

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 illnesses, 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 Financial Services publishes a variety of consumer guides to help you with this task. They include: *Automobile Insurance, Health Insurance, Small-Business Owners' Insurance* (the preceding guides are also available in Spanish), *Life Insurance and Annuities, Insuring Your Home, Health Maintenance Organizations, Long-Term Care and Other Options for Seniors and Medicare Supplement Insurance*. 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 calling the Florida Department of Financial Services Consumer Helpline toll-free at 1-800-342-2762. They may also be downloaded from our Web site at www.fldfs.com.

If you have questions after reading this guide, please call our Consumer Helpline toll-free at 1-800-342-2762 Monday through Friday. The hearing impaired may use a TDD to call 1-800-640-0886 (8 a.m. until 5 p.m. Eastern). You may also contact the service office in your area (listed inside the back cover of this guide).

Sincerely,

A handwritten signature in black ink that reads "Tom Gallagher". The signature is written in a cursive style with a horizontal line under the name "Tom".

Tom Gallagher
Chief Financial Officer
State of Florida

CONTENTS

- 3 HOW AN HMO WORKS
- 5 TYPES OF MANAGED CARE
- 6 WHO IS ELIGIBLE TO JOIN?
- 6 HOW DO I SHOP FOR AN HMO?
- 7 WEIGHING THE FACTS
- 8 LAWS AND REGULATIONS THAT AFFECT HMO MEMBERS
- 10 HMOs AND MEDICARE
- 11 CONTINUATION OF COVERAGE
- 13 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT
- 17 YOUR RIGHTS AND RESPONSIBILITIES
- 20 INSURANCE DISCRIMINATION AGAINST VICTIMS OF ABUSE
- 21 FREQUENTLY ASKED QUESTIONS
- 23 PROTECTING YOUR PRIVACY
- 25 HEALTH INSURANCE CLAIM DENIALS
- 27 INSURANCE FRAUD COSTS US ALL
- 27 COMMUNITY OUTREACH PROGRAMS

APPENDIX

- A LIST OF MANDATED HEALTH INSURANCE AND HMO BENEFITS
- B FLORIDA COUNTIES AND THEIR LICENSED HMOs
- C FLORIDA HMO COMPANY CONTACT INFORMATION
- D APPROVED MEDICARE HMOs BY COUNTY
- E GLOSSARY

**If you have a question or problem,
call the CONSUMER HELPLINE**

1-800-342-2762

or visit us on the Web at www.fldfs.com.

Telecommunications Device for the Deaf: 1-800-640-0886

NOTE:

Most insurance rates and forms in Florida are regulated by the Office of Insurance Regulation. Although it is administratively housed within the Department of Financial Services, OIR is a separate entity that reports to the Florida Cabinet. Because DFS handles consumer-related insurance matters, only DFS is mentioned throughout this publication. Consumers should remember that DFS is their point of contact for all insurance problems and questions.

A list of the service offices is located inside the back cover of this guide.

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



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Health Organ



Maintenance Organizations

A health maintenance organization (HMO) is an alternative to health insurance that has grown in popularity during the past 20 years. An HMO provides 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 it has 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.

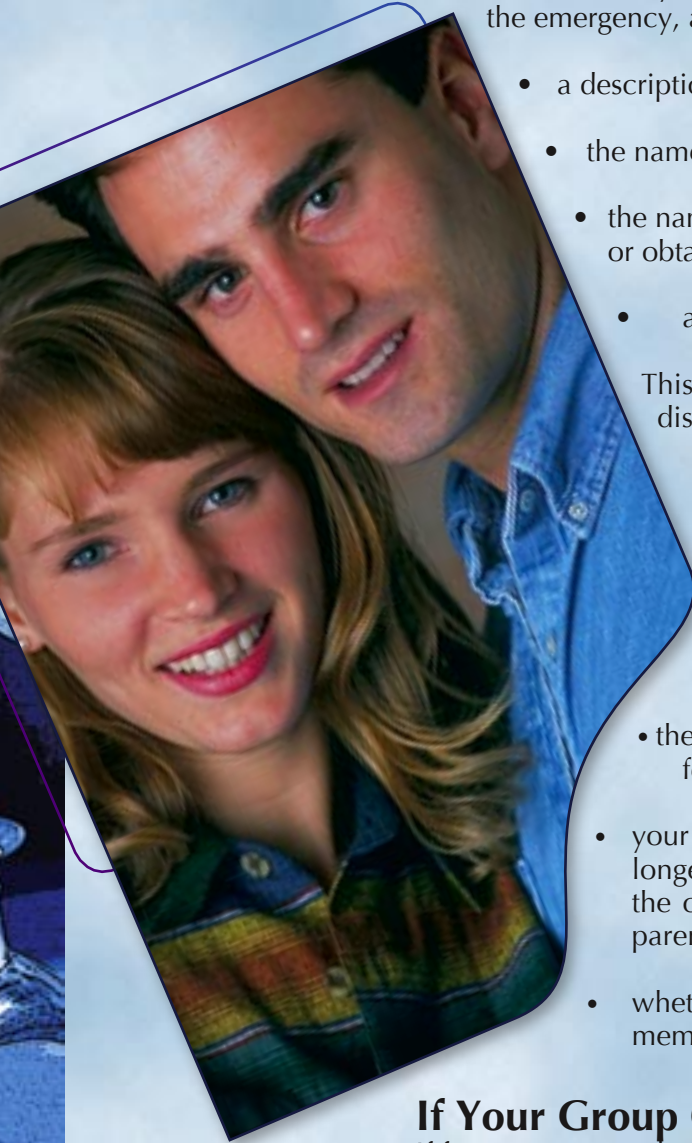
Your Eligibility Status

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 Cancelled

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



TYPES OF MANAGED CARE

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.

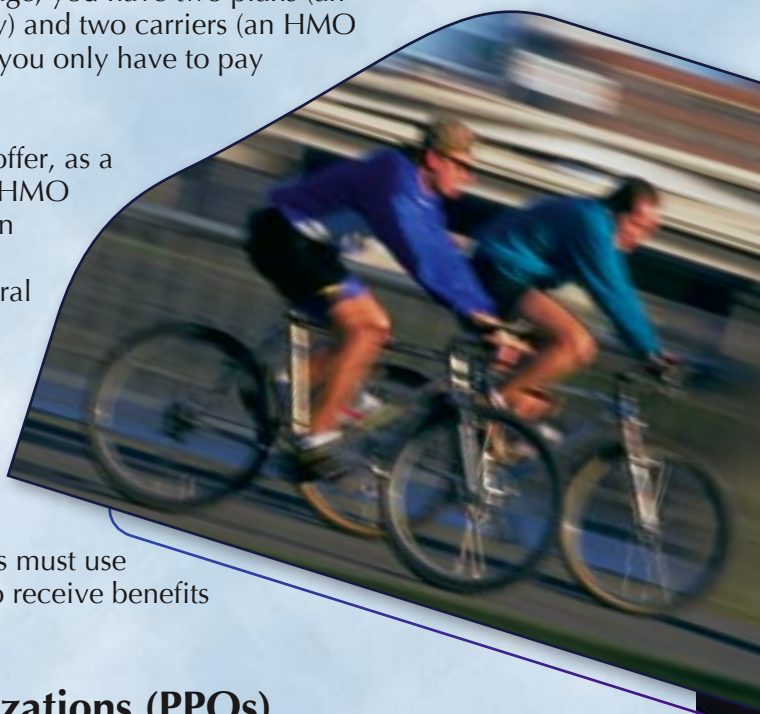
Certain HMOs are now authorized to offer, as a rider, a point-of-service benefit where HMO members may choose to receive certain services from a provider that does not have a contract with the HMO. A referral for such services is not required.

Exclusive Provider Organizations (EPOs)

In an EPO arrangement, an insurance company contracts with hospitals or specific providers. Insureds must use the contracted hospitals or providers to receive benefits by these plans.

Preferred Provider Organizations (PPOs)

A PPO offers another kind of provider network to meet the health care needs of employees. A traditional insurance carrier provides the health benefits. An insurer contracts with a group of health care providers to control the cost of providing benefits to employees. These providers charge lower-than-usual fees because they require prompt payment and serve a greater number of patients. Employees usually choose who will provide their health services, but pay less in coinsurance with a preferred provider than with a nonpreferred provider.



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 Florida Department of Financial Services Consumer Helpline toll-free at 1-800-342-2762 to verify that an HMO is licensed by the Department.



WEIGHING THE FACTS

Expenses:

- Be sure to compare all copayments, deductibles and coinsurance, since expenses may vary among plans.
- 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 visits, lab tests, X-rays and other medical services.
- A large portion of your health care expenses is 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 "noncontracted" 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 child.)



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 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 Consumer Helpline toll-free at 1-800-342-2762. If the problem involves a quality of care issue with an HMO, 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. Once the internal complaint is filed, the HMO has 60 days to respond to you 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 Financial Services 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 Consumer Helpline toll-free at 1-800-342-2762.*

Quality Control

Health Care

The Florida 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.

Protection Against Insolvent HMOs

The Department of Financial Services 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. There are also other safeguards to help protect consumers against HMOs that become bankrupt or insolvent.

Consumer Assistance Plan (HMO CAP)

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

Insolvency Deposit

HMOs must place a deposit with the Department 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.

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

Florida Department of Health
Division of Medical Quality Assurance
Consumer Services Unit
4052 Bald Cypress Way, Bin #C-75
Tallahassee, FL 32399-3275.

You may also call the Florida Department of Health toll-free at 1-888-419-3456 or (850) 414-1976. You may also access its Web site at www.doh.state.fl.us.

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



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 Appendix D for a list of approved Medicare HMOs by county). If a Medicare HMO is available in your county, consider 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 areas (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.

CONTINUATION OF COVERAGE

COBRA

The Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) allows employees and dependents who might otherwise lose coverage to continue group coverage for a limited period of time under certain conditions. 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 two percent processing fee.

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 in writing within 30 days of losing group eligibility that he or she is eligible to continue 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 for 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.

**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: Employee Benefits
Security Administration, Atlanta Regional
Office, 61 Forsyth St., SW, Suite 7B54,
Atlanta, GA 30303; or Employee Benefits
Security Administration, Miami District
Office, 8040 Peters Road, Building H,
Suite 104, Plantation, FL 33324.**

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 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 also will affect any person who changes health insurance policies.

Your insurance company or employer plan now will 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

"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?

There are three important requirements that 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.

Eligible individuals who leave a group plan may obtain access to a guaranteed-issue individual policy if one of the following conditions is satisfied:

- 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 moved 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 that 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 that complies with Florida law. In this case, you will not qualify for any other guaranteed-issue plan.

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 groups 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 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) that 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 Department is ready to help you. If you or your insurance agent has a question, call the 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, under certain circumstances, 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

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

You have the right to 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 copayment, 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 the 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

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 copayments, coinsurance and deductibles.

Service

You are responsible for arranging prior approval before accepting nonemergency care from a noncontracted 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 noncontracted 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 copayment, or possibly a deductible and coinsurance, that is the standard part of your HMO contract.

INSURANCE DISCRIMINATION AGAINST VICTIMS OF ABUSE

Florida has adopted laws to protect victims of abuse from discrimination. Florida law (Section 626.9541) provides that it is illegal for insurers to use information that someone has sought, or should have sought, treatment, protection or shelter in the past for abuse, or that abuse might occur in the future as a result of an assault, battery or sexual assault by a family or household member. Insurers cannot:

- Base a decision to underwrite a policy;
- Refuse to issue, reissue or renew a policy;
- Refuse to pay a claim;
- Cancel or otherwise terminate a policy; or
- Increase rates

based on a person's status as a victim, or potential victim, of abuse.

Abuse is broadly defined to mirror the definition of domestic violence in Section 741.28. These laws protect all Floridians from discriminatory actions by health, life, disability, property and casualty, or automobile insurers or managed care providers.

Steps to Take!

- If you are a victim of domestic violence or abuse and you are denied insurance, if your rates are raised or if the insurer refuses to pay a claim, demand in writing that the insurer explain in writing why it took this action.
- Find out if information about your medical history is in the Medical Information Bureau (MIB), and request a report to see if it mentions abuse or any abuse-related matters. The report is free if you have a letter from an insurance company saying it used MIB information to make a decision about you. [Medical Information Bureau, (617) 426-3660, P.O. Box 105, Essex Station, Boston, MA 02112; www.mib.com]
- File an appeal with the insurer, as described in your policy.
- Call the Consumer Helpline toll-free at 1-800-342-2762, or go to the Department's Web site at www.fldfs.com.

FREQUENTLY ASKED QUESTIONS

Do all HMOs offer individual and group contracts?

No. Approximately one-third of HMOs licensed by the Department of Financial Services 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 copayment, and possibly coinsurance and deductibles). 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. Nonemergency 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 Financial Services?

Yes. To verify whether a sales representative is licensed, call the 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 it and respond to you. If the matter is not resolved after that period of time, call the 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.

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 Department, provide a way for you to protect this personal information. As the policyholder, you must take the lead in protecting your personal information.

You already may have received, or soon will receive, privacy notices 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 Consumer Helpline toll-free at 1-800-342-2762.



Medical Privacy and the Medical Information Bureau

The Medical Information Bureau (MIB) is a data bank of medical and nonmedical 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 can help you resolve the situation by presenting your concerns to the HMO 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 acknowledgement 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 problem or question, 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 with the health plan provider itself.
- An external appeal is filed with the Department of Financial Services 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 Program Panel. Your claim cannot be denied if the Statewide Provider and Subscriber Assistance Program 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 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:

Fictional services – A health care provider bills an HMO for an unnecessary service, or unauthorized services that were never rendered.

Receipt of kickbacks – A health care provider receives illegal kickbacks from other providers for new patient referrals.

Applicant fraud – An applicant deliberately withholds information about a pre-existing condition in hopes of obtaining HMO coverage.

Unauthorized “balance billing” – A contracted health care provider bills a patient for the portion of services that the HMO is responsible for paying.

Deceptive 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 Department of Financial Services’ toll-free Fraud Hotline at 1-800-378-0445.

* Source: *The Coalition Against Insurance Fraud*

COMMUNITY OUTREACH PROGRAMS


The Department of Financial Services offers free community outreach programs on a variety of topics to help you make sound financial decisions and avoid becoming a victim of insurance or financial fraud. Speakers are available on the topic of your choice and will work with you to tailor programs to your group’s needs. Choose from one of the topics listed here or call us with your requests. For more information, please contact the Service Office in your area, or call toll-free 1-800-342-2762.

Consumer Protection Topics

- **Consumer Beware: Insurance Scams and Financial Fraud**
- **Wheels, Deals and Credit Card Spiels**
- **Are You Covered? Avoid Illegal Insurance Practices**
- **Predatory Lending**
- **Living in a Danger Zone: Hurricane and Disaster Preparedness**
- **New to Florida? How to Cover your Assets**
- **Young Drivers**
- **Insurance and Financial Needs in the Golden Years**
- **Health, HMOs, Long-Term Care and Medicare Supplement Insurance**
- **Small-Business Insurance Needs**
- **Workers’ Compensation**



List of Mandated Health Insurance and HMO Benefits



The term “mandatory health insurance benefits” is subject to different interpretations. Broadly interpreted to include any coverage requirement, mandatory benefits include: (1) required policy benefits; (2) required offer of benefits; (3) required payment to a class of providers; and (4) required coverage of insureds and other underwriting restrictions. Florida has currently mandated health benefits for each of the following categories.

CHART A: Mandated Health Insurance and HMO Benefits

	Coverage Required	Summary
1.	Acupuncturists	If a policy provides coverage for acupuncture, the policy must cover the services of an acupuncturist certified pursuant to Chapter 457 under the same conditions that apply to services of a licensed physician.
2.	Ambulatory Surgical Centers	A policy must provide coverage for any service performed in an ambulatory surgical center, as defined in S. 395.002, if such service would have been covered as an eligible inpatient service.
3.	Birthing Centers and Nurse Midwives	A policy or HMO contract that provides coverage for maternity care must cover the services of certified nurse midwives and midwives licensed under Chapter 467, and birth centers licensed under SS. 383.30-383.335.
4.	Bone Marrow Transplants	The policy may not exclude coverage for bone marrow transplant procedures recommended by referring and treating physicians under a policy exclusion for experimental or investigative procedures if the particular use of the procedure is determined to be accepted within the appropriate oncological specialty and not experimental pursuant to rules adopted by the Agency for Health Care Administration, based on the recommendations of an advisory panel. Procedures must include costs associated with the donor-patient.
5.	Cancer Drugs	If a policy covers the treatment of cancer, an insurer may not exclude coverage for any prescribed drug on the ground that the drug is not approved by the U.S. Food and Drug Administration, if that drug is recognized for treatment of that indication in a standard reference compendium or recommended in the medical literature, unless the FDA has determined that the use of the drug is contraindicated or has not otherwise approved the drug for any indication.
6.	Child Health Supervision Services	Policy benefits for children must include coverage for child health supervision services from birth to age 16 and be exempt from any deductible. Services include physical examinations, developmental assessment and anticipatory guidance, and immunizations and laboratory tests, consistent with the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics.
7.	Children: Adopted and Foster Children	Benefits applicable to children apply to an adopted child and foster child from the moment of placement in the residence. Coverage begins at the moment of birth if a prior written agreement to adopt the child has been executed. The policy may not exclude coverage for any pre-existing condition except in the case of a foster child. For HMOs and small group policies, only the benefits applicable to adopted children apply.
8.	Children: Handicapped	Policies covering children must continue to provide coverage beyond the age limit for dependent children as long as the child continues to be incapable of self-sustaining employment due to mental retardation or physical handicap, and is chiefly dependent on the policyholder or subscriber for support.
9.	Children: Newborn Coverage	Policies covering a family member of the insured must provide coverage for a newborn child from the moment of birth. The policy must also cover the newborn child of a covered family member (son or daughter), which coverage terminates 18 months after birth.

Individual Health Policies	Group Health Policies and Small Group Street Plans	HMO Contracts and Group Street Plans	Out-of-State Groups	Standard & Basic (HMO & Ins.)
required	required	not required	not required	not required
required	required	not required	not required	required
required	required	required	required	required
required	required	required	not required	required
required	required	not required	not required	not required
required	required	required	required	required
required	required	required	not required	required
required	required	required	not required	required
required	required	required	required	required

**Please Note:* This is a standardized policy form, and the benefit is included in the standardized form but it is not required by law.

CHART A: Mandated Health Insurance and HMO Benefits

	Coverage Required	Summary
10.	Children: Dependent Coverage to Age 25	Group health insurance policies that insure dependent children must continue coverage at least until the end of the calendar year in which the child reaches age 25 if the child is dependent upon the policyholder or certificateholder for support and the child is either living in the household of the certificateholder or is a full-time or part-time student.
11.	Chiropractors	A health insurance policy must be construed to include payment to a chiropractic physician who provides covered benefits or procedures within the scope of his or her license. (Not applicable to HMOs.)
12.	Cleft Lip/Palate for Children	Policy benefits for a child under age 18 must include treatment of cleft lip and cleft palate, including medical, dental, speech therapy, audiology and nutrition services if prescribed by the treating physician or surgeon and certified as medically necessary.
13.	Continuation of Group Coverage	Group policies covering fewer than 20 employees must allow an employee to continue coverage for 18 months (or 29 months for handicapped individuals; 36 months for divorced and widowed spouses) after their group coverage would otherwise terminate, subject to payment of up to 115 percent of the group premium. (Comparable to the federal COBRA law for employers with 20 or more employees.)
14.	Continued Coverage with Terminated Provider	If a contract between an HMO and a provider is terminated for any reason other than for cause, each party shall allow HMO subscribers for whom treatment was active, to continue coverage through completion of medically necessary treatment, until the subscriber picks another provider, or during the next open enrollment period offered by the HMO, not to exceed six months or through postpartum care if pregnant.
15.	Conversion to Individual Coverage	After group coverage (large or small) terminates (after any COBRA extension), the insurer or HMO must offer an individual conversion policy.
16.	Denial of Coverage Due to Breast Cancer	An insurer or HMO may not exclude or deny coverage solely because the insured has been diagnosed as having a fibrocystic condition or a nonmalignant lesion that demonstrates a predisposition to, or solely due to a family history of, breast cancer, unless the condition is diagnosed through a breast biopsy that demonstrates an increased disposition to developing breast cancer. Coverage also may not be denied nor canceled solely due to breast cancer if the insured has been free from breast cancer for more than two years before the request for coverage.
17.	Dental Care (Employer Offer of Open-Panel Plan)	Any employer, group, or organization that pays or contributes to the premiums of a group health plan or dental service plan which provides dental coverage only through an exclusive list of dentists must provide an alternative to enable the insured to have a free choice of dentist. (Note: This requirement applies to employers, not insurers.)
18.	Dental Procedures for Children: General	If the policy provides coverage for general anesthesia and hospitalization services, such services must be provided for dental care to a person under age 8, if the dental condition is likely to result in a medical condition if left untreated and if the child's dentist and physician determine dental treatment in a hospital or ambulatory surgical center is necessary due to the complex nature of the procedure or due to a significant or undue medical risk.

Individual Health Policies	Group Health Policies and Small Group Street Plans	HMO Contracts and Group Street Plans	Out-of-State Groups	Standard & Basic (HMO & Ins.)
not required	required	not required	not required	not required* (but included in policy)
required	required	not required	required	required
required	required	required	required	required
not required	required	required	not required	required
not required	not required	required	not required	not required
not required	required	required	required	not required* (but included in the policy)
required	required	required	not required	not required
not required	required	not required	not required	not required
required	required	required	not required	not required

*Please Note: This is a standardized policy form, and the benefit is included in the standardized form but it is not required by law.

CHART A: Mandated Health Insurance and HMO Benefits

	Coverage Required	Summary
19.	Dentists	The word “physician,” when used in a health insurance policy providing for the payment of surgical procedures performed in an accredited hospital in consultation with a licensed physician, must be construed to include payment to a dentist who provides benefits or procedures within the scope of his or her license.
20.	Dermatologists (Direct Access)	HMO contracts and insurer EPO contracts must provide direct access (without referral or authorization) for up to five office visits annually, including minor procedures and testing, to a dermatologist who is under contract with the insurer or HMO.
21.	Diabetes Treatment	Policy must cover all medically appropriate and necessary equipment, supplies, and diabetes outpatient self-management training and educational services used to treat diabetes, if the treating physician or a physician who specializes in the treatment of diabetes certifies that such services are necessary.
22a.	Emergency Care (EPO)	Insurers issuing exclusive provider organization (EPO) contracts must cover nonexclusive providers if the services are for symptoms requiring emergency care and a network provider is not reasonably accessible.
22b.	Emergency Care (HMO)	HMOs must provide coverage, without prior authorization, for emergency care (screening and stabilization) based on the determination by a hospital physician or appropriate licensed professional hospital personnel under supervision of a physician, provided by either a participating or nonparticipating provider.
23.	Enteral Feeding Formulas/ Treatment of PKU	The policy must make available to the policyholder (e.g., to an employer under a group policy) as part of the application, for an appropriate additional premium, coverage for prescription and nonprescription enteral formulas (nutrient and food supplements) for home use which are prescribed by a physician as medically necessary for the treatment of inherited diseases of amino acid, organic acid, carbohydrate, or fat metabolism or for malabsorption originating from congenital defects or acquired during the neonatal period. The coverage may not exceed \$2,500 per year for an insured through age 24.
24.	Extension of Benefits	A group policy must provide for a 12-month extension of major medical benefits for a person who is totally disabled at the date of discontinuance of the policy, regardless of whether replacement coverage is obtained. Specific requirements apply to extension of benefits for maternity expense and dental procedures. (The requirements for dental procedures do not apply to HMOs.)
25.	Guaranteed Availability of Individual Coverage (HIPAA-Eligible)	Persons who lose coverage after being covered for at least 18 months, the most recent of which is group coverage, are entitled to individual coverage. If the prior coverage is under an insured group plan, the group insurer must offer an individual conversion policy. If the prior coverage is with a self-insured plan, coverage may be obtained on a guaranteed-issue basis from any insurer or HMO issuing individual coverage. Persons who lose eligibility for individual coverage issued in Florida due to the insurer becoming insolvent, the insurer discontinuing all coverage in the state, or the individual moving out of the service area of the insurer or HMO, are entitled to guaranteed-issuance of coverage from any individual carrier.
26.	Guaranteed Renewability	All individual and group policies and group HMO contracts must be guaranteed renewable, subject to certain exceptions.

Individual Health Policies	Group Health Policies and Small Group Street Plans	HMO Contracts and Group Street Plans	Out-of-State Groups	Standard & Basic (HMO & Ins.)
required	required	not required	required	required
required	required	required	not required	not required
required	required	required	not required	required
required	required	not required	not required	not required
not required	not required	required	not required	required
required	required	not required	not required	not required
not required	required	required	required	not required* (but included in the policy)
required	required	required	required	required
required	required	required	required	required

*Please Note: This is a standardized policy form, and the benefit is included in the standardized form but it is not required by law.

CHART A: Mandated Health Insurance and HMO Benefits

	Coverage Required	Summary
27.	HIV Coverage	A policy may not exclude coverage for HIV infection or acquired immune deficiency syndrome, except as provided in a pre-existing condition exclusion.
28.	Home Health Care Services	A group policy must provide coverage of a least \$1,000 per year for home health care by a licensed home health care agency, as prescribed by a licensed physician.
29.	Mammograms	A policy must include coverage for a baseline mammogram for a woman age 35 to 39, a mammogram every two years for a woman age 40 to 49, every year for a woman age 50 or older, and one or more per year based on a physician's recommendation for a woman who is at risk for breast cancer based on specified criteria.
30.	Massage Therapists	If a policy or HMO contract provides coverage for a massage, it must cover the services of a person licensed to practice massage under Chapter 480, if the massage is prescribed as medically necessary by a physician licensed under chapters 458, 459, 460, or 461, and the prescription specifies the number of treatments.
31.	Mastectomy: Length of Stay and Outpatient Coverage	A policy that provides coverage for breast cancer may not limit inpatient hospital coverage for mastectomies to any period that is less than that determined by the treating physician to be medically necessary in accordance with prevailing medical standards and after consultation with the insured patient. Must also provide coverage for outpatient post-surgical follow-up care in keeping with prevailing medical standards by a licensed health care professional qualified to provide such care.
32.	Mastectomy: Surgical Procedures and Devices	If the policy provides coverage for a mastectomy, coverage must include prosthetic devices and breast reconstructive surgery incident to a mastectomy.
33.	Maternity Care: Length of Stay and Post-Delivery Care	A policy that provides coverage for maternity benefits or newborn coverage may not limit coverage for length of stay in a hospital or for follow-up care outside of a hospital to any time period less than that determined to be medically necessary by the treating obstetrical care provider or the pediatric care provider, in accordance with prevailing medical standards. The policy must provide coverage for post-delivery care for the mother and infant, including medically necessary clinical tests and immunizations.
34.	Mental and Nervous Disorders	Insurers and HMOs must make available to a group policyholder (e.g., the employer) as part of the application, for an appropriate additional premium, coverage for mental and nervous disorders. If mental health benefits are elected, coverage must include at least 30 days of inpatient coverage and at least \$1,000 per year for outpatient benefits for consultations with a licensed physician, psychologist, mental health counselor, marriage and family therapist, and/or clinical social worker.
35.	Newborn Hearing Screenings	Policies covering a family member of the insured must provide coverage for the initial hearing screening and any medically necessary follow-up re-evaluations leading to diagnosis shall be a covered benefit.
36.	Nurse Anesthetists	HMO contracts that provide anesthesia coverage or services shall offer to the subscriber, if requested and available, the services of a licensed certified registered nurse anesthetist.

Individual Health Policies	Group Health Policies and Small Group Street Plans	HMO Contracts and Group Street Plans	Out-of-State Groups	Standard & Basic (HMO & Ins.)
required	required	required	required	required
not required	required	not required	not required	not required* (but included in the policy)
required	required	required	required	required
required	required	required	not required	not required
required	required	required	required	required
required	required	required	required	required
required	required	required	required	required
not required	required	required	not required	required
required	required	required	required	required
not required	not required	required	not required	not required

*Please Note: This is a standardized policy form, and the benefit is included in the standardized form but it is not required by law.

CHART A: Mandated Health Insurance and HMO Benefits

	Coverage Required	Summary
37.	OB/GYN Annual Visits	Insurers issuing EPO contracts and HMOs must allow, without prior authorization, a female subscriber to visit a contracted OB/GYN for one annual visit and for medically necessary follow-up care detected at that visit.
38.	OB/GYNs	HMOs must allow each female subscriber to select as her primary physician an obstetrician/gynecologist.
39.	Ophthalmologists	Insurance policy and HMO contracts which provide coverage or services that are performed by physicians who are ophthalmologists, licensed under chapter 458 or 459, must offer the subscriber the services of an ophthalmologist.
40a.	Optometrists	A health insurance policy that provides coverage for services within the scope of an optometrist's licenses shall be construed to include payment to an optometrist who performs such procedures.
40b.	Optometrists (HMO)	HMO contracts that provide coverage or services as described in S. 463.002(5), must offer to the subscriber the services of an optometrist licensed under Chapter 463.
41.	Osteopathic Hospitals	Small-employer policies and HMO contracts that provide for inpatient and outpatient services by allopathic hospitals must provide as an option for the patient or subscriber similar inpatient and outpatient services by an osteopathic hospital when the services are available in the HMO service area.
42a.	Osteopaths	For insurance policies, a physician licensed under Chapter 459 (osteopaths).
42b.	Osteopaths (HMO)	For HMOs, a primary physician licensed under chapter 458 (allopathic physicians) or 459 (osteopaths), and chapters 460 (chiropractors) and 461 (podiatrists) must be designated for each subscriber upon request.
43.	Osteoporosis Diagnosis and Treatment	A policy must provide coverage for the medically necessary diagnosis and treatment of osteoporosis for high-risk individuals, including individuals with a family history of osteoporosis and other specified high-risk criteria.
44.	Out-of-Hospital Services	A policy must provide coverage for treatment provided outside a hospital if such treatment would be covered on an inpatient basis and is provided by a health care provider whose services would be covered under the policy if performed in a hospital.
45a.	Podiatrists	A health insurance policy that provides coverage for services within the scope of a podiatrist's license shall be construed to include payment to a podiatrist who performs such procedures.
45b.	Podiatrists (HMO)	For HMOs, a primary physician licensed under chapter 458 (allopathic physicians) or 459 (osteopaths), and chapters 460 (chiropractors) and 461 (podiatrists) must be designated for each subscriber upon request.
46a.	Pre-existing Conditions: Individual Policies	Individual health insurance policies and individual HMO contracts may not exclude pre-existing conditions for more than 24 months and may relate only to conditions that manifested themselves during the 24-month period before coverage. However, the policy may exclude coverage for named or specific conditions without any time limit.

Individual Health Policies	Group Health Policies and Small Group Street Plans	HMO Contracts and Group Street Plans	Out-of-State Groups	Standard & Basic (HMO & Ins.)
required	required	required	not required	not required
not required	not required	required	not required	required
required	required	required	required	required
required	required	not required	required	required
not required	not required	required	not required	required
not required	required	required	not required	not required* (but included in the policy)
required	required	required	required	not required* (but included in the policy)
not required	not required	required	not required	not required
required	required	required	not required	not required
required	required	not required	not required	not required
required	required	not required	required	required
not required	not required	required	not required	required
required	not required	required	not required	not required

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CHART A: Mandated Health Insurance and HMO Benefits

	Coverage Required	Summary
46b.	Pre-existing Conditions: Group Policies	Group policies and group HMO contracts may not exclude pre-existing conditions for more than 12 months, or 18 months in the case of a late enrollee, and may relate only to conditions that manifested themselves during the six-month period prior to coverage. The period of the exclusion is reduced by the time the insured was covered under prior creditable coverage.
47.	Primary Care Physicians	For HMOs, a primary physician licensed under chapter 458 (allopathic physicians) or 459 (osteopaths), and chapters 460 (chiropractors) and 461 (podiatrists) must be designated for each subscriber upon request.
48.	Psychotherapeutic Providers	An insurer issuing coverage through preferred providers (PPO policies) or through exclusive providers (EPO policies) that cover psychotherapeutic services, must provide eligibility requirements for all groups of health care providers licensed under Chapters 458, 459, 490 and 491, which include psychotherapy in their scope of practice, and certified advanced registered nurse practitioners in psychiatric mental health under S. 464.012.
49.	Special Enrollment Periods	Insurers and HMOs issuing group health policies and contracts must: 1) allow an employee to enroll who previously did not enroll due to having other coverage, and the other coverage terminates due to certain conditions; 2) allow a person to enroll who becomes a dependent of a covered person by reason of marriage, birth or adoption.
50.	Substance Abuse	Insurers and HMOs must make available to a group policyholder (e.g., the employer) as part of the application, specified benefits for substance abuse, subject to the right of the applicant to select any alternative benefits as may be offered. The specified level of benefits that must be offered must have a minimum lifetime benefit of \$2,000, a maximum of 44 outpatient visits and a maximum benefit of \$35 per outpatient visit. Treatment must be provided by, or under the supervision of, or prescribed by, a licensed physician or psychologist.
51.	TMJ	A policy that provides coverage for any diagnostic or surgical procedure involving bones or joints of the skeleton may not discriminate against coverage for such procedures involving bones or joints of the jaw and facial region if such procedure or surgery is medically necessary to treat conditions caused by congenital or developmental deformity, disease or injury.

Individual Health Policies	Group Health Policies and Small Group Street Plans	HMO Contracts and Group Street Plans	Out-of-State Groups	Standard & Basic (HMO & Ins.)
not required	required	required	not required	required
not required	not required	required	not required	not required
required	required	not required	not required	not required
not required	required	required	not required	required
not required	required	required	not required	required
required	required	required	required	not required* (but included in the policy)

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FLORIDA COUNTIES AND THEIR LICENSED HMOs

As of January 2004

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 (Appendix C). 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 Appendix D.

Alachua

Av-Med Health Plan, Inc.
Health Options, Inc.
United Healthcare of Florida, Inc.
Vista Healthplan, Inc.

Baker

Aetna U.S. Healthcare, Inc.
Av-Med Health Plan, Inc.
Health Options, Inc.
Humana Medical Plan, Inc.

Bay

NONE

Bradford

Av-Med Health Plan, Inc.
Health Options, Inc.
United Healthcare of Florida
Vista Healthplan, Inc.

Brevard

Aetna U.S. Healthcare, Inc.
Cigna Healthcare of Florida, Inc.
Health First Health Plans, Inc.
Health Options, Inc.
United Healthcare of Florida, Inc.
Well Care HMO, Inc.

Broward

America's Health Choice
Aetna U.S. Healthcare, Inc.
Av-Med Health Plan, Inc.
Careplus Health Plans, Inc.
Cigna Healthcare of Florida, Inc.
Great-West Healthcare of Florida
Health Options, Inc.

Humana Medical Plan, Inc.
JMH Health Plan, Public Health
Trust of Dade County
Neighborhood Health
Partnership, Inc.
Preferred Medical Plan, Inc.
Total Health Choice
United Healthcare of Florida
Vista Healthplan, Inc.
Vista Healthplan of South Florida, Inc.

Calhoun

Vista Healthplan, Inc.

Charlotte

Aetna U.S. Healthcare, Inc.
CarePlus Health Plans
Health Options, Inc.
United Healthcare of Florida, Inc.

Citrus

Av-Med Health Plan, Inc.
Health Options, Inc.
Humana Medical Plan, 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 Healthcare of Florida, Inc.

Collier

Careplus Health Plans
United Healthcare of Florida, Inc.

Columbia

Av-Med Health Plan, Inc.
Health Options, Inc.
United Healthcare of Florida, Inc.
Vista Healthplan, Inc.

Dade

Aetna U.S. Healthcare, Inc.
Av-Med Health Plan, Inc.
Careplus Health Plans, Inc.
Cigna Healthcare of Florida, Inc.
Great-West Healthcare of Florida
Health Options, Inc.
Humana Medical Plan, Inc.
JMH Health Plan, Public Health
Trust of Dade County
Neighborhood Health
Partnership, Inc.
Preferred Care Partners
Preferred Medical Plan, Inc.
Total Health Choice, Inc.
United Healthcare of Florida, Inc.
Vista Healthplan, Inc.
Vista Healthplan of South Florida

De Soto

CarePlus Health Plans, Inc.
Health Options, Inc.
United Healthcare of Florida, Inc.

Dixie

Av-Med Health Plan, Inc.
Health Options, Inc.
Vista Healthplan, Inc.

Duval

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

Escambia

Health Options, Inc.
United Healthcare of Florida, Inc.
Vista Healthplan, Inc.
Well Care HMO, Inc.

Flagler

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

Franklin

Vista Healthplan, Inc.

Gadsden

Capital Group Health Services of Florida, Inc.
Vista Healthplan, Inc.

Gilchrist

Av-Med Health Plan, Inc.
Health Options, Inc.
Vista Healthplan, Inc.

Glades

Vista Healthplan, Inc.

Gulf

NONE

Hamilton

Av-Med Health Plan, Inc.
Vista Healthplan, Inc.

Hardee

CarePlus Health Plans, Inc.

Hendry

Health Options, Inc.
Vista Healthplan, Inc.

Hernando

Av-Med Health Plan, Inc.
Health Options, Inc.
Humana Medical Plan, Inc.
Quality Health Plans, Inc.
United Healthcare of Florida, Inc.
Universal Health Care
Vista Healthplan, Inc.

Highlands

CarePlus Health Plans, Inc.
United Healthcare of Florida, Inc.

Hillsborough

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

Hillsborough (cont)

Cigna Health Care of Florida, Inc.
Citrus Health Care, Inc.
Great-West Healthcare of Florida
Health Options, Inc.
Humana Medical Plan, Inc.
United Healthcare of Florida, Inc.
Vista Healthplan, Inc.

Holmes

NONE

Indian River

Aetna U.S. Healthcare, Inc.
America's Health Choice

Jackson

NONE

Jefferson

Capital Group Health Services of Florida, Inc.
Vista Healthplan, Inc.

Lafayette

Vista Healthplan, Inc.

Lake

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

Lee

Aetna U.S. Healthcare, Inc.
Av-Med Health Plan, Inc.
CarePlus Health Plans, Inc.
Great-West Healthcare of Florida
Health Options, Inc.
United Healthcare of Florida, Inc.

Leon

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

Levy

Av-Med Health Plan, Inc.
Health Options, Inc.
Vista Healthplan, Inc.

Liberty

Vista Healthplan, Inc.

Madison

Vista Healthplan, Inc.

Manatee

Aetna U.S. Healthcare, Inc.
Amerigroup Florida, Inc.
Careplus Health Plans, Inc.
Health Options, Inc.
Humana Medical Plan, Inc.
United Healthcare of Florida, Inc.
Universal Health Care

Marion

Aetna U.S. Healthcare, Inc.
Av-Med Health Plan, Inc.
Health Options, Inc.
United Healthcare of Florida, Inc.
Vista Healthplan, Inc.

Martin

America's Health Choice
Health Options, Inc.
Humana Medical Plan, Inc.
Vista Healthplan of South Florida

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 Healthcare of Florida, Inc.

Okaloosa

Health Options, Inc.
United Healthcare of Florida, Inc.

Okeechobee

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

Orange

Aetna U.S. Healthcare, Inc.
Av-Med Health Plan, Inc.
Careplus Health Plans, Inc.
Cigna Health Care of Florida, Inc.
Great-West Healthcare of Florida
Health Options, Inc.

Orange (cont.)

Humana Medical Plan, Inc.
United Healthcare of Florida, Inc.
Vista Healthplan, Inc.

Osceola

Aetna U.S. Healthcare, Inc.
Av-Med Health Plan, Inc.
CarePlus Health Plans, Inc.
Cigna Healthcare of Florida, Inc.
Health Options, Inc.
Humana Medical Plan, Inc.
United Healthcare of Florida, Inc.
Vista Healthplan, Inc.

Palm Beach

Aetna U.S. Healthcare, Inc.
America's Health Choice
Av-Med Health Plan, Inc.
Careplus Health Plans, Inc.
Cigna Healthcare of Florida, Inc.
Great-West Healthcare of Florida
Health Options, Inc.
Humana Medical Plan, Inc.
Neighborhood Health
Partnership, Inc.
Total Health Choice
United Healthcare of Florida, Inc.
Vista Healthplan, Inc.
Vista Healthplan of South Florida

Pasco

Aetna U.S. Healthcare, Inc.
Av-Med Health Plan, Inc.
CarePlus Health Plans, Inc.
Cigna Healthcare of Florida, Inc.
Citrus Health Care, Inc.
Great-West Healthcare of Florida
Health Options, Inc.
Humana Medical Plan, Inc.
Quality Health Plans, Inc.
United Healthcare of Florida, Inc.
Vista Healthplan, Inc.

Pinellas

Aetna U.S. Healthcare, Inc.
Av-Med Health Plan, Inc.
CarePlus Health Plans, Inc.
Cigna Healthcare of Florida, Inc.
Citrus Health Care, Inc.
Great-West Healthcare of Florida
Health Options, Inc.
Humana Medical Plan, Inc.
United Healthcare of Florida, Inc.
Vista Healthplan, Inc.

Polk

Aetna U.S. Healthcare, Inc.
Av-Med Health Plan, Inc.
CarePlus Health Plans, Inc.
Cigna Healthcare of Florida, Inc.
Citrus Health Care, Inc.
Great-West Healthcare of Florida
Health Options, Inc.
Humana Medical Plan, Inc.
Quality Health Plans, Inc.
United Healthcare of Florida, Inc.

Putnam

United Healthcare of Florida, Inc.

St. Johns

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

St. Lucie

Aetna U.S. Healthcare, Inc.
America's Health Choice
Health Options, Inc.
Vista Healthplan of South Florida

Santa Rosa

Health Options, Inc.
United Healthcare of Florida, Inc.
Vista Healthplan, Inc.

Sarasota

Aetna U.S. Healthcare, Inc.
Av-Med Health Plan, Inc.
CarePlus Health Plans, Inc.
Health Options, Inc.
Humana Medical Plan, Inc.
United Healthcare of Florida, Inc.
Universal Health Care

Seminole

Aetna U.S. Healthcare, Inc.
Av-Med Health Plan, Inc.
CarePlus Health Plans, Inc.
Cigna Healthcare of Florida, Inc.
Florida Health Care Plan, Inc.
Great-West Healthcare of Florida
Health Options, Inc.
Humana Medical Plan, Inc.
United Healthcare of Florida, Inc.
Vista Healthplan, Inc.

Sumter

Health Options, Inc.
Quality Health Plans, Inc.

Suwannee

Av-Med Health Plan, Inc.
Health Options, Inc.
United Healthcare of Florida
Vista Healthplan, Inc.

Taylor

NONE

Union

Av-Med Health Plan, Inc.
United Healthcare of Florida, Inc.

Vista Healthplan, Inc.

Volusia

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

Wakulla

Capital Group Health Services of Florida, Inc.
Vista Healthplan, Inc.

Walton

Health Options, Inc.

Washington

FLORIDA HMO COMPANY CONTACT INFORMATION

As of March 31, 2004

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 in Appendix B.

Aetna Health, Inc.
4630 Woodlands Corporate Blvd.
Tampa, FL 33614
Toll-free: 1-800-936-2603
Enrollment: 524,657
Contracts: Group

America's Health Choice
Medical Plans, Inc.
1175 South U.S. Hwy. 1
Vero Beach, FL 32962
(772) 794-0030
Toll Free: 1-800-308-9823
Enrollment: 14,419
Contracts: Medicare

Amerigroup Florida, Inc.
4200 W. Cypress St.
Tampa, FL 33607
Toll-free: 1-800-873-7474
Enrollment: 231,696
Contracts: Medicaid

Av-Med, Inc.
4300 N.W. 89th Blvd.
Gainesville, FL 32606
Toll-free: 1-800-346-0231
Enrollment: 193,866
Contracts: Group, Medicare,

Capital Health Plan, Inc
2140 Centerville Place
Tallahassee, FL 32308
(850) 383-3333
Toll-free: 1-800-390-1434
Enrollment: 109,944
Contracts: Group, Medicare

CarePlus Health Plans, Inc.
(formerly Florida First Health Plan, Inc.)
55 Alhambra Plaza, Suite 700
Coral Gables, FL 33134
Toll-free: 1-800-577-1072
Enrollment: 48,077
Contracts: Medicare

Cigna Healthcare of Florida, Inc.
3101 W. Martin Luther King Blvd., Suite 200
Tampa, FL 33607
(813) 353-4400
Toll-free: 1-800-283-2357
Enrollment: 82,685
Contracts: Group

Citrus Health Care, Inc.
5420 Bay Center Drive, Suite 250
Tampa, FL 33609
(813) 490-8900
Enrollment: 72
Contracts: Individual

Florida Health Care Plan, Inc.
1340 Ridgewood Ave.
Holly Hill, FL 32117
Phone: (386) 676-7100
Toll-free: 1-800-352-9824
Enrollment: 65,871
Contracts: Group, Medicare

Great-West Healthcare of Florida, Inc.
7650 Courtney Campbell Causeway,
Suite 850
Tampa, FL 33607
Toll-Free: 1-800-663-8081
Enrollment: 2,463
Contracts: Group

Healthcare of Florida, Inc.
6800 N. Dale Mabry Hwy., Suite 270
Tampa, FL 33614
(813) 290-6200
Toll Free: 1-800-278-0656
Enrollment: 206,860
Contracts: Medicaid

Health First Health Plans, Inc.
6450 S. U.S. Highway 1
Rockledge, FL 32955
(321) 434-5665
Toll Free: 1-800-716-7737
Enrollment: 52,058

Contracts: Group, Medicare
Health Options, Inc.
4800 Deerwood Campus Parkway
Jacksonville, FL 32246
Toll-free: 1-800-876-2227
Enrollment: 612,016
Contracts: Group, Individual,
Medicare

Healthy Palm Beaches, Inc.
324 Datura St., Suite 401
West Palm Beach, FL 33401
Phone: (561) 659-1270
Enrollment: 5,776
Contracts: Medicaid,

Humana Medical Plan, Inc.
3501 S.W. 160th Ave.
Miramar, FL 33027
Toll-free: 1-800-709-7809
Enrollment: 459,158
Contracts: Group, Individual, Medicaid,
Medicare

Neighborhood Health
Partnership, Inc.
7600 Corporate Center Drive
Suite 300
Miami, FL 33126
Phone: (305) 715-2500
Toll-free: 1-800-354-0222
Enrollment: 194,848
Contracts: Group, Medicaid,
Medicare

Preferred Care Partners, Inc.
9100 S. Dadeland Blvd., Suite 1250
Miami, FL 33156
Phone: (305) 670-2200
Toll-free: 1-800-872-9750
Enrollment: 5,146
Contracts: Medicare

Preferred Medical Plan, Inc.
4950 S.W. Eighth St.
Coral Gables, FL 33134
Phone: (305) 648-4000
Toll-free: 1-800-767-5551
Enrollment: 51,543
Contracts: Individual, Medicaid

The Public Health Trust of Dade County-JMH
Health Plan
1801 N.W. Ninth Ave., Suite 700
Miami, FL 33136
Phone: (305) 575-3700
Toll-free: 1-800-721-2993
Enrollment: 26,832
Contracts: Group, Individual, Medicaid

Quality Health Plans, Inc.
Holiday Tower
2435 U.S. Highway 19, Suite 470
Holiday, FL 34691
Toll Free: 1-866-747-2700
Enrollment: 15,710
Contracts: Medicare

Total Health Choice, Inc.
8701 S.W. 137th Ave.
Suite 200
Miami, FL 33183
(305) 408-5700
Toll-free: 1-800-887-6888
Enrollment: 16,127
Contracts: Group, Individual

United Healthcare of Florida, Inc.
495 N. Keller Rd.
Maitland, FL 32751
Toll-free: 1-800-899-6500 (Central Florida)
Toll-free: 1-800-767-3099 (West Florida)
Toll-free: 1-800-762-6662 (South Florida)
Enrollment: 622,099
Contracts: Group, Individual, Medicaid,
Medicare

Universal Health Care, Inc
150 2nd Ave. North, Suite 860
St. Petersburg, FL 33701
Phone: (727) 822-3446
Enrollment: 2,120
Contracts: Medicare

Vista Healthplan, Inc.
300 S. Park Road
Hollywood, FL 33021
Toll-free: 1-866-847-8235
Enrollment: 254,955
Contracts: Group, Individual, Medicare,
Medicaid

Vista Healthplan of South Florida
1340 Concord Terrace
Sunrise, FL 33323
(954) 858-3000
Toll Free: 1-800-422-7335
Enrollment: 73,387
Contracts: Group, Individual,
Medicaid, Medicare

Well Care HMO, Inc.
6800 N. Dale Mabry Highway,
Suite 270-299
Tampa, FL 33614
Phone: (813) 290-6200
Toll-Free 1-800-935-5227
Enrollment: 285,749
Contracts: Individual, Medicaid, Medicare

APPROVED MEDICARE HMOs BY COUNTY

As of August 2004

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.

Baker

Humana Medical Plan:
1-800-798-2458

Brevard

America's Health Choice
Medical Plans:
(772) 794-0030
Health First Health Plans, Inc.
Medicaid, Medicare
1-800-856-8652

Broward

America's Health Choice
Medical Plans:
(772) 794-0030
Av-Med:
1-800-250-9243
BCBS/Health Options:
1-800-876-2227
CarePlus Plan
1-800-747-6975
Humana Medical Plan:
1-800-798-2458
Neighborhood Health
Partnership:
1-800-305-2858
United Healthcare of Florida:
1-888-706-6565
Vista Healthplan:
1-866-847-8235
Vista Healthplan of South Florida:
1-800-826-1013

Charlotte

United Healthcare of Florida:
1-888-706-6565

Dade

Av-Med:
1-800-250-9243
BCBS/Health Options:
1-800-876-2227
CarePlus Plan
1-800-794-4105
Humana Medical Plan:
1-800-798-2458
Neighborhood Health
Partnership: 1-800-305-2858
Preferred Care Partners (PSO)
(305) 670-8437

Dade (cont.)

United Healthcare of Florida:
1-888-706-6565
Vista Healthplan
1-800-826-1013
Vista Healthplan of South Florida:
1-800-826-1013
Well Care Choice HMO:
1-888-888-9355

Duval

Humana Medical Plan:
1-800-922-2551

Escambia

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

Flagler

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

Gadsden

Capital Health Plan:
(850) 383-3333

Hernando

Humana Medical Plan:
1-800-798-2458
Medicare Masterpiece
1-866-690-4842
Quality Health Plans
1-866-747-2700
United Healthcare of Florida:
1-888-973-6467
Well Care Choice:
1-888-888-9355

Hillsborough

Citrus Healthcare
(813) 490-8900
Humana Medical Plan:
1-800-798-2458
United Healthcare of Florida:
1-800-973-6467
Well Care Choice:
1-888-888-9355

Indian River

America's Health Choice
 Medical Plans:
 (772) 794-0030
 Health First Health Plans, Inc.
 1-800-856-8652

Jefferson

Capital Health Plan:
 (850) 383-3333

Lee

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

Leon

Capital Health Plan:
 (850) 383-3333

Manatee

Medicare Masterpiece
 1-800-973-6467
 United Healthcare
 1-866-690-4842

Martin

America's Health Choice
 Medical Plans:
 (772) 794-0030

Nassau

Humana Medical Plan:
 1-800-798-2458

Okeechobee

America's Health Choice
 Medical Plans:
 (772) 794-0030

Orange

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

Osceola

Humana Medical Plan:
 1-800-336-6702
 Well Care Choice:
 1-888-888-9355

Palm Beach

America's Health Choice
 Medical Plans:
 (772) 794-0030
 BCBS/Health Options:
 1-800-876-2227
 CarePlus
 1-800-747-6975
 Humana Medical Plan:
 1-800-798-2458
 United Healthcare
 1-888-706-6565
 Vista Healthplan:
 1-800-826-1013
 Well Care Choice:
 1-888-888-9355

Pasco

Citrus Healthcare
 (813) 490-8900
 Humana Insurance (PPO)
 1-800-833-2318
 Humana Medical Plan:
 1-800-798-2458
 Quality Health Plans
 1-866-747-2700
 United Healthcare of Florida:
 1-800-973-6467
 Well Care Choice:
 1-888-888-9355

Pinellas

Citrus Healthcare
 (813) 490-8900
 Humana Insurance (PPO)
 1-800-833-2318
 Humana Medical Plan:
 1-800-798-2458
 United Healthcare of Florida:
 1-800-973-6467
 Well Care Choice:
 1-888-888-9355

Polk

Quality Health Plans
 1-866-747-2700
 United Healthcare of Florida
 1-800-873-6467

St. Lucie

America's Health Choice
 Medical Plans:
 (772) 794-0030

Santa Rosa

Well Care Choice:
 1-888-888-9355

Sarasota

Medicare Masterpiece
 1-866-690-4842
 United Healthcare of Florida
 1-800-973-6467

Seminole

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

Volusia

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

Wakulla

Capital Health Plan:
 (850) 383-3333

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 Financial Services. After the HMO 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 subscribers 45 days written notice of cancellation (other than for nonpayment of premium or termination of eligibility), along with the reason.

Coinsurance

Coinsurance is the cost that a policyholder must pay out of pocket. Coinsurance usually involves a percentage of what a procedure costs. Many policies require the buyer to pay 20 percent up to a certain dollar amount.

Copayment

A copayment 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.

Deductible

The deductible is the amount the insured must pay out of pocket before an insurance company pays its share. Usually, the higher the deductible, the lower the premium.

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 an eligible dependent.

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.

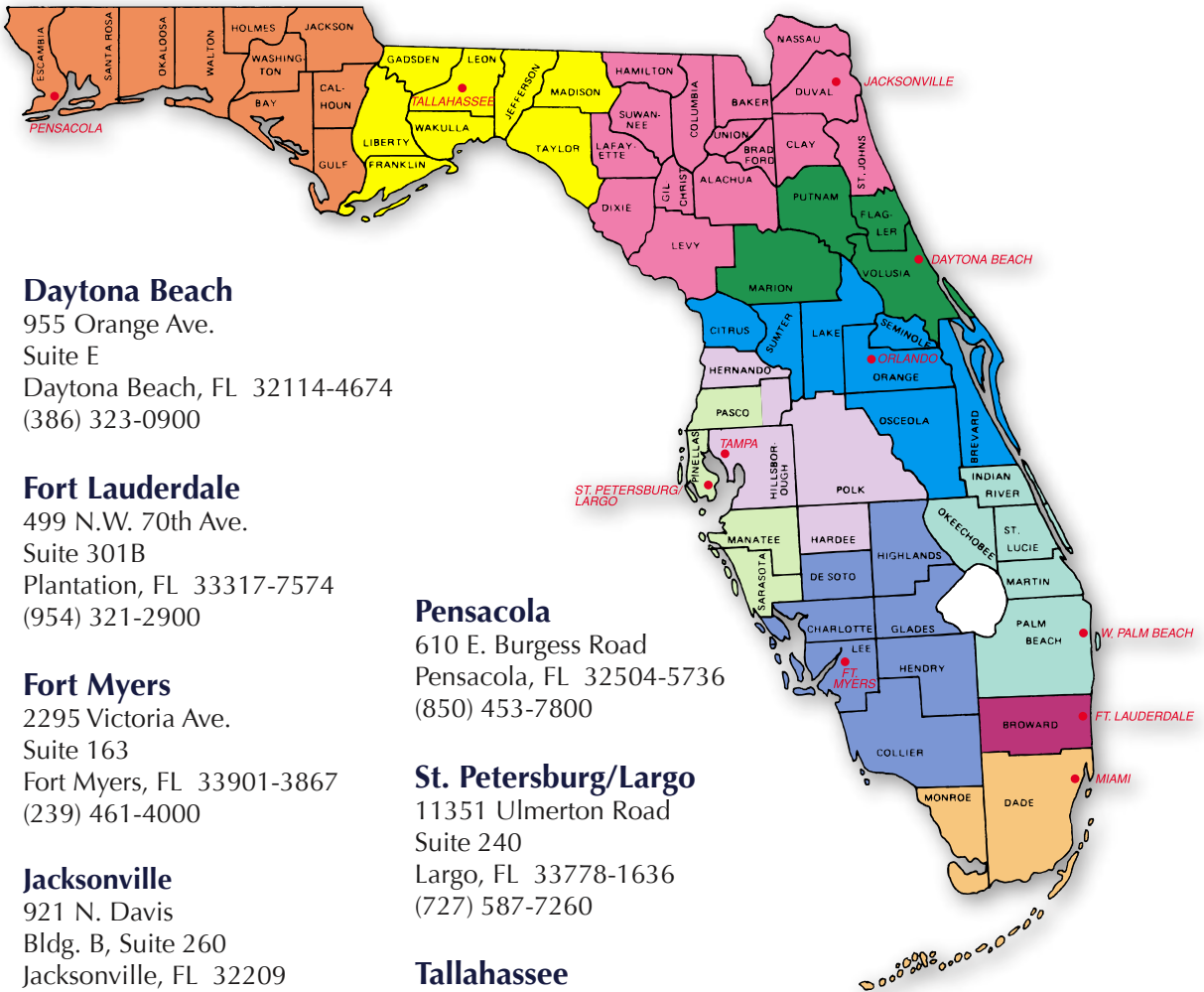
Statewide Provider and Subscriber Assistance Program Panel

The Statewide Provider and Subscriber Assistance Program Panel is a panel consisting of six members (three from the Department of Financial Services 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.

Service Offices



Daytona Beach

955 Orange Ave.
Suite E
Daytona Beach, FL 32114-4674
(386) 323-0900

Fort Lauderdale

499 N.W. 70th Ave.
Suite 301B
Plantation, FL 33317-7574
(954) 321-2900

Fort Myers

2295 Victoria Ave.
Suite 163
Fort Myers, FL 33901-3867
(239) 461-4000

Jacksonville

921 N. Davis
Bldg. B, Suite 260
Jacksonville, FL 32209
(904) 798-5800

Miami

401 N.W. Second Ave.
Suite N-307
Miami, FL 33128-1700
(305) 536-0300

Orlando

400 W. Robinson St.
Suite N-401
Orlando, FL 32801-1751
(407) 835-4400

Pensacola

610 E. Burgess Road
Pensacola, FL 32504-5736
(850) 453-7800

St. Petersburg/Largo

11351 Ulmerton Road
Suite 240
Largo, FL 33778-1636
(727) 587-7260

Tallahassee

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

Tampa

5309 E. Fowler Ave.
Tampa, FL 33617-2221
(813) 899-6160

West Palm Beach

400 N. Congress Ave.
Suite 210
West Palm Beach, FL 33401-2933
(561) 640-6700



FLORIDA
DEPARTMENT OF

FINANCIAL SERVICES

DIVISION OF CONSUMER SERVICES
200 E. GAINES ST.
TALLAHASSEE, FL 32399-0323