This consumer guide is sponsored by:

- **Citizens for the Right to Know**
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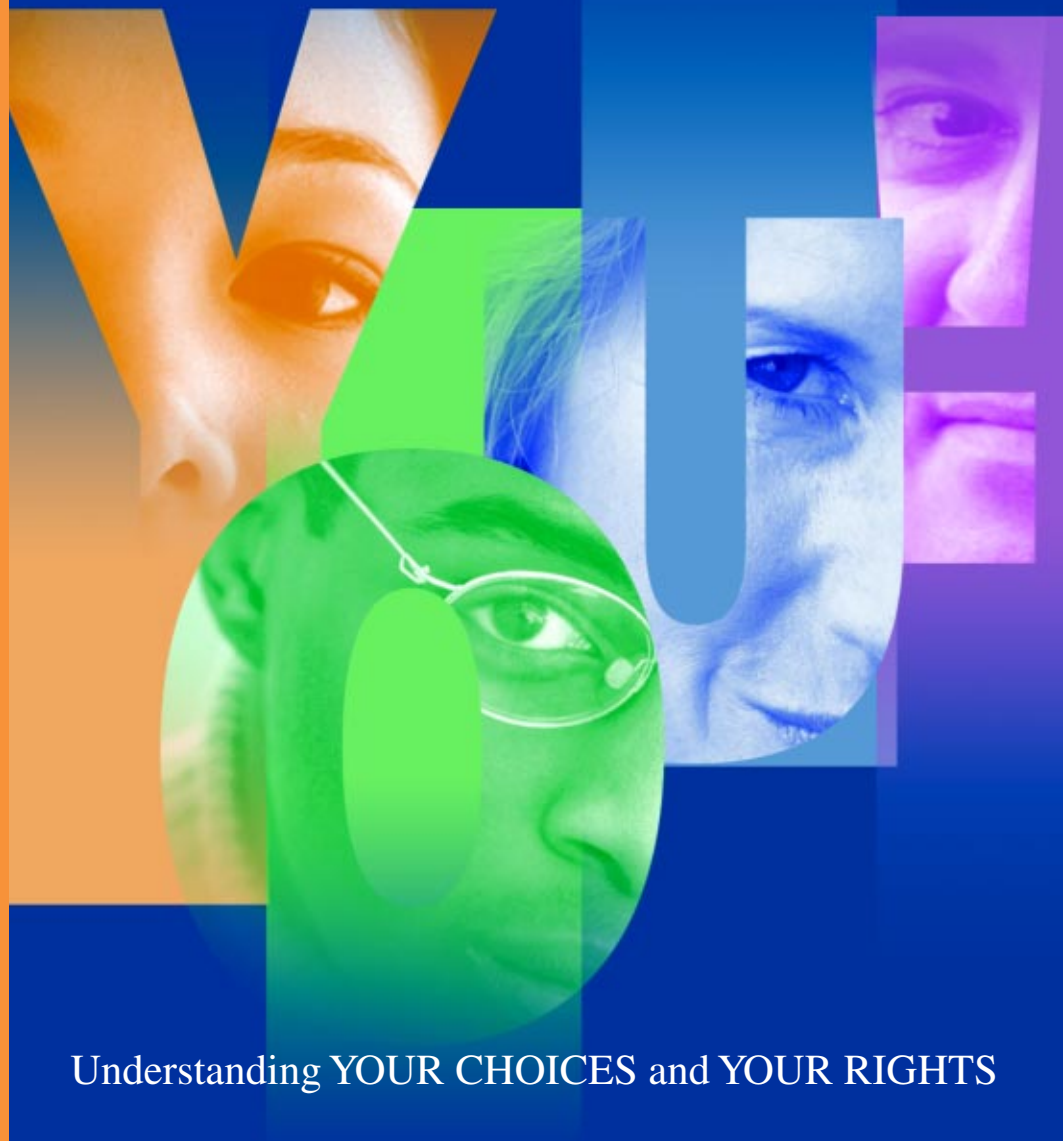
California's Emerging Health Care Advocate: You!



Understanding YOUR CHOICES and YOUR RIGHTS

California's Emerging Health Care Advocate: YOU!

Understanding YOUR CHOICES and YOUR RIGHTS

The ADVOCATE in YOU

In the past, determining how to select and get the most of your managed care health plan (commonly referred to as a HMO or PPO) has been anything but easy for most Californians. We took it for granted that the benefits and freedom to control our own health care destiny would continue, but we were wrong. Suddenly the rules and restrictions had changed, and the process of getting the care you felt was necessary had become a nightmare.

The managed care system was designed to help:

- Control skyrocketing premiums and make it possible for employers to continue offering health care benefits to their employees.
- Reduce the costs involved with providing quality care.
- Reduce out-of-pocket expenses for patients.
- Maintain a healthier lifestyle by encouraging healthy choices through education and preventative measures.

Physicians, hospitals, and other service providers have played a supportive role in the form of networks, merging with a manager (the HMO) as a means to lower costs by providing only those tests and treatments that were deemed “necessary.” But over time, stories of desperate patients emerged suggesting that profits had begun to matter more than quality of care. Our new health care model had created frustrated consumers and an overall lack of confidence in the system itself, which now dominated the health care industry in our state.

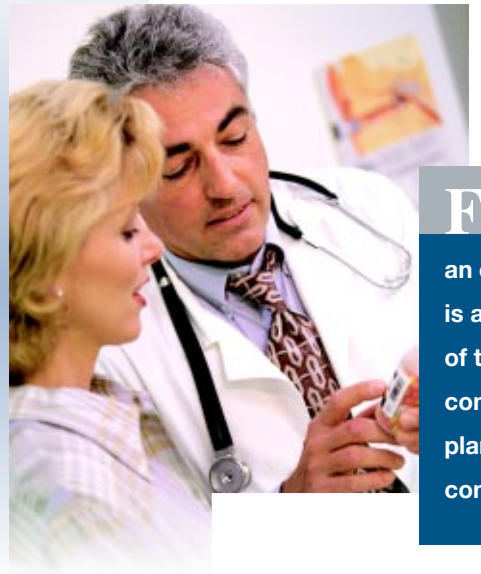
In recent years, patients, physicians, attorneys, health care advocates, and lawmakers have been working overtime with the managed care industry to improve services by:

- Ensuring better access to quality care.
- Developing patients' rights and guidelines that are clear.
- Providing effective and timely review of denied claims.
- Creating outside, independent medical review of denied services.

In short, the goal is to enable consumers to **take back** control of their health care choices. Whether you're choosing from a range of plans made available to you by your employer, or purchasing a plan independently, the success of your chosen plan to meet your health care needs depends greatly on ***your*** ability to act as your own advocate for quality care – but now there's help available.

California leads the nation in new laws that increase a patient's rights under managed care plans. You must be able to evaluate ongoing changes in your medical plan, engage the assistance of your physician or local advocacy groups and ***understand your rights***. Armed with information, you'll be able to avoid obstacles that could cause delays or denials of your current health care needs, as well as those in the future.

The Department of Managed Health Care now offers a California HMO Report Card. Which HMO makes the grade? Find out online at: www.dmhc.ca.gov



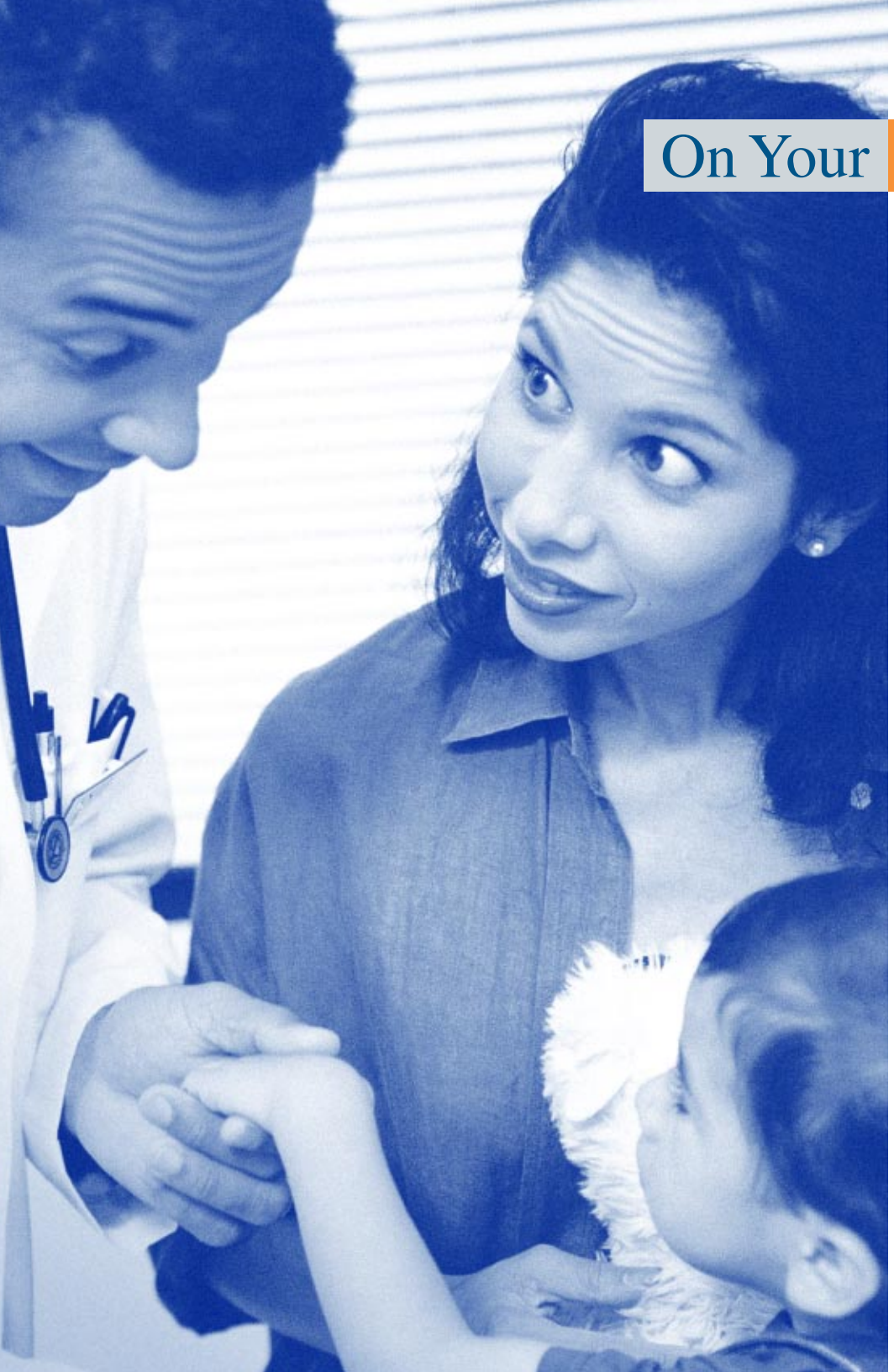
For your convenience, an easy-to-use checklist is available at the back of this guide to help you compare those health plans you are now considering.

The key to your success includes:

Understanding the different types of managed care programs available.

- Know if your plan is a "self-insured" program sponsored by your employer.
- Evaluate the current and future health care needs of your family.
- Ensure that your choice of plan allows for preventative care measures, advanced technologies, and improved medications.
- Manage your care through proper documentation and record keeping.
- Know where to turn when you need outside assistance.

Be forewarned: As health care costs continue to rise, your managed care plan may alter its benefits from one year to the next. *Never assume that last year's plan offers the same coverage.*



On Your Mark, Get Set, STOP!

Managed care organizations are made up of networks of physicians, hospitals, and other health care providers. When you choose a health care plan, you agree to abide by that plan's guidelines – those procedures, services, and restrictions that are outlined in the plan's Explanation of Benefits. Each plan carries its own restrictions and may deny you access to outside doctors or specialists, improved medications, experimental procedures, and preventative measures.

Your first challenge is to understand the types of plans available to you and their unique features.

HMO or PPO? There IS a difference!

Health Maintenance Organizations (HMO)

- You select a primary care physician (PCP) from a group or network of providers. In some cases you may be able to choose a specialist, such as your Gynecologist or Pediatrician, as a primary care physician. Your PCP (and the group or network) must authorize all tests, prescriptions, and referrals to specialists.

- HMO physicians are paid by a process called **Capitation**, which means they are paid a flat monthly fee for every patient enrolled in the program and under their care *regardless of whether you seek care or not during any given month*. If your doctor recommends a treatment that costs more than the plan will pay that month (or is not covered by your plan), the doctor must pay for it out of his or her own pocket. **Unfortunately, there have been cases in which a doctor has chosen to withhold expensive tests or referrals due to this cost overrun.**

Preferred Provider Organizations (PPO)

- You select a primary care doctor from a list of participating physicians and specialists who have agreed to accept a reduced payment for their services.
- You may choose to see a physician from outside the plan, such as continuing with your current doctor, but you will be responsible for any charges above what the plan typically pays for services provided by a plan physician. Some PPOs pay less for visits to non-participating physicians, increasing your out-of-pocket costs.
- While there is greater flexibility in a PPO plan, the monthly premium and the out-of-pocket expenses are often greater.

Fee-For-Service Plans

The more traditional "fee-for-service" plans that most of us grew up with are still available in California today, but are generally the most expensive type of plan.

- Typically, there are no restrictions on your choice of doctors.
- Payment is based on a company's "reasonable and allowable" pre-set fee schedule when services are provided.
- Fee-for-service plans will pay (on average) 80% of those charges "allowed" by the benefits they outline. What is considered "reasonable and allowable" on their fee schedule may be far less than what your doctor charges for office visits, labs, and routine x-rays. You'll be responsible for paying the difference.

Employer Sponsored "Self-Funded" Health Care Plans

Large companies often finance their own medical plans referred to as "self-funded" and contract with a plan administrator to manage it. Often that plan administrator is an HMO or a PPO. Employees typically recognize the HMO/PPO name, yet have no idea their plan falls under the category of "self-funded." Check your ID card. In most cases your medical identification card will list your company's name, as well as the name of the plan's administrator (HMO/PPO) for customer service or billing questions.

"What difference does it make if my plan is a company 'self-funded' Federal ERISA(Employer Retirement Income Security Act) policy?"
It could make a great deal of difference! California's new and aggressive laws enacted to protect consumers do not apply to "self-funded" company plans. If you're not sure if your company's plan is "self-funded" ask your plan administrator or your employer's human resources department.

A "self-funded" company plan is not considered to be an insurance company, and therefore, is *not* regulated by the state of California. Instead, it falls under Federal jurisdiction. For example: In the case of a lawsuit, Federal ERISA law applies. If you win your lawsuit, your monetary recovery will be limited to only those expenses for treatment and possibly attorney's fees. Health care plans regulated by California law, however, could also be liable for damages for the loss of a loved one, other medical expenses, and emotional distress.

If you are currently enrolled in your company's "self-funded" HMO plan you are not protected by the laws set forth for consumers of California.

Balancing Health Care NEEDS, ACCESS and PREMIUMS

Choosing a health plan based on a low monthly premium alone can be a prescription for disaster. Carefully review a plan's outline of Benefits and Restrictions, and ask yourself the following questions:

- Is my current physician covered under this plan?
- How do I get a referral to a specialist?
- What ongoing care do I need, and is it covered? (Family planning, dialysis, physical therapy)
- Is there a restriction of benefits for pre-existing conditions? For how long?
- Are my current medications covered or will I be limited to a plan's restricted drug formulary?
- Does the plan provide for preventative care?
- What are the requirements for after-hours care? Can I go to any emergency room?
- When do I need to call for prior authorization for treatment?
- Are experimental procedures and treatments, or clinical trials covered?
- Is an ambulance covered for emergencies?
- Are there caps on my benefits?
- Are medical devices covered?

Dare to Ask

Consumers are becoming much more educated about preventative health care and alternative methods of treatments, such as chiropractics and acupuncture, and new drug therapies with reduced side effects. If you fall within a specific needs group that requires "outside the box" consideration, arm yourself with information and ask the tough questions.

Illnesses that require special blood products, for instance, are not created equally in the eyes of all plans. If someone in your family has a special need you must ask specifically about available coverage.

Never assume that "cutting edge" technology and treatment programs are available as a covered item in a plan.

Preventative Care for Women

After the onset of menopause, a woman's risk factors for stroke, heart disease, anxiety disorders, and bone loss associated with osteoporosis increase due to the lack of estrogen her body produces. Despite available diagnostic tests and medications to reduce these risks, many plans do not provide this added coverage. Bone density screening (recommended by the Foundation for Osteoporosis Research for all women who are entering menopause) is not covered by all plans.

Cardiovascular Disease is the number one killer of women age 50 and over, with cancer coming in second. Will your plan cover preventative diagnostic exams for early detection?

Equally restricted in some cases are anti-depressant medications for anxiety and hormone replacement therapies. Some plans require that a patient fail several less expensive medications before authorization is given for a more costly, but better, medication.

Women must think in terms of "tomorrow," not just today, regardless of their age. Ask about a plan's coverage for mammograms, hormone therapy, and yearly-recommended examinations such as pap smears.

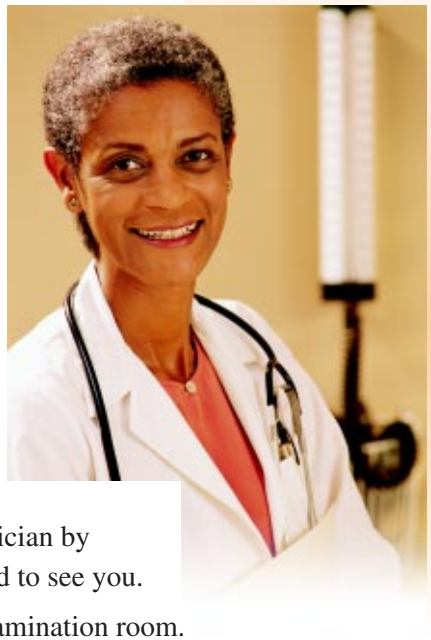
Diabetes Care

People with diabetes have the choice of a range of new, approved oral and injectable therapies. Regardless of your type of diabetes, inquire about any restrictions placed on these advanced therapies and devices. Also, determine any limitations on the number of syringes for insulin injections, test strips for monitoring glucose, and other tools that help you manage your diabetes and prevent complications. Also ask about any limitations on the frequency of testing for sight reduction and kidney problems associated with diabetes. Should your diabetic condition change, the cost of a different and more advanced treatment may not be covered.

Durable Medical Equipment

Does the plan you're considering cover wheelchairs, special beds, walkers, or crutches? What about oxygen or respiratory equipment necessary at home? Does someone in your family suffer from asthma? Know what the plan's benefits include and exclude.

Your Physician – Your Partner



By law, you are considered to have a patient/physician relationship once any of the following conditions are met:

- You have chosen a primary care physician and he/she has begun to receive capitation payments on your behalf.
- You have spoken to a physician by phone and they have agreed to see you.
- You enter a physician's examination room.
- You have received a referral for consultation and have been given an appointment.

It is your physician's duty to act on your behalf as your advocate for quality care, but in today's managed care environment a physician is allowed (on average) 12 minutes per patient for an examination. That's hardly enough time for bonding, but establishing a good relationship with your physician and communicating your health care wishes openly is a vital part of receiving quality care. Your first and best line of defense during a delay or denial by your HMO of a recommended treatment is direct contact between your physician and your managed care plan on your behalf. Should you need to go further and file a formal appeal to your HMO, documentation from your physician supporting your recommended treatment is very helpful.

It is against the law for a health plan to prohibit a physician from talking freely with you regarding your treatment options. This includes those options that are not covered by your health care plan, and/or those treatments that are considered experimental. Your health plan is not required, however, to pay for any treatment specifically excluded in your Explanation of Benefits.

Above all, it's very important that you understand everything there is to know about your medical condition and ask what alternative treatments are available in addition to what your physician has recommended. Ask your doctor:

- Why he/she would recommend one treatment over another.
- What risk factors should be considered.
- When it would be appropriate to consider another form of treatment.

Make sure that your physician will be available to you by phone if you have additional questions after leaving the office.

The Real "Drug War"

Managed care plans try to reduce costs by restricting benefits of prescription medications to only those drugs approved under a plan's formulary. A formulary is a list of approved drugs that are commonly used and typically, less expensive. Under a plan's formulary, a generic drug might be favored over a more expensive brand name medication.

Example: A generic Ibuprofen might be used instead of the brand name Motrin.

Some plans will require you to pay the cost difference (or a higher co-pay) if you wish to receive the brand name medication. New and more effective medications may become available, including those associated with fewer side effects, but these drugs are often more expensive and therefore discouraged as a first choice of therapy.

Once a patient has failed to respond to one or more of the medications on a plan's formulary (harmful side effects, or failure of the drug itself to adequately treat the condition) most plans will approve an alternative drug. Some plans however, require a patient to fail two or more formulary drugs before an alternative drug can be prescribed.

While a drug formulary is designed to reduce costs, studies have shown that over time the cost of changing medications multiple times counteract any financial savings and can result in a delay of care that may endanger a patient. A once easily treated condition may become an acute problem in need of hospitalization, or other more expensive services. Ask your doctor if there are considerations such as age, gender, or medical history that may support the use of a non-formulary drug for your illness, and if so, would they be willing to seek prior approval on your behalf?

Under section 1367.22 (a), a health care service plan, "... that covers prescription drug benefits shall not limit or exclude coverage for a drug for an enrollee if the drug previously had been approved for coverage by the plan for a medical condition..."

"Drug-switching" is a term used when a prescribed medication is switched to a different drug based on your HMO's formulary ***without*** the knowledge or approval of your physician. Since it's difficult to read what's actually written on your prescription, ask your doctor for the name of what he/she has prescribed and write it down. Your physician can mark "do not substitute" on the form. Once your prescription is filled, check to make sure that the label matches. If it doesn't, verify with the pharmacist that there wasn't an error. Have the pharmacist call your physician to get his/her approval of the switch.

Your doctor may feel that switching to a less expensive generic drug (similar to the originally prescribed medication) does not pose a problem. Often times, a HMO will cover more of the cost of a generic medication. However, if the prescribed medication is specifically not covered by your insurance and your physician feels it is the drug of choice, the pharmacist or your physician must get authorization for a non-formulary drug. Meanwhile, you may have to pay for the medication while your physician appeals to the HMO on your behalf.

By California law, if you are taking a medication that is approved by your plan's formulary (a covered drug) and the plan drops that medication from their formulary, your HMO must continue to provide you coverage for that drug. A plan must also provide you (upon request) with a copy of their drug formulary. You can save yourself delays by requesting a copy of this formulary and making it available to your physician. Don't assume they have it memorized…they don't!

It's always a good idea to select and use the same pharmacy for your prescriptions. Choose one that supports patient education and where the pharmacist is eager to discuss your medications or questions with you. Not only will going to the same pharmacy be helpful should you need records regarding medications you have taken in the past, but their internal system will often alert them with red flags when a prescribed medication will present a problem, such as a reaction to another medication you are currently taking. Most pharmacies now use computer systems that keep track of your medications and your medical conditions. When a doctor prescribes a medication in error, it's often your pharmacist who will catch it and prevent an adverse reaction that could be life threatening. Make your pharmacist your best friend!

By California law, if you are taking a medication that is approved by your plan's formulary (a covered drug) and the plan drops that medication from their formulary, your HMO must continue providing you coverage for that drug.

Clinical Cancer Trials and Experimental Treatments

Your doctor may recommend participation in a clinical trial for cancer, or that you seek treatment that is described as experimental (sometimes called investigational). Clinical trials and experimental procedures/treatments are generally excluded by most plans.

If you are denied access to a clinical trial program or for treatment that is categorized as experimental, you may be able to have your denial reviewed by a panel of independent medical experts. The process requires you to follow the standard procedures for appeal set forth by your health plan before you can request an independent review and you must meet certain eligibility requirements, but the California Department of Managed Health Care (DMHC) can assist you.

For more information on obtaining an independent review, contact the Department of Managed Health Care at: (888) HMO-2219, or TDD (877) 688-9891.

The ABCs of DENIALS and Delays: Know Your RIGHTS!

Creating a Paper Trail

Keeping good medical records is vital to your success as your own patient advocate, especially if you suspect that you may have difficulty with a specific course of treatment recommended by your physician.

- Maintain a file that includes your health plan contract and explanation of benefits.
- Keep detailed notes of your conversations with your doctor and representatives of your medical plan.
- Send follow-up letters to your health plan representatives after all conversations clarifying your understanding of what was discussed, and clarify what you should expect to happen next and any time frames promised during your conversation.
- Keep copies of all correspondence and medical expense receipts.
- Get copies of your medical records.

If you were denied coverage or have experienced delays in obtaining authorization from your medical plan, ask your physician to write a letter for you with an explanation of his recommended course of treatment. The letter should explain why this treatment is recommended over another. Keep a copy of this letter in your file.

The more armed you are with information about your condition and can support the recommended treatment with a statement from your physician (in addition to any case studies you can find on the internet or at the library) the better chance you have at addressing the objections of your health plan up front and during the appeal process if that should be necessary.

How to Appeal Your Heath Plan's Decision

If your physician, medical group, or health plan delays or denies care that you feel should be covered, or makes any other decision that you feel adversely affects your care, you have the right to file a complaint (grievance) with your health plan and the California Department of Managed Health Care (DMHC). Both your health plan and the DMHC must conform to specific standards and timelines in the management of your grievance.

You must first be clear about your medical plan. Is the treatment requested a covered benefit? Review your Evidence of Coverage material or plan contract to know for sure.

Confirm who is responsible for the delay or denial of your requested treatment. If it was your doctor's medical group, explaining your concern and discussing your wishes further may do the trick.

If the decision was made by your health plan, contact your customer service department and request an explanation of the denial in writing. Be polite, but firm in your request and don't hesitate to speak to a supervisor if you feel you request is not being received well. Make sure you get the name of the representative you're speaking with. Ask when you can expect the written explanation to arrive, and quickly forward a letter reviewing your conversation and understanding of the representative's response.

If your physician or health plan recommended an alternative treatment, or if the treatment you desire was determined not to be "medically necessary," you'll need to become an aggressive advocate on your own behalf. Arm yourself with research about your condition and treatment options, and be able to make a strong case for ***your*** desired option of treatment.

Under California law you have the right to:

- File a grievance with your health plan for any decision that you believe has/will adversely affect your care.
- Have your grievance resolved within 30 days, when possible.
- File your grievance with the California Department of Managed Health Care (DMHC) after your plan's grievance process has exceeded 30 days.
- Have DMHC resolve your grievance within 30 days.

- Request a review of your grievance by a panel of independent medical experts once your plan's grievance process has been completed and you meet specific requirements.

If you are confronted with a delay or denial for any treatment that should take place immediately in order to prevent further harm or the loss of life, always get the necessary treatment first and resolve problems with your health plan coverage afterward. Never delay emergency care.

Under California law, health plans must have a system in place for addressing a grievance filed by a member patient. Your plan must inform you in writing at the time of enrollment, and each year afterwards, how and where to file a grievance.

Timelines for Resolving Your Grievance

- Your health plan must resolve your grievance within 30 days, when possible, and provide you with a written statement regarding the status of your grievance within three days from when the company received your appeal. If you file your own grievance, do so by certified mail with a return receipt.

- If you have completed your health plan's grievance process and are not satisfied, or if it has been more than 30 days and your grievance is still not resolved, submit your grievance to the California Department of Managed Health Care for review. You must complete a "Consumer Complaint Form" to proceed with the DMHC.

Note: *Your health plan MUST inform you of your right to file a complaint with the DMHC.*

- The DMHC will review your documentation and complaint form, and may hold meetings with the parties involved. A decision normally requires 30 days. Once a decision has been reached, the DMHC must send you a written notice of their final decision including their reasons for that decision. The same written notice will be sent to your health plan and anyone assisting you.

Emergency Situations

When your health plan is advised of an emergency situation they must provide a speedier review and immediately inform you in writing of your right to contact the DMHC. An emergency is described as any situation in which a serious or imminent threat to your health exists. Your plan must also notify you and the DMHC in writing (within three days of receiving your appeal) of their decision or the status of your grievance.

For assistance in filing a grievance or to obtain a Consumer Complaint Form, contact the California Department of Managed Health Care at (888) HMO-2219, or TDD (877) 688-9891. Consumer Complaint Forms can also be completed online at: **www.dmhc.ca.gov/gethelp/complaint.asp**.

The Independent Review Process

Your rights to obtain an independent review of a denied treatment are limited to those cases in which your HMO's decision was based on the treatment being deemed "medically unnecessary." In most cases, the denied treatment must be specified in your plan as a "covered" treatment, however, it is possible to obtain a review if there are no provisions in writing specifically "excluding" the treatment, or if the treatment is deemed "experimental." The California Department of Managed Health Care's HMO Help Center can assist you in determining if your denial is eligible for an independent review.

You must have completed the HMO's grievance process before you can file for an independent review unless (in extreme cases only) your condition poses a serious threat to the loss of a limb, acute pain, danger to a major bodily function, the loss of life, or the immediate and serious deterioration of your health.

The review is conducted by an independent panel of medical experts and supervised by the California Department of Managed Health Care. If the review panel agrees with you and finds in your favor, the HMO is required to provide the service or reimburse you if the service was obtained at your own expense.

BRIDGING the GAP

This important consumer guide speaks to some of the challenges you face in choosing and managing your health plan options.

Helping to Educate Employers

Large companies and unions generally offer several plans to choose from, while smaller firms may limit the plans available. In either case, those who are delegated the responsibility of selecting a company's choice of plans are most likely finding it difficult to balance their employees' health care options with low premiums. You can help educate your company's decision makers by having them contact The Office of the Patient Advocate (OPA), (an independent office within the DMHC) for assistance.

The Office of the Patient Advocate can help your company evaluate the health care needs of their employees and make sense of the wide range of available plans. Dedicated to educating consumers about their health care rights and responsibilities, OPA is available to provide a "HMO Health Fair" at your place of business, school, union hall, community center, or place of worship.

For more information about The Office of the Patient Advocate or to request an HMO Health Fair, contact: Office of the Patient Advocate at **(916) 327-6352**, or visit their Web site: **www.dmhc.ca.gov/pa**.

Citizens for the Right to Know

Citizens for the Right to Know is an advocacy network of voluntary health agencies, provider organizations and consumer groups representing millions of people.

The networks' objective is to provide access to quality information on health care plans and to enable patients to make informed decisions by requiring insurers, health service organizations, and HMOs to provide clear information regarding covered benefits and any exclusions or restrictions within their policies.

For more information about Citizens for the Right to Know, call: **(916) 443-7239**, or email **RTK-feedback@mindshare.net**. You can also learn more about their organization and review featured news articles, pending legislation, and other publications that are available to assist you at their web site: **www.RTK.org**.

The California Medical Association

The California Medical Association (CMA) is an advocacy organization that represents more than 34,000 California physicians. Dedicated to the health of Californians, promoting the science and art of medicine and the care and well-being of patients, the CMA is active in the legal, legislative, reimbursement and regulatory areas on behalf of California physicians and their patients. The CMA is committed to the protection of the public health and the betterment of the medical profession.

The CMA dates back to 1856 and arose from the needs of doctors to professionalize in the post Gold-Rush era. Those needs expanded greatly in the 20th century. By 1946, CMA included just under 8,000 members; today it consists of more than 30,000 members. It is the largest state medical association and has become the leader in the socio-economics of medicine.

The CMA has also earned a national reputation as a leader in legal advocacy on behalf of physicians and patients. In the 1990s the CMA emerged as a leading advocate for improving the quality of health care. For more than a century, the California Medical Association has continued to ensure high quality care for all Californians through legislation, continuing medical education and peer review. The CMA can be found online at: **www.cmanet.org**.

The Department of Managed Health Care

The Department of Managed Health Care (DMHC) is a unique consumer rights project unlike any other in the country. While committed to resolving a patient's HMO complaint as quickly as possible, the department is also pro-active in targeting efforts that will assist in the formation of a more stable and better-managed health care system.

The department's HMO Help Center is assisted by a team of experts including ***The Office of the Patient Advocate*** (an independent office within the DMHC) as well as a team of health care law enforcers and liaisons within the HMO and health care industry to address problems that may delay or deny access to quality patient care. Their success on behalf of Californians is self-evident with over 1.5 million in fines levied against state HMOs since the department began on July 1, 2000. The HMO Help Center is available 24 hours a day, seven days a week and offers assistance in 150 different languages by calling **(888) HMO-2219**.

The DMHC (in partnership with The California Wellness Foundation and the California Department of Consumer Affairs) commissioned a comprehensive information booklet that outlines your health care rights. Titled, **The California Patient's Guide: Your Health Care Rights and Remedies**, the publication offers clear explanations of your rights, the laws that support them, and what steps to take when you have a problem with your HMO. Sample forms for filing a complaint are also included, along with case examples to help you understand the policies and processes involved.

Within this easy-to read publication, you'll find in-depth answers to following:

- Your rights to continuous care, second opinions, referrals, and information.
- Your right to informed consent.
- Your rights to medical records and confidentiality.
- Your right to emergency medical care.
- Your right to coverage of pre-existing conditions.
- Your right to file a grievance with your health plan and the California Department of Managed Health Care (DMHC).
- Your right to have your HMO's decisions independently reviewed and to sue your HMO.
- Your right to appeal and litigate benefit denials under ERISA.
- Your health care coverage options.

For a free copy of *The California Patient's Guide: Your Health Care Rights and Remedies*, or for more information about the Department of Managed Health Care, call **(888) HMO-2219,** or TDD (**877) 688-9891**. The DMHC can also be found online at: **www.dmhc.ca.gov**.

Health Plan COMPARISON and CHECK LIST

Use this easy checklist to quickly evaluate and compare the benefits and restrictions within the health plans you're considering. Place a √ in the space provided if a plan provides coverage for that item. Leave the space blank if no coverage exists.

	Name of Health Plan		
	Plan A	Plan B	Plan C
Example: Office visit co-pay	**$10**	**$10**	**$15**
Can I continue to use my current physician?			
Can I see a physician outside the plan?			
Is there a specific hospital I must use? (Name)			
Is there coverage for current on-going care?			
Office visit co-payment ($)			
Hospitalization benefit (%)			
Hospitalization co-payment ($)			
Emergency Room co-pay ($)			
Prior authorization needed for an ER visit?			
X-ray / Lab co-pay ($)			
Vision Coverage / co-pay?			
Hearing Examinations / Hearing Aids			
Prenatal Care / Office Visits / co-pay			
Well child exams and immunizations			
Annual Mammograms			
Bone Density Scans			
Restricted Hormonal Therapy			
Pre-cancer screening (male)			
Do I need a referral to see a specialist?			
Experimental treatment / clinical trials ?			
Prescription Drug coverage? Restrictions? Brand name or generics covered? What are the Co-Pays? Caps?			
Are my current medications covered?			
Out-patient Mental Health consultation			
• number of out patient visits allowed			
• coverage for in-patient treatment			
Drug Rehabilitation – out patient			
Home Health Care / Assistance			
Durable Medical Equipment			
Maximum out-of-pocket annually ($)			
$ Limit per illness, per year			
Maximum policy benefit ($)			
Monthly Premium –	**$**	**$**	**$**