typical business day during the preceding year. Continuation coverage is available for medical coverage only.

Fraud; Self-Funded Plans

Protect your personal information from fraud: The federal government does not make unsolicited phone calls and generally does not conduct business via e-mail. Nor should you assume any text message or fax that says it's from a government agency is credible. Never give out any information to unsolicited callers. This includes: medical (health history or Medicare account numbers), personal (Social Security number, birthdate), or financial (checking or credit card account numbers) information.

If anyone calls you and tells you that "you must act now" to keep your coverage simply hang up the phone. Don't rely on caller ID. Some scammers are able to display a company's name or phone number on the caller ID screen.

You can always call the Department of Insurance if you are not sure if an offer or a call to action is fraudulent or legitimate.

Plans not regulated by the Delaware Department of Insurance: While many health insurance plans are regulated by the Department of Insurance, some are not. For example, **self-funded employee benefit plans** are those that are funded by an employer rather than through a health insurance company and are regulated by the US Department of Labor, Employee Benefits, Security Administration (EBSA). To contact the Dept. of Labor EBSA call 1-866-444-3272 or visit www.dol.gov/ebsa.

How do I know if I have a self-funded plan? The easiest way to find out if you have a self-funded plan is to ask your HR department. You can also call the phone number listed on your health benefits card and ask the customer service department.

Need Help?

Medicare, Medicare Part D, Medigap and Long-Term Care Insurance

Information and tips on Medicare, Medicare Part D, Medigap policies, longterm care insurance and other issues affecting seniors are also available on the website and from the Delaware Medicare Assistance Bureau (DMAB).

The latest version of the Medicare Supplement Insurance Shopper's Guide is available online at insurance.delaware.gov/dmab. Or, to have one sent to you, please call DMAB directly at 1-800-336-9500.

The Delaware Insurance Commissioner's Office does not run the state's Health Insurance Marketplace, www.choosehealthde.com. The answers to questions related to the Health Insurance Marketplace, including the plans that are offered, subsidies, taxes and all others can be found on the Marketplace website at www.choosehealthde.com or by calling 1-800-318-2596.

ChooseHealthDE.com

Consumers are encouraged to visit the website and read the frequently asked questions (FAQs) and, if applicable, fill out an application. With one application, you can learn if you qualify for lower costs based on your income, compare your coverage options side-by-side, and purchase a plan that best meets your needs. If you need help with this process there are Marketplace Guides available to assist you, free-of-charge.

The federal Health Insurance Marketplace website, www.healthcare.gov, also contains an abundance of information about the Affordable Care Act. Please note that if you decide to obtain a health insurance plan through the Marketplace you will be re-routed from www.choosehealthde.com to the federal website, www.healthcare.gov

To access Delaware's Health Insurance Marketplace visit www.choosehealthde.com

To access the Federal Health Insurance Marketplace website visit www.healthcare.gov or call 1-800-318-2596.

Use this space for notes or questions for your agent or Consumer Services staff:

Insurance Commissioner's Office

The Delaware Insurance Commissioner's Office is here to help if you have questions about or problems with your insurance coverage or insurance company.

Questions about insurance or complaints about an insurance company or insurance agent can be made to the Consumer Services division by phone, by fax, by letter, by email or with an online complaint form:

**Phone: 1-800-282-8611 (Toll-free in Delaware)
or 302-674-7300**

Fax: 302-739-6278

Email: consumer@delaware.gov

**1351 W North St STE 101.
Dover, DE 19904**

Visit the Delaware Department of Insurance website to find more information and tips about health insurance and the services we provide at **insurance.delaware.gov**

"Protecting Delawareans through regulation and education while providing oversight of the insurance industry to best serve the public."

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302-674-7300**