Health Maintenance Organization

A Guide for Consumers

PRINTED 4/02

The Florida Department of Insurance

Are You Prepared

Contents

You may obtain this guide in alternative formats such as audiotape or large print by calling our Insurance Consumer Helpline toll-free at 1-800-342-2762. You may also download this guide through the Internet at http://www.fldoi.com; Telecommunications Device for the Deaf (TDD) users may obtain it by calling 1-800-640-0886.

DOI Publications

Printed 4/02

Dear Consumer:

The need for insurance is a fact of life in many situations. Knowing how our insurance policies work, in addition to having the correct type and amount of insurance, can help us recover financially when we experience such things as illness, car accidents, natural disasters or even death. And since the insurance industry and insurance policies often change, it's essential to be aware of new developments.

The Florida Department of Insurance publishes a variety of consumer guides to help you in this task. They include: *Automobile Insurance* (also available in Spanish), *Life and Annuities, Small-Business Owner's Insurance, Insuring Your Home, Health Maintenance Organization, Long-Term Care and Other Options for Seniors* and *Medicare Supplements.* Each guide contains basic information, definitions of common terms and tips on selecting an insurance agent and company. Each guide also details your rights and responsibilities as an insurance consumer. You can have any of our guides sent to you by filling out and mailing the order form at the back of this guide, or by calling the Florida Department of Insurance Consumer Helpline toll-free at 1-800-342-2762.

If you have questions after reading this guide, please call our Insurance Consumer Helpline toll-free at 1-800-342-2762 between 8 a.m. and 4:45 p.m. Monday through Friday. The hearing impaired may use a TDD to call 1-800-640-0886. You may also contact the service office in your area (listed inside the back cover of this guide).

Sincerely,

Tom Gallagher
Florida's Treasurer, Insurance Commissioner
and State Fire Marshal

If you have an insurance question or problem, call the:

INSURANCE

CONSUMER *Helpline*

1-800-342-2762

TDD Users Only

Telecommunications **D**evice for the **D**eaf

1-800-640-0886

Internet

Browse the Florida Department of Insurance Web site at:

www.fldoi.com

Service Offices

DAYTONA BEACH
955 Orange Ave., Suite E
Daytona Beach, FL 32114-4674
(386) 254-3920

FORT LAUDERDALE
499 N.W. 70th Ave.
Suite 301B
Plantation, FL 33317-7574
(954) 327-6027

FORT MYERS
2295 Victoria Ave.
Suite 163
Fort Myers, FL 33901-3867
(941) 332-6948

JACKSONVILLE
9000 Regency Square Blvd.
Suite 201
Jacksonville, FL 32211-8100
(904) 727-5505

MIAMI
401 N.W. 2nd Ave.
Suite N-307
Miami, FL 33128-1700
(305) 377-5235

ORLANDO
400 W. Robinson St.
Suite N-401
Orlando, FL 32801-1794
(407) 245-0870

PENSACOLA
160 Governmental Center
Suite 515
Pensacola, FL 32501-5739
(850) 595-8040

ST. PETERSBURG LARGO
11351 Ulmerton Road
Suite 240
Largo, FL 33778-1636
(727) 588-3638

TALLAHASSEE
Larson Building
200 E. Gaines St.
Tallahassee, FL 32399-0323
(850) 413-3132

TAMPA
5309 E. Fowler Ave.
Tampa, FL 33617-2221
(813) 987-6741

WEST PALM BEACH
400 N. Congress Ave.
Suite 210
West Palm Beach, FL 33401-2913
(561) 681-6392

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Health Maintenance Organization (HMO)

A **health maintenance organization**, or HMO, is an alternative to health insurance that has grown in popularity during the past 20 years. In simple terms, you pay a fixed membership fee in advance (usually once a month) for a wide range of health care services (such as preventive care, hospitalization and surgery) with the HMO's approved providers in the designated service area. The service area of an HMO is usually limited to an individual county.

How an HMO Works

HMO members must use the HMO's doctors and facilities. HMOs may provide services at more than one location, with a variety of doctors, assistants and technicians. The doctor you choose is called your **primary care physician** (often referred to as a "gatekeeper"). Your primary care physician usually oversees all your medical treatments and referrals.

Once you join an HMO, you will receive a contract, certificate or member handbook. Read these documents carefully to learn how your HMO works. The material will include an explanation of the services, benefits, exclusions and limitations of your coverage. Although most of your interactions with your HMO will probably be routine, unusual situations can arise.

Specialized Treatment

If you need an examination and/or treatment not provided by your primary care physician, he or she must refer you to an approved specialist.

Emergency Situations

If you or a family member require emergency medical treatment, you must follow the procedures outlined in your member handbook in order to receive benefits. The procedures you must follow may be different if you require emergency treatment outside your HMO's local service area. Read and understand the emergency guidelines established by your HMO before an emergency occurs.

If you are outside of your service area and have a medical emergency, always contact your HMO as soon as possible so they have a record of your situation. Make sure you keep a record of the emergency, as well. The record should include:

- a description of the accident, illness or symptoms;
- the names and titles of medical personnel involved;
- the name and title of the person who authorized or obtained authorization from the HMO; and
- a summary of the initial diagnosis.

This information can be helpful if there is any dispute regarding the billing.

Your Eligibility Status

Your ability to join or remain in an HMO depends on:

- the availability of an HMO in your area;
- the payment of your monthly membership fee;
- your age — for example, if you are no longer considered a dependent as defined in the contract, you may be removed from your parent's HMO coverage; and
- whether you have fraudulently misused your membership card or the HMO services.

If Your Group Contract is Canceled

If, for some reason, the HMO decides to cancel your group contract, you should be able to convert your HMO membership benefits into individual coverage. The HMO's consumer representative or administrator can assist you with this process.

Point-of-Service Products

It is commonplace for employers to offer a **point-of-service product** for their employees. This is a combination of traditional insurance coverage and HMO coverage that allows you to select the type of coverage you want for certain illnesses or health care needs.

You can choose to stay in the HMO network and generally have lower out-of-pocket expenses, or you can choose to use the more traditional health insurance product. The traditional health insurance product enables you to choose your own physicians and providers, but your out-of-pocket expenses may be significantly higher, and you are no longer entitled to use the HMO's grievance procedure.

Also, by having point-of-service coverage, you have two plans (an HMO contract and an insurance policy) and two carriers (an HMO and an insurance company), although you only have to pay one premium.

Certain HMOs are now authorized to offer, as a rider, a point-of-service benefit where HMO

members may choose to receive certain services from a provider that does not have a contract with the HMO. A referral for such services is not required.

Who is Eligible to Join?

HMOs specify their service areas and member eligibility requirements in their contracts. These vary among HMOs.

Common Eligibility Factors:

- Where you live — HMOs require you to live in a county they serve, but not all Florida counties are served by HMOs.
- Your associations — Some HMOs will only accept members through a group or organization, such as an employer. Others may accept individuals.
- Your current benefits — If you are covered by Medicare or Medicaid and wish to join

an HMO, the HMO you join must have a contractual arrangement with the federal Medicare program or state Medicaid program.

How Do I Shop for an HMO?

Contact the HMOs in your area and compare them as you would when you shop for other products.

- Ask about services, physicians and costs. Find out if dental and optical care options are available.
- Ask your friends and neighbors about their HMO experiences.
- Ask about the HMO's policies for treating pre-existing medical conditions.
- Request an outline of coverage from the HMO.
- Find out when you can start receiving health care services.
- Verify licenses. Call the Insurance Consumer Helpline toll-free at 1-800-342-2762 to verify that an HMO is licensed by the Department.

Weighing the Facts

Expenses:

- HMO co-payments are usually less than traditional health insurance deductibles and are easier to budget.
- Other than co-payments and membership fees, HMO members have no other out-of-pocket expenses to providers (doctors, hospitals, pharmacies, etc.) for covered services.
- Medicare recipients who subscribe to HMOs may have lower out-of-pocket expenses than those with the traditional combination of Medicare and Medicare supplement insurance.
- Some HMOs provide prescription drugs at reduced costs.

Services:

- HMOs may provide wellness and prevention programs.
- HMOs cover routine medical visits.
- HMOs offer physician's visits, lab tests, X-rays and other medical services.
- A large portion of your health care expenses are paid directly by the HMO, whereas some traditional health insurance

policies only reimburse you for the cost of medical care after you have paid for the services, products or treatments.

- Some HMOs provide examinations by nurse practitioners or physician assistants who are under the supervision of doctors.

- HMOs do not require members to complete claim forms.

Limitations:

- An HMO member must use the HMO's network of providers (physicians, pharmacies, hospitals, etc.). Failure to obtain permission to use a specialist or "non-contracted" provider may cause the HMO to limit or deny benefits. You may be liable for these expenses.

- Those who travel a great deal or want to cover dependents who live outside an HMO's service area may not find it convenient to use an HMO. (If you have a dependent in an out-of-state college, you may want to find out if the school offers health care coverage you can purchase for your son or daughter.)

Laws and Regulations that Affect HMO Members

A number of laws and regulations protect HMO members by ensuring they receive quality care. Other measures ensure that HMOs stay financially sound.

Licensing

Florida law mandates that HMO sales representatives be qualified and licensed. This requires that they meet certain educational and licensing requirements. Call the Insurance Consumer Helpline toll-free at 1-800-342-2762 to verify that a sales representative is licensed.

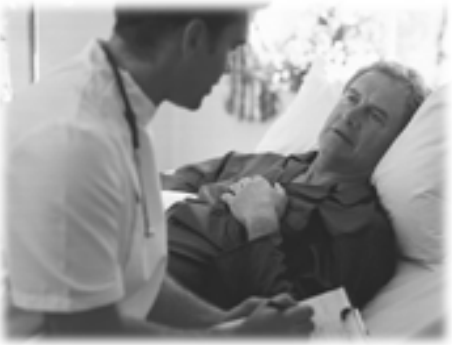
Where to Turn for Help

If you have a problem with your HMO, help is available. If the problem involves billing or enrollment, call the Insurance Consumer Helpline toll-free at 1-800-342-2762. If the problem involves a quality of care issue, call the Agency for Health Care Administration toll-free at 1-888-419-3456.

If you have not filed a complaint directly with the HMO's internal grievance coordinator, follow the procedure outlined in your policy. The internal grievance procedure is outlined in your HMO handbook. Once the internal complaint is filed, the HMO has 60 days to respond to or correct the problem.

If after 60 days the problem has not been resolved, you can appeal to the Statewide Provider and Subscriber Assistance Program panel. This six-member panel consists of three representatives from the Department of Insurance and three representatives from the Agency for Health Care Administration. The panel reviews the grievances and recommends the appropriate action to resolve the problem. For further information, call the Agency for Health Care Administration toll-free at 1-888-419-3456.

Note: If the grievance is about coverage or payment for Medicare beneficiaries, the administrative appeals procedure is available through the Centers for Medicare and Medicaid Services (CMS). For more information, call CMS at (404) 562-7500, or call the Insurance Consumer Helpline toll-free at 1-800-342-2762.



Quality Control

Health Care

The Agency for Health Care Administration is responsible for controlling the quality of health care provided by HMOs. AHCA conducts

periodic reviews of HMOs to ensure they are maintaining an adequate network of qualified, certified and licensed providers who render health care services to members.

If you have a question or a complaint regarding the quality of health care you receive, including specific complaints concerning the conduct of doctors employed or contracted by your HMO, write to:

Agency for Health Care Administration
Managed Care Unit
2727 Mahan Drive
Tallahassee, FL 32308

You may also call the Agency for Health Care Administration's toll-free HMO Hotline at 1-888-419-3456.

Protection Against Insolvent HMOs

The Florida Department of Insurance is charged with monitoring and regulating the financial activities of HMOs in the state to ensure financial solvency. Each HMO is required to file quarterly and annual financial statements with the Department. However, there are safeguards to help protect consumers against HMOs that become bankrupt or insolvent.

Consumer Assistance Plan

This plan guarantees that members of an insolvent HMO continue to receive health care coverage for up to six months. It helps members enroll in another HMO within the same geographical area so that benefits are

continued. The plan is funded by all licensed HMOs and is administered by a board of directors representing HMOs licensed in Florida, but the Department of Insurance oversees the plan.

Insolvency Deposit

HMOs must place a deposit with the Department of Insurance to protect consumers in the event the HMO becomes insolvent.

Protection Against Unpaid Bills

If an HMO becomes insolvent, Florida's "hold harmless" law protects consumers from being billed for services that are the responsibility of the HMO.

HMOs and Medicare

Some senior citizens choose to enroll in a Medicare HMO instead of relying on a combination of Medicare and Medicare supplement insurance. However, there may not be a Medicare HMO operating in your county. (See page 45 for a list of approved Medicare HMOs by county.) If a Medicare HMO is available in your county, consider all the risks and effects involved before you make this decision.

- Except for beneficiaries with end-stage renal disease, or those in need of kidney dialysis, Medicare HMO applicants cannot be screened for pre-existing conditions.

- Door-to-door solicitation by Medicare HMOs is not allowed.

- Medicare members have specific rights to appeal denials of services or payments.

- Medicare has specific rules that require prompt written notification of the effective date of enrollment.

- If you are a frequent traveler or live part time in another state, be aware that HMOs restrict coverage outside their primary service area (usually a single county).

- If you have been accepted into an HMO's Medicare program, and you wish to leave or "disenroll" from the program, the HMO or your local Social Security office will assist you with the necessary paperwork. Be sure to keep a copy of the disenrollment forms for your records.

- Remember that you are "locked-in" to the HMO rules and restrictions, except for emergency or urgent care, until the effective date of change or disenrollment.

For more information on Medicare HMOs, contact your local Social Security office.

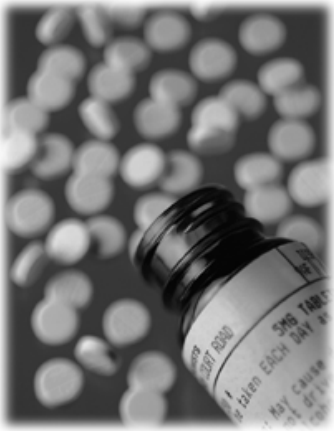
Medicare HMO Appeals

Members of Medicare HMOs have the right to appeal any decision about their Medicare services.

You can file an appeal if your plan does not allow, will not pay for, or stops a service that you think should be covered or provided. If you think your health could be harmed by waiting for a decision about a service, ask the plan for a quick decision. The plan must answer you within 72 hours.

The Medicare HMO must tell you in writing how to appeal. After you file an appeal, the plan will review its decision. If your plan does not decide in your favor, the appeal is then reviewed by an independent group that works for Medicare, not for the plan.

For more information about your Medicare HMO appeal rights, refer to your Medicare membership materials, or contact your plan.



Health Plan Coverage Requirements

The following pages alphabetically list specified benefit requirements in Florida for different types of private insurer and HMO health plans as of June 2001.

EPO ..... Exclusive Provider Organization
PPO ..... Preferred Provider Organization
PCP ..... Primary Care Provider
Note ..... These benefits could be provided by the contract or required by federal law. However, if you are making your purchase decision based on the need for these specific benefits, check with your insurance agent to be sure YOUR policy provides them.

***** Certain insurance plans marketed to individuals in Florida do not provide all the listed benefits. Such individual plans are offered through group associations and are governed by states other than Florida.

INSURER HEALTH PLANS

Q: Covered on Insurer & HMO Health Plans? Health Benefit	Individual		Small Employer (Basic/Standard plans)	Large or Other Small	
	Insurer*	HMO*		Insurer	HMO
1. Acupuncturists	Yes	Note	Yes	Yes	No
2. Ambulatory surgical centers	Yes	Note	Yes	Yes	No
3. Birthing centers	Yes	Yes	Yes	Yes	Yes
4. Bone marrow transplant procedures must include donor-patient	Yes	Yes	No (limited coverage-standard)	Yes	Yes

INSURER HEALTH PLANS *continued*

Q: Covered on Insurer & HMO Health Plans? Health Benefit	Individual		Small Employer (Basic/Standard plans)	Large or Other Small	
	Insurer*	HMO*		Insurer	HMO
5. Bone marrow transplants	Yes	Yes	No (limited coverage-standard)	Yes	Yes
6. Cancer: certain rarely used cancer drug therapies	Yes	Note	No	Yes	No
7. Children: adopted and foster	Yes	Yes	Yes	Yes	Yes (adopted children)
8. Children: handicapped children services	Yes	Yes	Yes	Yes	Yes
9. Children: newborn	Yes	Yes	Yes	Yes	Yes
10. Children: well-child care	Yes	Yes	Yes	Yes	Yes
11. Chiropractors	Yes	Yes	Yes	Yes	No
12. Cleft palate	Yes	Yes	Yes	Yes	Yes
13. Continuity of care from same provider, for up to six months, or through postpartum care, if pregnant, if a provider leaves an HMO network	No	Yes	No	No	Yes
14. Conversion to non-group	Yes	Yes	Yes	Yes	Yes

INSURER HEALTH PLANS *continued*

Q: Covered on Insurer & HMO Health Plans? Health Benefit	Individual		Small Employer (Basic/Standard plans)	Large or Other Small	
	Insurer*	HMO*		Insurer	HMO
15. Dental treatment: general anesthesia and hospitalization	Yes	Yes	No	Yes	Yes
16. Dependent coverage	Yes	Yes	Yes	Yes	Yes
17. Dermatologists: access to care	Yes	Yes	No	Yes (EPO/ PPO)	Yes
18. Diabetes treatment	Yes	Yes	Yes	Yes	Yes
19. Emergency room screening coverage for non-emergencies	Note	Yes	Note	Yes (EPO)	Yes
20. Enteral feeding supplies	Yes	No	No	Yes	No
21. Extension of benefits	No	No	Yes	Yes	Yes
22. HIV protections	Yes	Yes	Yes	Yes	Yes
23. Home health care services	No	No	Yes	Yes	No
24. Mammogram coverage	Yes	Yes	Yes	Yes	Yes
25. Massage	Yes	Note	No	Yes	No
26. Mastectomy: coverage for prosthetic devices and breast reconstructive surgery incident to a mastectomy	Yes	Yes	Yes	Yes	Yes

INSURER HEALTH PLANS *continued*

Q: Covered on Insurer & HMO Health Plans? Health Benefit	Individual		Small Employer (Basic/Standard plans)	Large or Other Small	
	Insurer*	HMO*		Insurer	HMO
27. Mastectomy: length of stay	Yes	Yes	Yes	Yes	Yes
28. Mastectomy: outpatient	Yes	Yes	Yes	Yes	Yes
29. Maternity care: length of hospital stay	Yes	Yes	Yes	Yes	Yes
30. Maternity care: nurse-midwives/midwives	Yes	Yes	Yes	Yes	Yes
31. Maternity care: post-delivery	Yes	Yes	Yes	Yes	Yes
32. Mental/nervous disorders: optional coverage	No	No	Yes (different limits)	Yes	Yes
33. OB/GYN: access to care	Yes	Yes	No	Yes (EPO)	Yes
34. Ophthalmologists	Yes	Yes	Yes	Yes	Yes
35. Optometrists	Yes	Yes	Yes	Yes	Yes
36. Osteopathic hospitals	Yes	Yes	Yes	Yes	Yes
37. Osteoporosis diagnosis and screening	Yes	Yes	No	Yes	Yes
38. Out-of-hospital services	Yes	Yes	Yes	Yes	No

INSURER HEALTH PLANS *continued*

Q: Covered on Insurer & HMO Health Plans? Health Benefit	Individual		Small Employer (Basic/Standard plans)	Large or Other Small	
	Insurer*	HMO*		Insurer	HMO
39. Podiatrists	Yes	Yes	Yes	Yes	Yes
40. Pre-existing condition	Yes	Yes	Yes	Yes	Yes
41. PCP: Chiropractor	N/A	Yes	No	N/A	Yes
42. PCP: OB/GYN	N/A	Yes	Yes	N/A	Yes
43. PCP: Osteopath	N/A	Yes	Yes	N/A	Yes
44. PCP: Podiatrist	N/A	Yes	Yes	N/A	Yes
45. Psychotherapeutic services	Yes	No	No	Yes	No
46. Substance abuse: optional coverage	No	No	No	Yes (optional coverage)	Yes (optional coverage)
47. TMJ: medically necessary	Yes	Yes	Yes	Yes	Yes

Continuation of Coverage

COBRA

The Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) allows retiring employees, or those who lose coverage due to quitting a job or reduced work hours, to continue group coverage for a limited period of time. This also applies to dependents of covered individuals who lose coverage because of divorce or legal separation; death of the covered employee; the covered employee qualifies for Medicare; or a loss of dependent status under the health plan's provisions. COBRA applies only to employers with 20 or more employees.

If you qualify for COBRA benefits, your health-plan administrator must give you a notice stating your right to choose to continue benefits provided by the plan. You then have 60 days to accept coverage or lose all rights to the benefits. Once you select COBRA coverage, you may have to pay 100 percent of the total insurance cost plus a 2 percent processing fee.

To obtain a free publication that explains COBRA in more detail, contact the U.S. Department of Labor at 1-800-998-7542. You can also write to: Pension and Welfare Benefits Administration, Atlanta Regional Office, 61 Forsyth St., SW, Suite 7B54, Atlanta, GA 30303; or Pension and Welfare Benefits Administration, Miami District Office, 8040 Peters Road, Building H, Suite 104, Plantation, FL 33324.

Mini-COBRA

Florida's Mini-COBRA law provides similar continuation of coverage protection for employees who work for employers with *fewer than 20 employees.*

Note: Under Florida's mini-COBRA law, *the employee must notify the insurer* within 30 days of losing group eligibility that he or she is eligible to continue their coverage.

Qualifying for COBRA and Mini-COBRA

Continuation of coverage runs from a minimum of 18 months to a maximum of 36 months, depending upon the individual situation. The coverage may continue an additional 11 months for an insured's disability that occurs during a **qualifying event** such as termination (except for gross misconduct) or a reduction in work hours for the employee; however, it cannot exceed the limit of 36 months. Other qualifying events may include:

- a beneficiary loses coverage due to the employee's death;
- a divorce or legal separation of the employee and a spouse;
- the employee's qualification for Medicare;
- and a dependent child's loss of status under the health plan's provisions.

In addition, Florida law gives you the option of converting your policy to an individual plan if

you leave the group. If you terminate employment, get divorced, or reach age 25 and no longer qualify under a parent's group plan, you may convert your group policy to an individual policy. A conversion policy usually costs more than a group policy. It may provide fewer benefits, but you don't need a physical exam to qualify for coverage.

Health Insurance Portability and Accountability Act

A federal law called the **Health Insurance Portability and Accountability Act** (HIPAA) made some important changes concerning health insurance in the United States. The Florida Legislature passed a law implementing these requirements. In some cases, state law already met or exceeded the new federal standards. However, HIPAA and the state law that implements it are subject to differing interpretations due to the complexity and variety of situations addressed. State laws will likely evolve to clarify and address HIPAA for many years to come.

For this reason, you may call the Insurance Consumer Helpline toll-free at 1-800-342-2762 to discuss your options under HIPAA and state law. The Helpline staff may have more current information to help answer your questions.

In general terms, HIPAA and the state law that implements it apply to persons who have maintained continuous health care coverage but leave or move from one group to another.

In some cases, these laws apply to persons who lose individual coverage.

Portability

One of the most important aspects of HIPAA involves **portability**, or allowing your time under previous coverage to reduce any waiting period for a pre-existing condition under a new group plan you want to join. The law also limits these waiting periods to 12 months for a new employee joining the plan or 18 months if an employee decides to join the plan at a later date.

Credit for Previous Coverage

The law will also affect any person who changes health insurance policies.

Your insurance company or employer plan will now provide a "Certificate of Previous Coverage" when you leave a major medical or comprehensive health plan. This certificate will include a statement of how long you and any dependents were insured. It will also explain to your new employer or company the range of benefits and coverage you had under that plan or policy.

You may have had health plan benefits for the most recent 12 months from either a group plan or an individual insurance policy. In either case, your previous coverage will generally reduce any waiting period for a pre-existing condition if you apply for a new group plan within 63 days.

Pre-existing Conditions

Florida law has already addressed many of the federal changes for pre-existing conditions. For example, it limits waiting periods for pre-existing conditions to 12 or 18 months, depending upon when you join a group plan.

Our state law includes one important change that prevents insurers from considering pregnancy a pre-existing medical condition. This means a pregnant woman who changes jobs and joins a new plan does not have to fulfill a waiting period before the health plan must pay for health care services associated with the pregnancy. However, if you are part of a group of fewer than two, pregnancy can be subject to a pre-existing condition waiting period.

"Guaranteed issue" Individual Health Insurance Policies

The term **guaranteed issue** means an insurance company must issue a health insurance policy to you regardless of any health conditions. Before this change, if you had a pre-existing condition or certain chronic health conditions, an insurer could deny your application or exclude coverage for that condition.

Under the new law, if you leave a group plan or have your Florida individual policy terminated, you may now qualify for an individual policy on a guaranteed-issue basis.

Who Qualifies for a "Guaranteed-issue" Policy?

There are three important requirements which determine whether you qualify for a guaranteed-issue individual health insurance policy:

- You previously held membership under a group health, governmental, or church plan, and no longer qualify for that plan or any other group plan;
- You exhausted COBRA or similar continuation of coverage periods; and
- You have had no "break in coverage" for a period greater than 63 days in which you lacked group or COBRA insurance.

What do I qualify for?

Eligible individuals who leave a group plan may obtain access to a guaranteed-issue individual policy in one of three ways:

- You and your employer had a group health insurance plan issued in Florida.
- You belonged to an employer's "self-insured" or "self-funded" plan, a group church plan, or any other type of group health plan not regulated by Florida law.
- The insurer or HMO terminated your coverage due to insolvency, dropping all individual coverage in Florida, or, moving out of the applicable service area.

After you exhaust COBRA, you may qualify for a **conversion plan**, which refers to guaranteed-issue individual coverage that the group-plan insurer must offer. You should receive an offer for a choice of two conversion options with different levels of comprehensive, major medical benefits. However, these benefits may differ from those offered by your previous group plan.

If your company does not offer a conversion plan, you may choose an individual health insurance policy. You can then apply for a policy from any insurance company which sells such coverage in Florida, with one exception. This exception applies when the administrator of a self-insured, group health plan offers a conversion option which complies with Florida law. In this case, you will not qualify for any other guaranteed-issue plan except for a choice between the two conversion options above.

When you apply for coverage, the company must offer you a choice between its first and second most popular policies marketed in Florida. The "most popular" means the policy issued to the largest and second largest group of individuals insured by that company in this state.

New Protections for "Guaranteed-issue" Policies

Guaranteed-issue individual policies include the following new protections:

Credit for prior coverage — If you have 18 months of previous group and/or COBRA

coverage, you will not have a pre-existing condition waiting period for your individual policy to begin. Your previous coverage acts as a "credit" against the longest of such periods (12 months) which an insurer may require for a guaranteed-issue policy. Any previous coverage of your spouse or dependents also acts as a credit.

Coverage for a pre-existing condition — The policy may not completely exclude coverage for pre-existing conditions on you, your spouse or dependents.

Coverage for a newborn or newly adopted child — If your child was born or adopted within the last 18 months, the child does not have to meet a "prior coverage" requirement. The child qualifies for benefits as soon as the policy begins.

The Florida Department of Insurance is ready to help you. If you or your insurance agent has a question, call the Insurance Consumer Helpline toll-free at 1-800-342-2762. You may also call the Helpline to find out if a company sells individual health insurance in Florida.

Your Rights and Responsibilities

As an HMO member, you have certain rights. You also have certain responsibilities. The next few pages outline these rights and responsibilities to help you understand HMOs and your role as an HMO member.

Your Rights

Contract

You have the right to receive a contract, certificate or member handbook that clearly states the services and limitations of your membership.

You have the right to receive copies of all forms and applications signed by you or your agent.

You have the right to a written translation of your membership contract in the language used to negotiate the contract. For example, if you negotiated the contract in Spanish, you can request a Spanish translation of the contract.

You have the right to convert from a group to an individual contract if the group contract is canceled, as long as you were a member under the group contract for at least three months.

Monthly Rates/Co-payments

You have the right to fair rates. HMOs are prohibited from charging rates that are deemed by the Department of Insurance to be excessive, inadequate or discriminatory.

You have the right of at least 10 days from the due date to pay your premium. If the premium is paid within the 10-day grace period, your coverage remains in force.

Service

You have the right to accessible health care, including a convenient location, prompt

attention, reasonable hours of operation, adequate staffing and after-hours service.

You have the right to receive a list of all hospitals and primary care physicians employed by, or under contract with, the HMO.

You have the right to quality emergency care. HMOs are required to pay for your emergency care, even if it is rendered outside your HMO's service area without prior notification or approval. The HMO may require you to pay a co-payment, not to exceed $100 per claim.

You have the right to a second medical opinion on any surgical or life-threatening injury or illness. Your HMO is required to pay a portion of the cost for the second opinion.

Cancellation

You have a right to a 45-day notification before your contract is canceled or not renewed, except for nonpayment of premium or termination of eligibility. An HMO may not terminate your membership on the basis of race, color, creed, marital status, gender or national origin.

Grievances

You have the right to receive a clear and understandable description of an HMO's methods of resolving member grievances. If the grievance is not resolved to your satisfaction, you may request a review of your case by the Statewide Provider and Subscriber Assistance Program panel. However, you must first give your HMO a chance to solve your problem by appealing through the HMO's internal grievance procedure.

Your Responsibilities

Contract

You are responsible for ensuring the accuracy and completeness of information on your application. Do not sign any blank, incomplete or inaccurate forms.

You are responsible for reading and understanding your HMO contract. Know what your HMO recognizes as a medical emergency and what is not covered.

Coverage

You are responsible for maintaining continuous coverage. Do not switch health plans if you have an ongoing medical problem, unless it is absolutely necessary. A new health plan may not pay for pre-existing conditions for a specified period of time.

Premiums/Co-payments

You are responsible for paying your monthly premium, even if you are involved in a financial dispute with your HMO. If you stop

paying your premium, the HMO can cancel your membership and stop paying for medical services.

You are responsible for paying your co-payments.

Service

You are responsible for arranging prior approval before accepting non-emergency care from a non-contracted provider.

You are responsible for knowing the emergency treatment procedures outlined in your member handbook or contract for treatment both in and out of the service area.

You *may be* responsible for paying the medical bills if you choose to see a specialist or other non-contracted provider unauthorized by your HMO.

Consumer Warning:

Some health care providers in an HMO network may feel the HMO is slow in paying for a treatment or service. In some cases they may even send a strongly worded or threatening letter to the member, demanding payment or implying that it is the member's responsibility.

This practice, known as **balance billing**, should not be tolerated The only money the provider can demand is the co-payment that is the standard part of your HMO contract.

Frequently Asked Questions

Do all HMOs offer individual and group contracts?

No. Approximately one-third of HMOs licensed by the Department of Insurance issue individual contracts.

Are HMO members responsible for bills sent to them by providers (doctors, hospitals, etc.)?

Generally, no. The law prohibits providers from billing members for covered services (except for the co-payment). They may, however, bill members for uncovered services (those services that are not listed in the contract).

What happens if I'm out of the HMO's service area and I need medical care?

Emergency claims are billed to the HMO. Non-emergency cases must receive prior approval by the HMO.

Do HMOs coordinate benefits if I have other insurance?

Yes. You cannot collect extra benefits on a single incident, treatment or illness.

Are the sales representatives who enroll consumers in HMOs licensed by the Department of Insurance?

Yes. To verify whether a sales representative is licensed, call the Insurance Consumer Helpline toll-free at 1-800-342-2762.

Are employers required to offer their employees a choice of HMO coverage?

An employer with at least 25 employees must offer employees an HMO choice.

The HMO has denied my hospital claim because I did not use a participating service provider. What are my rights, and what should I do?

Your first step is to file a written grievance with the HMO as outlined in your member booklet. The HMO is allowed 60 days from the date that a formal written grievance is filed to review and respond to you. If the matter is not resolved after that period of time, call the Insurance Consumer Helpline toll-free at 1-800-342-2762.

Do I have a conversion privilege under my group HMO contract?

Yes. A subscriber or covered dependent whose coverage has been terminated and who has had continuous coverage for at least three months immediately prior to termination is in most cases entitled to a converted contract issued by the HMO.

Does an HMO contract have a grace period?

Yes. The contract must provide no less than a 10-day grace period to make your monthly payment.

Must an HMO give notice of cancellation?

Yes. HMOs must provide 45 days written notice of cancellation, except in cases of nonpayment of premium or termination of eligibility.

Are adopted children automatically covered under an HMO program?

Yes. Coverage begins when the child is placed in the HMO member's home. For newborns, coverage begins at birth if a written agreement to adopt the child has been entered into by the HMO member prior to the birth. Check with your HMO to determine if pre-enrollment is required.

Are HMOs required to offer chiropractic coverage?

Yes. By law, HMOs must offer chiropractic coverage without a primary care physician's referral, as long as the chiropractor is an approved provider.

Florida Counties and Their Licensed HMOs

As of September 2001

The following list identifies all licensed HMOs approved to provide service in each county of the state. Once you find the HMO(s) you are interested in, you may obtain contact information by looking in the HMO directory in the following section (page 42). Remember that some HMOs do not provide service to certain counties, even though they are approved to do so. For a list of Medicare-approved HMOs, see page 45.

Alachua
Av-Med Health Plan, Inc.
Cigna Healthcare of Florida, Inc.
Health Options, Inc.
Healthplan Southeast, Inc.
Humana Medical Plan, Inc.
United Health Care of Florida

Baker
Aetna U.S. Healthcare, Inc.
Av-Med Health Plan, Inc.
Cigna Healthcare of Florida, Inc.
Health Options, Inc.
Healthplan Southeast, Inc.
Humana Medical Plan, Inc.

Bay
NONE

Bradford
Av-Med Health Plan, Inc.
Health Options, Inc.
Healthplan Southeast, Inc.
Humana Medical Plan, Inc.
United Health Care of Florida

Brevard
Aetna U.S. Healthcare, Inc.
Av-Med Health Plan, Inc.
Cigna Healthcare of Florida, Inc.
Health First Health Plans, Inc.
Health Options, Inc.
Humana Medical Plan, Inc.
United Health Care of Florida, Inc.
Well Care HMO, Inc.

Broward
Aetna U.S. Healthcare, Inc.
Av-Med Health Plan, Inc.
Beacon Health Plans, Inc.

Cigna Healthcare of Florida, Inc.
Foundation Health, A Florida
Health Plan, Inc.
Health Options, Inc.
Healthplan Southeast
HIP Health Plan of Florida, Inc.
Humana Medical Plan, Inc.
JMH Health Plan, Public Health
Trust of Dade County
Neighborhood Health
Partnership, Inc.
One Health Plan
Physicians Healthcare Plans, Inc.
Preferred Medical Plan, Inc.
Total Health Choice
United Health Care of Florida
Well Care HMO, Inc.

Calhoun
Healthplan Southeast, Inc.

Charlotte
Aetna U.S. Healthcare, Inc.
Cigna Healthcare of Florida, Inc.
Health Options, Inc.
Physicians Healthcare Plans, Inc.
United Health Care of Florida, Inc.

Citrus
Av-Med Health Plan, Inc.
Health Options, Inc.
Humana Medical Plan, Inc.
Well Care HMO, Inc.

Clay
Aetna U.S. Healthcare, Inc.
Av-Med Health Plan, Inc.
Cigna Healthcare of Florida, Inc.
Health Options, Inc.
Humana Medical Plan, Inc.
United Health Care of Florida, Inc.

Collier
Florida First Health Plan, Inc.

Columbia
Av-Med Health Plan, Inc.
Health Options, Inc.
Healthplan Southeast, Inc.
Humana Medical Plan, Inc.

Dade
Aetna U.S. Healthcare, Inc.
Av-Med Health Plan, Inc.
Beacon Health Plans, Inc.
Cigna Healthcare of Florida, Inc.
Foundation Health, A Florida
Health Plan, Inc.
Health Options, Inc.
Healthplan Southeast
HIP Health Plan of Florida, Inc.
Humana Medical Plan, Inc.
JMH Health Plan, Public Health
Trust of Dade County
Neighborhood Health
Partnership, Inc.
One Health Plan
Physicians Healthcare Plans, Inc.
Preferred Medical Plan, Inc.
Total Health Choice, Inc.
United Health Care of Florida, Inc.
Well Care HMO, Inc.

DeSoto
Health Options, Inc.
Florida First Health Plan, Inc.
United Health Care of
Florida, Inc.

Dixie
Av-Med Health Plan, Inc.
Health Options, Inc.
Healthplan Southeast, Inc.
Humana Medical Plan, Inc.

Duval
Aetna U.S. Healthcare, Inc.
Av-Med Health Plan, Inc.
Cigna Healthcare of Florida, Inc.
Health Options, Inc.
Healthplan Southeast, Inc.
Humana Medical Plan, Inc.
United Health Care of Florida, Inc.

Escambia
Health Options, Inc.
Healthplan Southeast, Inc.
United Health Care of
Florida, Inc.

Flagler
Aetna U.S. Healthcare, Inc.
Florida Health Care Plan, Inc.
Health Options, Inc.
Humana Medical Plan, Inc.
United Health Care of Florida, Inc.

Franklin
Healthplan Southeast, Inc.

Gadsden
Capital Group Health Services of
Florida, Inc.
Healthplan Southeast, Inc.

Gilchrist
Av-Med Health Plan, Inc.
Health Options, Inc.
Healthplan Southeast, Inc.
Humana Medical Plan, Inc.

Glades
Beacon Health Plans, Inc.
Humana Medical Plan, Inc.

Gulf
NONE

Hamilton
Av-Med Health Plan, Inc.
Healthplan Southeast, Inc.

Hardee
Florida First Health Plan, Inc.
Humana Medical Plan, Inc.

Hendry
Beacon Health Plans, Inc.
Health Options, Inc.
Humana Medical Plan, Inc.

Hernando
Av-Med Health Plan, Inc.
Cigna Healthcare of Florida, Inc.
Health Options, Inc.
HIP Health Plan of Florida, Inc.
Humana Medical Plan, Inc.
United Health Care of Florida, Inc.
Well Care HMO, Inc.

Highlands
Florida First Health Plan, Inc.
Humana Medical Plan, Inc.
United Health Care of Florida, Inc.

Hillsborough
Aetna U.S. Healthcare, Inc.
Av-Med Health Plan, Inc.
Beacon Health Plans, Inc.
Cigna Health Care of Florida, Inc.
Florida First Health Plan, Inc.
Foundation Health, A Florida Health Plan, Inc.
Healthease, Inc.
Health Options, Inc.
HIP Health Plan of Florida, Inc.
Humana Medical Plan, Inc.
One Health Plan, Inc.
Physicians Healthcare Plans, Inc.
United Health Care of Florida, Inc.
Well Care HMO, Inc.

Holmes
NONE

Indian River
Aetna U.S. Healthcare, Inc.
America's Health Choice
Humana Medical Plan, Inc.

Jackson
NONE

Jefferson
Capital Group Health Services of Florida, Inc.
Healthplan Southeast, Inc.

Lafayette
Healthplan Southeast, Inc.

Lake
Aetna U.S. Healthcare, Inc.
Cigna Healthcare of Florida, Inc.
Health Options, Inc.
Humana Medical Plan, Inc.
United Health Care of Florida, Inc.

Lee
Aetna U.S. Healthcare, Inc.
Av-Med Health Plan, Inc.
Cigna Healthcare of Florida, Inc.
Florida First Health Plan, Inc.
Health Options, Inc.
One Health Plan, Inc.
Physicians Healthcare Plans, Inc.
United Health Care of Florida, Inc.
Well Care HMO, Inc.

Leon
Av-Med Health Plan, Inc.
Capital Group Health Services of Florida, Inc.
Healthplan Southeast, Inc.

Levy
Av-Med Health Plan, Inc.
Health Options, Inc.
Health Plan Southeast, Inc.
Humana Medical Plan, Inc.

Liberty
Healthplan Southeast, Inc.

Madison
Healthplan Southeast, Inc.

Manatee
Aetna U.S. Healthcare, Inc.
Cigna Healthcare of Florida, Inc.
Health Options, Inc.
Humana Medical Plan, Inc.
Physicians Healthcare Plans, Inc.
United Health Care of Florida, Inc.
Well Care HMO, Inc.

Marion
Aetna U.S. Healthcare, Inc.
Av-Med Health Plan, Inc.
Cigna Healthcare of Florida, Inc.
Health Options, Inc.
Healthplan Southeast, Inc.
Humana Medical Plan, Inc.
United Health Care of Florida
Well Care HMO, Inc.

Martin
America's Health Choice
Beacon Healthplans, Inc.
Cigna Healthcare of Florida, Inc.
Foundation Health, A Florida
Health Plan, Inc.
Health Options, Inc.
Humana Medical Plan, Inc.

Monroe
NONE

Nassau
Aetna U.S. Healthcare, Inc.
Av-Med Health Plan, Inc.
Cigna Healthcare of Florida, Inc.
Health Options, Inc.
Humana Medical Plan, Inc.
United Health Care of Florida

Okaloosa
Health Options, Inc.
United Health Care of Florida, Inc.

Okeechobee
Aetna U.S. Healthcare, Inc.
America's Health Choice
Health Options, Inc.
United Health Care of Florida, Inc.
Well Care HMO, Inc.

Orange
Aetna U.S. Healthcare, Inc.
Av-Med Health Plan, Inc.
Beacon Health Plans, Inc.
Cigna Health Care of Florida, Inc.
Health Options, Inc.
Humana Medical Plan, Inc.
One Health Plan, Inc.
Physicians Healthcare Plans, Inc.
United Health Care of Florida, Inc.
Well Care HMO, Inc.

Osceola
Aetna U.S. Healthcare, Inc.
Av-Med Health Plan, Inc.
Beacon Health Plans, Inc.
Cigna Healthcare of Florida, Inc.
Health Options, Inc.
Humana Medical Plan, Inc.
One Health Plan, Inc.
Physicians Healthcare Plans, Inc.
United Health Care of Florida, Inc.
Well Care HMO, Inc.

Palm Beach
Aetna U.S. Healthcare, Inc.
Av-Med Health Plan, Inc.
Beacon Health Plans, Inc.
Cigna Healthcare of Florida, Inc.
Foundation Health, A Florida
Health Plan, Inc.
Health Options, Inc.
Healthplan Southeast
Healthy Palm Beaches, Inc.
HIP Health Plan of Florida, Inc.
Humana Medical Plan, Inc.
Neighborhood Health
Partnership, Inc.
One Health Plan, Inc.
Physicians Healthcare Plans, Inc.
Total Health Choice
United Health Care of Florida, Inc.
Well Care HMO, Inc.

Pasco
Aetna U.S. Healthcare, Inc.
Av-Med Health Plan, Inc.
Cigna Healthcare of Florida, Inc.
Florida First Health Plan, Inc.
Foundation Health, A Florida
Health Plan, Inc.
Healthease, Inc.
Health Options, Inc.
HIP Health Plan of Florida, Inc.
Humana Medical Plan, Inc.
One Health Plan, Inc.
Physicians Healthcare Plans, Inc.
United Health Care of Florida, Inc.
Well Care HMO, Inc.

Pinellas
Aetna U.S. Healthcare, Inc.
Av-Med Health Plan, Inc.
Beacon Health Plans, Inc.
Cigna Healthcare of Florida, Inc.
Florida First Health Plan, Inc.
Foundation Health, A Florida
Health Plan, Inc.
Health Options, Inc.
HIP Health Plan of Florida, Inc.
Humana Medical Plan, Inc.
One Health Plan, Inc.
Physicians Healthcare Plans, Inc.
United Health Care of Florida, Inc.
Well Care HMO, Inc.

Polk
Aetna U.S. Healthcare, Inc.
Av-Med Health Plan, Inc.
Cigna Healthcare of Florida, Inc.
Florida First Health Plan, Inc.
Healthease, Inc.
Health Options, Inc.
Humana Medical Plan, Inc.
One Health Plan, Inc.
Physicians Healthcare Plans, Inc.
United Health Care of Florida, Inc.
Well Care HMO, Inc.

Putnam
Humana Medical Plan, Inc.
United Health Care of Florida

St. Johns
Aetna U.S. Healthcare, Inc.
Av-Med Health Plan, Inc.
Health Options, Inc.
Humana Medical Plan, Inc.
United Health Care of Florida, Inc.

St. Lucie
Aetna U.S. Healthcare, Inc.
America's Health Choice
Foundation Health, A Florida
Health Plan, Inc.
Health Options, Inc.
Well Care HMO, Inc.

Santa Rosa
Health Options, Inc.
Healthplan Southeast, Inc.
United Health Care of Florida, Inc.

Sarasota
Aetna U.S. Healthcare, Inc.
Av-Med Health Plan, Inc.
Cigna Healthcare of Florida, Inc.
Health Options, Inc.
Physicians Healthcare Plans, Inc.
Well Care HMO, Inc.

Seminole
Aetna U.S. Healthcare, Inc.
Av-Med Health Plan, Inc.
Beacon Health Plans, Inc.
Cigna Healthcare of Florida, Inc.
Florida Health Care Plan, Inc.
Health Options, Inc.
Humana Medical Plan, Inc.
One Health Plan, Inc.
Physicians Healthcare Plans, Inc.
United Health Care of Florida, Inc.
Well Care HMO, Inc.

Sumter
Health Options, Inc.

Suwannee
Av-Med Health Plan, Inc.
Health Options, Inc.
Healthplan Southeast, Inc.
United Health Care of Florida

Taylor
NONE

Union
Av-Med Health Plan, Inc.
Healthplan Southeast, Inc.
Humana Medical Plan, Inc.
United Health Care of Florida

Volusia
Aetna U.S. Healthcare, Inc.
Av-Med Health Plan, Inc.
Cigna Healthcare of Florida, Inc.
Florida Health Care Plan, Inc.
Health Options, Inc.
Humana Medical Plan, Inc.
Physicians Healthcare Plans, Inc.
United Health Care of Florida, Inc.
Well Care HMO, Inc.

Wakulla
Capital Group Health Services of
Florida, Inc.
Healthplan Southeast, Inc.

Walton
Health Options, Inc.

Washington
NONE

Florida HMO Company Contact Information

As of June 2001

The following HMOs are licensed to provide service in Florida. It is important to remember that although an HMO may be licensed to provide service in a county, not all HMOs provide service for all the counties listed in their service areas. Even when an HMO lists a county in its service area, it is still a good idea to check with the HMO to determine if it is currently providing service in that county. You can find the list of counties, and the HMOs licensed to serve them, starting on page 35.

Aetna U.S. Healthcare, Inc.
5100 W. Lemon St., Suite 218
Tampa, FL 33609-1138
Toll-free: 1-800-232-2385
Enrollment: 557,969
Contracts: Group

America's Health Choice Medical Plans, Inc.
1175 South U.S. Hwy. 1
Vero Beach, FL 32962
(561) 794-0030
Toll Free: 1-800-308-9823
Enrollment: 5,954
Contracts: Medicare

Av-Med Health Plan, Inc.
4300 N.W. 89th Blvd.
Gainesville, FL 32606
Toll-free: 1-800-346-0231
Enrollment: 257,324
Contracts: Group, Medicare, Medicaid

BCBS Health Options, Inc.
4800 Deerwood Campus Parkway
Jacksonville, FL 32246
Toll-free: 1-800-734-6656
Enrollment: 823,579
Contracts: Group, Individual, Medicare

Beacon Health Plans, Inc.
2511 Ponce De Leon Blvd., Fifth Floor
Coral Gables, FL 33134
(305) 460-2000
Toll-free: 1-800-850-0979
Enrollment: 52,935
Contracts: Group, Individual, Medicaid, Medicare

Capital Group Health Services of Florida, Inc.
2140 Centerville Place
Tallahassee, FL 32308
(850) 383-3333
Toll-free: 1-800-390-1434
Enrollment: 108,312
Contracts: Group, Medicare

Cigna Healthcare of Florida, Inc.
5404 Cypress Center Drive, Suite 365
Tampa, FL 33609
(813) 281-1000
Toll-free: 1-800-942-2471
Enrollment: 121,191
Contracts: Group

Florida First Health Plan, Inc.
3425 Lake Alfred Road
Winter Haven, FL 33881-1445
Phone: (863) 293-0785
Toll-free: 1-800-226-3155
Enrollment: 12,743
Contracts: Group, Medicaid

Florida Health Care Plan, Inc.
1340 Ridgewood Ave.
Holly Hill, FL 32117
Phone: (386) 676-7100
Toll-free: 1-800-352-9824
Enrollment: 55,507
Contracts: Group, Medicare

Foundation Health, A Florida Health Plan, Inc.
1340 Concord Terrace
Sunrise, FL 33323
(954) 858-3000
Toll Free: 1-800-422-7335
Enrollment: 157,551
Contracts: Group, Individual, Medicaid, Medicare

Healthease of Florida, Inc.
6800 N. Dale Mabry Hwy.
Suite 270
Tampa, FL 33614
(813) 290-6200
Toll Free: 1-800-278-0656
Enrollment: 111,955
Contracts: Medicaid

Health First Health Plans, Inc.
8247 Devereaux Drive, Suite 103
Melbourne, FL 32940-7955
(321) 434-5665
Toll Free: 1-800-716-7737
Enrollment: 46,825
Contracts: Group, Medicare

Healthplan Southeast, Inc.
3520 Thomasville Road,
Suite 200
Tallahassee, FL 32308
Phone: (850) 668-3000
Toll-free: 1-800-833-2169
Enrollment: 64,369
Contracts: Group, Medicaid

Healthy Palm Beaches, Inc.
324 Datura St., Suite 401
West Palm Beach, FL 33401
Phone: (561) 659-1270
Enrollment: 5,522
Contracts: Medicaid, group

HIP Health Plan of Florida, Inc.
300 South Park Road
Hollywood, FL 33021
Phone: (954) 962-3008
Toll-free: 1-800-385-4447
Enrollment: 193,984
Contracts: Group, Medicare

Humana Medical Plan, Inc.
3400 Lakeside Drive
Miramar, FL 33027
Toll-free: 1-800-533-5001
Enrollment: 436,507
Contracts: Group, Medicaid,
Medicare

JMH Health Plan, The Public Health Trust of Dade County
1801 N.W. Ninth Ave.,
Highland Professional Bldg.,
Suite 700
Miami, FL 33136
Phone: (305) 575-3700
Toll-free: 1-800-721-2993
Enrollment: 41,741
Contracts: Group, Medicaid

Neighborhood Health Partnership, Inc.
7600 Corporate Center Drive
Suite 300
Miami, FL 33126
Phone: (305) 715-2500
Toll-free: 1-800-354-0222
Enrollment: 142,111
Contracts: Group, Medicaid,
Medicare

One Health Plan of Florida, Inc.
7650 Courtney Campbell
Causeway, Suite 850
Tampa, FL 33607
Phone: (813) 207-0216
Toll-free: 1-800-533-0919
Enrollment: 10,731
Contracts: Group

Physicians Healthcare Plans, Inc.
1410 N. Westshore Blvd.,
Suite 200
Tampa, FL 33607
Toll-free: 1-800-873-7474
Enrollment: 143,751
Contracts: Group, Individual,
Medicaid, Medicare

Preferred Medical Plan, Inc.
4950 S.W. Eighth St.
Coral Gables, FL 33134
Phone: (305) 447-8373
Toll-free: 1-800-767-5551
Enrollment: 39,809
Contracts: Individual, Medicaid, group

Total Health Choice, Inc.
8701 S.W. 137th Ave.
Suite 200
Miami, FL 33183
(305) 408-5700
Toll-free: 1-800-887-6888
Enrollment: 20,990
Contracts: Group, Individual

United Healthcare of Florida, Inc.
800 N. Magnolia Ave.
Orlando, FL 32803
Toll-free: 1-800-543-3145
Enrollment: 869,069
Contracts: Group, Individual, Medicaid, Medicare

Well Care HMO, Inc.
6800 N. Dale Mabry Highway,
Suite 209-211
Tampa, FL 33614
Phone: (813) 290-6200
Toll-free: 1-800-960-2530
Enrollment: 185,641
Contracts: Group, Individual, Medicaid

Approved Medicare HMOs by County

As of January 2002

The following list identifies all Florida counties with federally approved Medicare HMO plans. The list also contains the HMO's phone number to call for more information. Counties not listed did not have a federally approved Medicare HMO plan at the time of publication. Remember, some HMOs approved by Medicare may not accept new customers at this time.

Alachua
Av-Med Health Plan:
1-800-535-9355

Baker
Humana Medical Plan:
1-800-798-2458

Bradford
Av-Med Health Plan:
1-800-535-9355

Brevard
America's Health Choice Medical Plans:
1-800-308-9823 or (561) 794-0030

Health First Health Plans, Inc.:
(321) 434-5665 or 1-800-716-7737

Broward
Av-Med Health Plan:
1-800-535-9355
BCBS Health Options:
1-800-333-7586
Beacon Health Plans:
1-800-826-1013, ext. 6201
Foundation Health, A Florida Health Plan, Inc.:
1-800-977-8440
Humana Medical Plan:
1-800-798-2458
Neighborhood Health Partnership: 1-800-354-0222 or (305) 715-2687
Physician's Health Care Plans:
1-800-794-5907
Well Care Choice HMO:
1-888-888-9355
Vista Healthplan:
1-800-385-4447

Charlotte
United Healthcare of Florida:
1-800-973-6467

Clay
BCBS Health Options:
1-800-333-7586

Dade
Av-Med Medicare Plan:
1-800-535-9355
BCBS Health Options:
1-800-333-7586
Beacon Health Plans:
1-800-826-1013, ext. 6201
Foundation Health, A Florida Health Plan:
1-800-977-8440
Humana Medical Plan:
1-800-798-2458
Neighborhood Health Partnership: 1-800-354-0222 or (305) 715-2687
Physician's Health Care Plans:
1-800-794-5907
United Healthcare of Florida:
1-800-973-6467
Well Care Choice HMO:
1-888-888-9355
Vista Healthplan:
1-800-385-4447

Duval
BCBS Health Options:
1-800-333-7586
Humana Medical Plan:
1-800-798-2458

Flagler
Florida Health Care Plan:
1-800-352-9824 or (386) 676-7110
Humana Medical Plan:
1-800-798-2458

Gadsden
Capital Group Health Services of Florida: 1-800-390-1434 or (850) 383-3311

Hernando
United Healthcare of Florida:
1-800-973-6467

Well Care Choice HMO:
1-888-888-9355

Hillsborough
Humana Medical Plan:
1-800-798-2458
United Healthcare of Florida:
1-800-973-6467
Well Care Choice HMO:
1-888-888-9355

Indian River
America's Health Choice
Medical Plans:
1-800-308-9823 or (561) 794-0030
Health First Health Plans, Inc.
1-800-716-7737

Jefferson
Capital Group Health Services of
Florida: 1-800-390-1434 or
(850) 383-3311

Lee
United Healthcare of Florida:
1-800-973-6467

Leon
Capital Group Health Services of
Florida: 1-800-390-1434 or
(850) 383-3311

Martin
America's Health Choice
Medical Plans:
1-800-308-9823 or (561) 794-0030

Nassau
Humana Medical Plan:
1-800-798-2458

Okeechobee
America's Health Choice
Medical Plans:
1-800-308-9823 or (561) 794-0030

Orange
Humana Medical Plan:
1-800-798-2458
Well Care Choice HMO:
1-888-888-9355

Osceola
Humana Medical Plan:
1-800-798-2458
Well Care Choice HMO:
1-888-888-9355

Palm Beach
America's Health Choice
Medical Plans:
1-800-308-9823 or (561) 794-0030
BCBS Health Options:
1-800-333-7586
Foundation Health, A Florida
Health Plan:
1-800-977-8440
Humana Medical Plan:
1-800-798-2458
Neighborhood Health
Partnership: 1-800-354-0222 or
(305) 715-2687
Well Care Choice HMO:
1-888-888-9355
Vista Healthplan:
1-800-385-4447

Pasco
Humana Medical Plan:
1-800-798-2458
United Healthcare of Florida:
1-800-973-6467
Well Care Choice HMO:
1-888-888-9355

Pinellas
BCBS Health Options:
1-800-333-7586
Humana Medical Plan:
1-800-798-2458
United Healthcare of Florida:
1-800-973-6467
Well Care Choice HMO:
1-888-888-9355

St. Lucie
America's Health Choice
Medical Plans:
1-800-308-9823 or (561) 794-0030

Seminole
Humana Medical Plan:
1-800-798-2458

Well Care Choice HMO:
1-888-888-9355

Suwannee
Av-Med Health Plan:
1-800-535-9355

Volusia
Florida Health Care Plan:
1-800-352-9824 or
(386) 676-7110
Humana Medical Plan:
1-800-798-2458

Wakulla
Capital Group Health Services of
Florida: 1-800-390-1434 or
(850) 383-3311

Protecting Your Privacy

Your Insurers and Financial Institutions

Under federal law, some banks and insurance companies may have the right to share sensitive and personal information about you with other entities and business interests - without your permission.

Fortunately, Florida laws, and rules established by the Florida Department of Insurance, provide a way for you to protect this personal information. As the policyholder, you must take the lead in protecting your personal information.

You may have already received, or soon will receive, a privacy notice from the financial and insurance companies you do business with. These forms give you the opportunity to tell the company that you want your personal information kept private. Unless you complete and return these forms, your personal financial and medical information may be shared with other companies. You may receive these forms on an annual basis, and be required to complete them to keep your information confidential.

When you receive a privacy notice form, read it carefully before signing it to avoid unintentionally giving the company permission to share information about you. If you have questions or concerns about these forms, call the Insurance Consumer Helpline toll-free at 1-800-342-2762.

Medical Privacy and Medical Information Bureau

The Medical Information Bureau (MIB) is a data bank of medical and non-medical information on nearly 15 million Americans. Are you one of them? You may be if you have ever applied for health insurance from any of the MIB's 800 insurance company members.

The companies send the MIB any information you have written on any applications, enrollment forms, or requests for upgrading coverage for health, life or disability insurance. The MIB also records information from medical exams, blood and lab tests, and hospital reports, when such information is legally obtainable.

If you have been denied life or disability insurance and wonder why, your file at the MIB may be the answer. Although the MIB's database seems like an invasion of your privacy, it prevents fraud and abuse of the nation's private insurance system. However, you have the right to make sure the information in your MIB file is correct. Call the MIB and ask for a copy of your records at (617) 426-3660, or access its Web site at www.mib.com.

Now that you know about the MIB, you understand why it is important to provide truthful information on any insurance application. If an insurer spots false information on an MIB report, that insurer may cancel your policy. Even worse, you may find it difficult to find coverage in the future.

Health Insurance Claim Denials

If you are in a dispute with an HMO or agent, the Department of Insurance can help you resolve the situation by presenting your concerns to the HMO and/or agent, or by suggesting actions you can take on your own.

While the Department may ask the HMO to reconsider its position when the facts of a situation are in doubt, the Department cannot make a final determination about the facts of a situation or act as your legal representative.

There are steps you can take to lower the chances of your claim being denied:

- Know before receiving treatment what your health insurance will and will not cover. Read your health plan's requirements, outlined in its handbook. This way, you can find out whether the treatment you are considering is covered before you get the treatment.

- Make sure your pre-authorization requests contain correct patient information. Insurers often return or deny pre-authorization requests because of missing data. **Pre-authorization** (also called pre-certification) is the insurer's prior approval of an insured entering a hospital. Many health policies or contracts require pre-authorization as part of an effort to control

costs. Pre-authorization is not a guarantee of payment. Your physician will need to request the pre-authorization for you, or at least provide all necessary medical documentation.

- Document all communication involving any health insurance problems or questions, including names of people you talk to, when you talked to them, and photocopies of any paperwork.

If Your Claim is Denied

You may consider an appeal if your claim is denied.

Appeals

Your HMO should provide an appeals process procedure, usually detailed in its handbook. Be sure to follow any timeline requirements.

There are two types of appeals:

- An **internal** appeal is filed to the health plan provider itself.

- An **external** appeal is filed to the Florida Department of Insurance or other governing body.

Internal Appeals

Filing an internal appeal is the first step you would take if your claim has been denied. An

internal appeal involves getting more detailed information and asking your health plan provider to reconsider its position.

Find out the correct person to whom you should send your appeal letter, and send all letters by certified mail so you have documentation that the letter was sent and received.

External Appeals

If you are a member of an HMO, you may file an external appeal once you have had an internal appeal denied, and the HMO won't change its decision. In Florida, once your internal appeal is denied and you are a member of an HMO, you have the right to a review by the Statewide Provider and Subscriber Assistance Panel. Your claim cannot be denied if the Statewide Provider and Assistance Panel decides in your favor.

Note: Not all health plans operating in Florida are subject to Florida law. If your health plan is self-insured (the employer pays 100 percent of the claims), it is not subject to Florida law. If your plan is not self-insured, call the Insurance Consumer Helpline toll-free at 1-800-342-2762 to find out what laws apply.

Insurance Fraud Costs Us All!

Insurance fraud costs each Florida family an additional $1,500 per year in increased premiums.* In fact, it can inflate your premiums by as much as 30 percent, according to the National Insurance Crime Bureau.

You can protect your personal and family pocketbook by learning about the many different types of fraud schemes and scams. Some common examples within the health care arena include:

F*ictional services* — A health care provider bills an HMO for an unnecessary service, or unauthorized services that were never rendered.

R*eceipt of kickbacks* — A health care provider receives illegal kickbacks from other providers for new patient referrals.

A*pplicant fraud* — An applicant deliberately withholds information about a pre-existing condition in hopes of obtaining HMO coverage.

U*nauthorized "balanced billing"* — A contracted health care provider bills a patient for the portion of services that the HMO is responsible for paying.

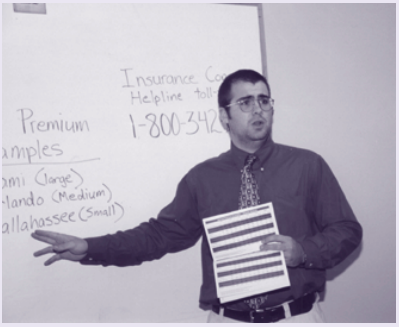
D*eceptive billing* — An individual sells insurance information to a health care provider that bills the health plan for services never rendered.

There are many other types of insurance fraud. If you suspect insurance fraud has occurred, call the Florida Insurance Department's toll-free Fraud Hotline at 1-800-378-0445.

** Source: The Coalition Against Insurance Fraud*

Community Outreach Programs (COPs)

The Department of Insurance offers free Community Outreach Programs (COPs) on a number of insurance topics. Speakers will talk to your group or organization on the insurance topic you choose, and will try to help answer any general questions you have about insurance. For more information, please contact the service office in your area. A list of the service offices is located inside the back cover of this guide.



Insurance Topics:

Health Insurance
Automobile Insurance
Disaster Preparedness
Small-Business Insurance
Life Insurance
Health Maintenance Organizations (HMOs)
Medicare Supplement Insurance
Long-Term Care Insurance
Insurance Fraud

Glossary

Application
An application is the document a person signs to join an HMO. It includes the names, ages and addresses of the covered persons and may ask questions about medical history.

Authorized HMO
An "authorized" HMO is one that has received a "Certificate of Authority" from the Florida Department of Insurance. After it has met certain quality of care standards, the Agency for Health Care Administration is responsible for issuing a Health Care Provider Certificate to the HMO providers.

Cancellation
Cancellation is termination of the contract between an HMO and a subscriber. By law, HMOs must give a subscriber 45 days written notice of cancellation (other than for non-payment of premium or termination of eligibility) along with the reason.

Co-payment
A co-payment is a specified dollar amount a member must pay to a provider at the time of service for covered health care services offered by an HMO.

Disenrollment
Disenrollment is a procedure for ending membership in an HMO or a Medicare HMO program.

Gatekeeper (Primary Care Physician)
A gatekeeper is the HMO doctor that provides or authorizes all medical treatments and referrals.

Grievance Coordinator
A grievance coordinator is the individual designated by an HMO to coordinate complaints filed by HMO members.

Health Maintenance Contract
A health maintenance contract is a contract between an HMO and a subscriber (or group of subscribers) to provide comprehensive health care services in exchange for a fixed, prepaid sum. The health maintenance contract must outline the responsibilities of the HMO and the subscriber.

HMO Member Handbook
An HMO member handbook is an easy-to-read booklet that explains an HMO's services, benefits, limitations and exclusions.

Individual Converted Contract (Conversion)
An "individual converted contract" is a contract that has been converted from a group contract to an individual contract. If you are an HMO member under a group contract for at least three months and your coverage is terminated, you can elect to transfer coverage from the group plan to an individual contract, under certain circumstances. (Refer to your member handbook for complete information.)

Lock-in Provision
A lock-in provision is the requirement that members use only HMO doctors and facilities for all medical care, except for emergency care, while temporarily away from the service area.

Medicare HMO
A Medicare HMO is an HMO that has a contract with the federal government to provide health care services to Medicare beneficiaries.

Member
A "member" is an individual covered by an HMO contract. The person can be the subscriber or eligible dependent(s).

Pre-existing Condition or Illness
A "pre-existing condition" is a condition or symptom that is diagnosed or treated before the start date of health care coverage.

Provider
A provider is any licensed physician, hospital, or other institution, organization or person that furnishes health care services, supplies or equipment.

Quality of Care
"Quality of care" is the nature of the care received by a member. By law, an HMO must ensure that the health care services it provides are consistent with the community's current professional standards of medical practice. The Agency for Health Care Administration monitors HMOs to ensure that providers furnish appropriate and safe health care to HMO members.

Service Area (Geographic area)
A "service area" refers to the counties served by a particular HMO.

Statewide Provider and Subscriber Assistance Panel

The Statewide Provider and Subscriber Assistance Panel is a panel consisting of six members (three from the Department of Insurance and three from the Agency for Health Care Administration) established by law to hear grievances filed by HMO members and providers, once all internal grievance procedures have been exhausted. This panel makes recommendations to resolve the problem or grievance.

Subscriber

Subscribers are individuals, groups or employers who sign a health maintenance contract with an HMO and subsequently become HMO members.

Notes: