



Individual Accident & Health Insurance

Illinois Department of Insurance

Frequently Asked Questions

Revised
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Note: This information was developed to provide consumers with general information and guidance about insurance coverages and laws. It is not intended to provide a formal, definitive description or interpretation of Department policy. For specific Department policy on any issue, regulated entities (insurance industry) and interested parties should contact the Department.

General Questions

1. Are companies required by law to issue individual policies to anyone who applies?

No. Companies that issue individual coverage underwrite the applications prior to the policy being issued. Underwriting is based on many things including, but not limited to, age, health status, occupation and certain hobbies. The company may (1) issue the policy as applied for; (2) issue the policy with stipulated exclusions either for a limited or unlimited period of time; (3) issue the policy with an added premium; or (4) decline issuance of the policy. If a policy is issued other than as applied for, the company must provide reason for offering exclusions or a declination, upon request.

2. I had knee surgery last year. The insurance company will issue me a policy, but refuses to cover anything that happens to my knee. They have asked me to sign a rider that states there will be no coverage for anything that happens to my knee. Can the company do this?

Yes. Insurance companies may attach an exclusion rider to the policy that specifies that benefits will not be provided for any loss that results from the condition specified in the rider. In this example, the rider may exclude any claim for injury, disease or disorder to your knee.

3. Do exclusion riders continue for the life of the policy?

In most instances, the exclusion rider is attached for the life of the policy. In some instances, the rider will state that it may be reviewed at some time in the future (usually two years). It is up to you as the policyholder to request the review. The rider will not be automatically reviewed or removed by the company.

4. If I am refused a policy or it is not issued as applied for, how can I find out why?

You must make a written request to the company. They are required to inform you of the reason(s) for their decision. If the reason is based on medical information, they may request the name and address of the doctor to whom you would like the information sent. The doctor then would explain the medical reason for the adverse outcome.

5. Can I return my policy if I am not satisfied with it?

When a policy is issued to you, you will have a “free look” period of at least 10 days to review the policy and make certain that it meets your expectations. If you are not satisfied with the policy, you may return it within the 10-day period and request a full refund of the premium. To avoid any delay or confusion, return the policy directly to the company by certified mail within the “free look” period.

6. How can I find insurance for my children if I don't have family coverage?

Some insurance companies will issue policies to children without their parents being included on the policy. If your children are not insured for financial reasons, they may qualify for coverage under the State of Illinois AllKids program. AllKids insures the children of parents who meet income requirements. For information call the Department of Public Aid toll-free at 866-255-5437.

7. Do individual policies pay for prescription medications?

You need to read your policy carefully. Some policies do not pay for any prescription medications; some pay for only those medications administered while confined in a medical facility; some pay a percentage of the actual charge; and some policies provide a drug card which enables you to purchase prescriptions for a specified co-payment amount, such as \$5.00.

8. Is pregnancy covered by individual health plans?

Some individual major medical plans offer normal pregnancy benefits as an optional coverage. Coverage for complications of pregnancy is a required benefit for all individual major medical plans currently issued in Illinois. Although normal maternity benefits may be offered as an option, the benefits are usually on a graduated scale based on the length of time the policy has been in force. Sometimes individual policies have a sliding scale for the percentage for this benefit. It may pay nothing the first 12 months of the policy, 50% between 13 and 24 months, 65% from 25 to 36 months, and 80 % after 37 months. Before accepting a policy, be sure you are clear as to how the benefit applies to you.

You may qualify for coverage under the State of Illinois AllKids program. AllKids insures expectant mothers who meet income requirements. For information call the Department of Public Aid toll-free at 866-255-5437.

Claims Questions

9. Can my insurance company require me to get approval prior to receiving medical services?

Often individual medical policies will require pre-certification prior to a scheduled hospital stay or within a short period of time following an emergency admission. There may be other requirements or restrictions in your policy. Be sure you understand the requirements of your policy.

10. What is a deductible?

A deductible is the amount of covered expenses you must pay before the insurance company will pay for any of the covered medical expenses. Check carefully to be sure you understand exactly how the deductible works before buying a policy. There are a number of ways deductibles may be administered by the company.

- Some policies apply the deductible to covered expenses on a per person, per calendar year basis. If the policy is a family policy, there is normally a maximum number of deductibles per family per year, and sometimes a single deductible for a common family accident.
- Some policies apply the deductible per medical condition or cause. This type of deductible can cause a single individual to pay several separate deductibles in a calendar year. Policies with this type of deductible may not have a maximum number of deductibles to satisfy in a calendar year. These policies normally have a lower premium than those with a calendar year deductible.
- Some policies apply the deductible for each hospital confinement separated by a specified number of days (usually 60 days).

11. Is there a maximum on the amount of expenses I have to pay each year?

Some individual major medical policies have a provision called an out-of-pocket maximum that limits the amount you must pay in a given benefit period, usually a calendar year. As an example, let's say your policy pays 80% of covered charges, requires a deductible of \$1,000, and has an out of pocket maximum of \$10,000. If you had \$75,000 in covered charges, the payout would be as follows:

\$75,000	(total covered medical bills)
- 1,000	(your deductible)
74,000	
- 59,200	(80% of remaining charges)
\$14,800	(20% you owe)
- 10,000	(maximum amount you are required to pay out of pocket)
\$ 4,800	(additional amount the company must pay)

Note: Not everything accrues toward the out-of-pocket maximum. For example, costs for excluded items and amounts that are over the usual and customary determination do not accrue toward the out-of-pocket maximum.

12. How long does a company have to pay medical claims?

Once due proof of loss has been received, the company has a reasonable time period within which to pay or deny a claim. If the claim is not paid within 30 days after they have all needed information, they must pay interest on the claim at the rate of 9% per annum.

13. What does a company mean by usual and customary charges?

Usual and customary, also called reasonable and customary, means the fee charged by most of the providers in a given geographical area for a particular service. Insurance companies may subscribe to an independent service which periodically surveys providers in a given area, or they may use their own claims experience to establish usual and customary allowances. Most companies pay claims based upon a percentile of the usual and customary fee schedule. For example, if your policy pays at the 80th percentile of usual and customary, that means they pay based upon the fee charged by 80% of the providers for that particular service within the geographical area. Although usual and customary provisions are explained within the policy, companies seldom disclose the percentile at which they pay usual and customary. For more information, please see Fact Sheet entitled [Usual and Customary Fees](#).

14. I have a preferred provider option (PPO) with my insurance policy that allows me to receive medical treatment from a provider of my choice. The policy benefit for non-PPO providers is 60%. I recently incurred a bill for \$1,000 from a non-PPO provider; the policy only paid \$200.00. How could this happen?

PPO policies pay out of network providers charges based on **eligible expenses**. The definition of **eligible expenses** within the policy is the key. Some plans define eligible expenses as usual and customary; others define eligible expenses as a percentage of Medicare (such as 110%), while others define eligible expenses as the amount that would have been accepted by a contracted PPO provider. The 60% benefit within your policy is then applied to the eligible expense, not to the actual charge for the service. The benefit for non-PPO providers is quite limited due to the definition of eligible expenses used in the policy. Please see the Fact Sheet entitled [Usual and Customary Fees](#) for more information.

15. My insurance company is delaying payment of my claim because they are checking for a pre-existing condition and are requesting information about all the doctors I have seen in the past two years. I know the condition was not pre-existing, and this is just a waste of time. Can they do this?

Individual health insurance policies are allowed to exclude benefits for pre-existing conditions for the first two years the policy is in force. The company is allowed to look back two years to determine if treatment was received for a condition, or if symptoms were present that would have caused a prudent person to seek treatment for a condition. Some companies only exclude preexisting conditions for one year and only look back for one year. This varies from policy to policy. If a claim is submitted to the company within the pre-existing exclusion period, a pre-existing condition investigation will most likely take place.

Note: Any condition that has been excluded by a rider may be excluded for the life of the policy. Please refer to question Number 2 for more information.

If you believe the company has taken too long to complete the investigation, you may file a complaint with the Department of Insurance. Be sure to provide copies of any correspondence received from the company, as well as a copy of the insurance contract. We will contact the company to find out why the claim is being delayed, and see if anything can be done to expedite the process.

16. My insurance company has rescinded my health insurance coverage. What exactly does that mean?

Illinois law permits health insurance policies to have a minimum two-year incontestability period during which the company may rescind a policy under certain circumstances. An insurance policy is issued based on information contained in the application or enrollment form. When an individual fails to completely and accurately disclose health information, including weight and height, on the application, it affects how the policy would have been issued. The company may have issued the policy with an exclusionary rider, issued the policy for a higher premium, or declined coverage altogether had they been provided with correct information.

Insurance companies will generally review the application for accuracy and completeness when they receive the first claim. If they find an error or omission that is material (one that would have changed their offering of coverage to you), the company will take action to rectify the situation. They may issue an exclusionary rider for the health condition in question and ask that you accept it as part of the policy. Or, if the error or omission is significant enough, the company may rescind the policy and return your premiums to you. Rescission means that the policy will be null and void from the beginning.

It is most important to fill out your application accurately and completely to avoid having your policy rescinded. When you receive your policy, check your copy of the application in the back of the policy to be sure that information was accurately recorded if you did not fill out the application personally.

For More Information

Call our Consumer Services Section at (312) 814-2427 or our Office of Consumer Health Insurance toll free at (877) 527-9431 or visit us on our website at <http://www.insurance.illinois.gov>