Who is behind the promises?

☑ **Company Checklist**

Many fraud artists invent company names that sound impressive, or are designed to sound similar to existing companies. Confirm that a company is a legitimate business before you give them any personal information.

- **Note** whether the company has a street address (not a post office box alone) and business phone number.
- **Compare** listings with the main office if someone claims to represent a national company. Verify the person is an employee.
- **Ask** the business to provide a copy of any offer or contract in writing and allow time for review, without pressure to close the deal if you aren't ready. Legitimate companies look for long-term relationships, not just quick profits.
- **Be sure** the company provides more than one way to reach a representative. Be wary if the representative can only be reached by leaving a message, or if all contact is by email or fax.
- **Find out** if the company is listed in the yellow pages, or if it has a website.
- **Contact** the appropriate state agency to see if the company is licensed, if required.
- **Check** the company's complaint record with the consumer affairs department of the state attorney general's office.
- **Avoid** businesses that solicit door-to-door, via email or fax; anyone who pressures you to make immediate decisions; and anyone who offers good "deals" and long-term guarantees ONLY if you act quickly.
- **Pay attention** to your instincts. If a deal seems too good to be true, it often is.

Don't share your personal information with anyone you don't know and trust.

Are you a victim of Identity Theft or Identity Fraud?

The Colorado Attorney General's office has an *"Identity Theft Repair Kit"* available on line at: **www.ago.state.co.us/idtheft/IDTheft.cfm**

For more information on these and other consumer protection tips, contact these divisions of the **Colorado Department of Regulatory Agencies:**

Division of Banking
1560 Broadway, Suite 975
Denver, CO 80202
(303) 894-7575 — Phone
(303) 894-7570 — Fax
Email: banking@dora.state.co.us

Division of Financial Services
1560 Broadway, Suite 950
Denver, CO 80202
(303) 894-2336 — Phone
(303) 894-7886 — Fax
Email: financialservices@dora.state.co.us

Division of Insurance
1560 Broadway, Suite 850
Denver, CO 80202
(303) 894-7499 — Phone
(303) 894-7455 — Fax
(303) 894-7490 — Consumer Information
(800) 930-3745 —Toll-Free (outside Denver)
Email: insurance@dora.state.co.us

Division of Securities
1560 Broadway, Suite 900
Denver, CO 80202
(303) 894-2320 - Phone
(303) 861-2126 – Fax
Email: securities@dora.state.co.us

DOI/DORA December 2007

IDENTITY THEFT & IDENTITY FRAUD

PROTECTING YOUR ASSETS AND YOUR REPUTATION

A joint publication by:

Division of Banking
Division of Insurance
Division of Securities
Division of Financial Services

Dora
Department of Regulatory Agenc

Attachment B

Fighting Identity Theft ... ...and Identity Fraud

What is Identity Theft?

Identity theft allows one person to pretend to be someone else, often for financial gain.

Identity theft is a serious crime that occurs when one person collects identifying information about another individual, and uses that information to do harm by conducting a variety of crimes, often negatively affecting the victim's finances.

With enough personal information about an individual, a person can take over that individual's identity or financial records. For example, the thief can falsify applications for credit cards, withdraw money from bank accounts, take out loans, use telephone calling cards, purchase cell phones and run up charges, or obtain goods and privileges by using another person's credit history and good name.

Often a victim may not become aware of what has happened until the criminal has damaged the victim's assets, credit, and reputation.

Safeguard personal banking information; never share a PIN number or let another person watch over your shoulder.

Guard your personal information

If a purse or wallet is stolen, the driver's license, credit cards and other details can provide easy resources for an identity thief. Minimize the number of cards and personal information you carry with you, so thieves have access to the least possible personal information.

Research shows the average American discards nearly 200 pounds of paper each year — including stacks of unwanted junk mail. Often, junk mail and paper trash includes valuable information about personal identity and should be discarded carefully.

- Guard your Social Security number, credit card numbers, personal identification numbers (*PINs*), passwords and other personal information.

- Protect incoming and outgoing mail. For example, thieves can steal and change checks in bill envelopes, or take incoming mail and sign up for credit card offers — but reroute to another address.

- Keep your trash "clean" of personal information. Shred credit applications.

- Watch bank statements and credit card bills for unexpected charges.

- Choose passwords and *PIN* numbers that can't be guessed.

Dora
Department of Regulatory Agencies

Do Your Homework — check out business contacts

There is a new wave of identity theft and fraud created by people posing as representatives of businesses. Sometimes people pretend to be working for a well-known business, but in fact, have no relationship. You may discover these people are not really associated with the business, or the business itself only exists to collect personal information.

Smart consumers are careful with offers that come through email, by phone, or by fax. These deals may sound "too good to be true," but are often attempts to secure your name, date of birth, social security number and details in order to commit crimes and harm your finances.

Check with the appropriate agency to be sure the company is licensed in Colorado. A business name must be registered with the Secretary of State's office, but registration alone will not tell you if this is a legitimate business. The Department of Regulatory Agencies can tell you if the type of business requires licensing and direct you to the appropriate agency in Colorado.

Ask for written materials to support any offer made to you. Real companies will provide a physical office address (not just a P.O. Box,) local phone numbers, a fax, phone book listing, and often a website. When these listings are missing, it can indicate a new company without a proven history — a warning sign to consumers to proceed with caution.

December, 2007

Important Questions to Ask

Before Purchasing a Discount Health Plan or Medical Card

► What guarantees do I have as part of this Plan? Does the Plan *guarantee* access to health care providers or a minimum discount for the provided services?

► Will the Plan's discount be better than a cash discount? Will I be required to pre-pay services or pay at the time of service?

► Will I receive discounts for emergency services or when traveling? Do health care services have to be preauthorized?

► Will I receive regular statements outlining my savings? Can I pay the fee monthly rather than on an annual basis?

► What do I have to do to cancel my membership? If I do cancel, is the entire membership fee refundable?

► Does the Plan have a 24-hour customer service line? If not, during which hours can I call for assistance?

► What privacy protections are provided? Who is allowed to access the personal information that I have submitted?

► Does the Discount Health Plan share or sell my personal information with other companies when I become a member?

Be sure you are dealing with a legitimate company and that you understand what you are buying.

The Price You May Pay

At best, Discount Health Plans and cards may offer some savings for healthy individuals who are looking for a "buyers club" for eyeglasses, prescriptions and visits to health care professionals.

Be aware that similar discounts may be available if you offer to pay in cash for the same services and health-related items, even if you are not a member of a Plan.

Medical Discount Plans charge a fee for a list of health care providers and sellers of health-related items who offer discounts to members of the Plan — but **Discount Health Plans are *not* health insurance.**

At worst, you could:
lose coverage for pre-existing conditions, even when you purchase health insurance in the future;

be liable for most large health care bills;

discover that promised discounts have been exaggerated or do not exist;

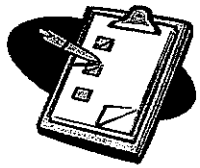
compromise your health care if the providers and treatments you need are not included in the discount Plan;

or become a victim of fraud or identity theft. It is possible that unscrupulous companies could use personal information for their own gain, stealing your money, identity and financial information.

Colorado Division of Insurance—February 2008

Consumer Protections Under Colorado Law

► **Discount Health Plans and Medical Cards must disclose, when marketing, that the plans are *not* insurance.**



► The Plan Administrator's name, address and telephone number must be provided.

► The provider listing must be updated semi-annually and made available upon request through a toll-free number.

► Discount Health Plans and Discount Medical Card Plans must provide a full refund if the consumer cancels within 30 days of purchase.

Consumer Protection

Consumer protection is our mission

To learn more about Discount Health Plans and Discount Medical Cards, or obtain information about filing a complaint, call the

Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, Colorado 80202
303.894.7499 Phone 303.894.7455 Fax
303.894.7490 Consumer Information
800.930.3745 Toll Free (outside Denver)
Email: insurance@dora.state.co.us
Web: www.dora.state.co.us/insurance

Discount Health Plans & Discount Medical Cards

- what consumers should know

Colorado Division of Insurance

Dora
Department of Regulatory Agencies

Discount Health Plans
& Discount Medical Cards
— what consumers should know

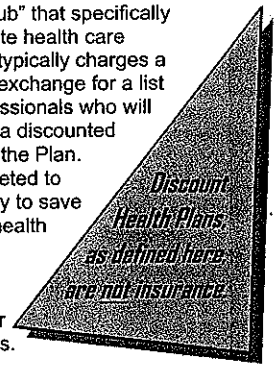
Consumers who are looking for ways to reduce the cost of health care may be tempted to purchase a Discount Health Plan or Discount Medical Plan instead of health insurance.

Using a Discount Plan instead of true health insurance will affect you on many levels. Please read the Plan's proposal carefully before choosing a Discount Plan instead of health insurance.

By giving up your health coverage, because you think you have found a better deal, you may actually have NO health coverage. You may expect some savings when visiting a health care provider, or get a discount on eyeglasses or prescriptions, but all of your medical bills will still be your responsibility.

What is a Discount Health Plan?

The term ***Discount Health Plan*** refers to a type of "buyers club" that specifically markets reduced-rate health care services. The Plan typically charges a membership fee in exchange for a list of health care professionals who will provide services at a discounted rate to members of the Plan. Plans may be marketed to consumers as a way to save money on various health services, such as medical, dental and vision care, as well as pharmacy and/or chiropractic services.



How Discount Health Plans Work —

Discount Health Plans contract with health care providers to offer services on a discounted basis to enrolled Plan members. When a Plan member uses one of the contracted providers for a service covered by the Plan, he or she should be charged a discounted rate for the service.

The amount of the discount may vary by provider and by the type of service received, and payment in full may be required at the time services are provided.

Will that be cash ... *or cash?* Inquire about payment rules. Be aware: some health care providers participate in a discount health plan only if consumers pay in full at the time of service. With some Plans, the consumer must pay for discounted services at the time of service *in cash*.

Hidden fees, such as administrative fees for each use of the card, may reduce or effectively erase the advertised discount. Make sure the discounts available exceed the cost of membership in the Plan.

Be sure you understand discounts being offered. Ask about any additional costs, including administrative fees, associated with the Plan.

Be sure your preferred doctor or other health professional is on the approved list— Verify with the health care professionals you plan to use that they are participating in the Plan. Some Discount Health Plan provider lists may not be current. Contact your preferred health care professionals to confirm they participate. Do not depend on the Plan's list alone — check it out.

Pre-Existing Conditions and Potential Problems —

Discount Health Plans do not qualify as "*creditable health insurance coverage.*" This means that if you drop your health insurance after purchasing a Discount Health Plan and later decide to purchase health insurance again, your new insurance may not — and probably will not — cover pre-existing conditions for a period of time.

State insurance laws and consumer protections may not apply— Be aware that state laws protecting buyers of insurance will **not** protect people who buy Discount Health Plans. For example, the state guaranty fund law to protect consumers in the event an insurance company fails, and health insurance laws that guarantee access to providers, do not apply.

Other state and federal laws, such as mandated health insurance benefits, may apply to specific types of health insurance, not to Discount Health Plans or Cards.

Purchasing Tips — Read all promotional material carefully and ask questions. If it seems too good to be true, it probably is.

Review the proposed Plan carefully. Companies selling Discount Health Plans or Cards may not guarantee advertised services. Read the fine print and get any clarifications in writing.

Colorado Division of Insurance—February 2008

Ask what happens if you move or need services while you are traveling.

Always keep the telephone number and address for the Discount Health Plan, along with copies of all documents that you have submitted to the Plan.

Seniors, Medicare and Long Term Care — Seniors should be especially cautious when considering one of these Plans. Some health care providers may not honor advertised discounts below scheduled Medicare rates.

Be wary of Discount Health Plans offering "long-term care" discount options. These Plans are **not** a substitute for long-term care insurance.

Internet Sales and Scams — Discount Health Plans can be sold directly over the Internet or by fax.

If purchasing online, make sure the website is secure. Review the company's privacy policies to learn if your information will be shared with other companies or if your information will be sold.

Do not give out any bank or credit card information until you have checked out the company, determined it is legitimate, and decided to purchase the Plan. Ask about the Plan's cancellation and refund policies and get policies in writing before enrolling.

NOTIFICATIONS
The following information must be included in all notifications:

- the name, title, and qualifying credentials of the reviewers;
- a statement of the reviewers' understanding of the request;
- the decision, in clear terms; and
- a reference to the evidence or documentation used as the basis for the decision.

If the review results in an adverse determination, the following must also be included:

- the specific reason(s) for the adverse determination, including the specific plan provisions and medical rationale;
- a statement that you have the right to receive copies of all documents, records, and other relevant information;
- a copy of any internal rule, guideline, etc. that was relied upon by the reviewer, or information on how you can request a free copy of what was relied upon; and
- an explanation of the clinical or scientific basis for a denial based on medical necessity or experimental treatment, or information on how you can request a free explanation.
- a statement describing the procedures for obtaining an independent external review of the adverse determination.

For first level reviews (both standard and expedited), the notification must include an explanation of the procedures for obtaining a voluntary second level review of an independent external review.

INDEPENDENT EXTERNAL REVIEW

If you are denied benefits for general services and disagree with your health plan's adverse determination, you may be able to request an independent external review after the first or second level review. The denial notice sent to you by your health plan will explain the procedures for obtaining an independent external review. Here is a summary of the process:

- Your request must be submitted in writing to your health plan within 60 days of receiving the final adverse determination from your health plan.
- The independent external review will be conducted by an entity certified by the Division of Insurance, and selected on a rotating basis.
- For the external review, you may submit new information with your request, if it is significantly different from information provided or considered during the health plan's internal review process.
- In most cases, the external reviewer will provide you with written notice of its decision within 30 working days after you have filed your request with your health plan.
- If your medical condition warrants it, the process can be expedited.
- If the external reviewer reverses your health plan's decision, your health plan must approve benefits for the covered services (in accordance with the terms and conditions of the plan).

MEDICARE AND MEDICAID

Medicare has a different set of rules for appeals. The requirements in this brochure do not apply. Call the Division of Insurance at 303-894-7553 or 800-930-3745 to find out about Medicare's appeals rules.

People on **Medicaid** may have additional appeal rights. Call Medicaid at 303-866-3513 or 800-221-3943 for more information.

OTHER TYPES OF GRIEVANCES

If you have a complaint about something other than denial of coverage resulting from a utilization review decision (for example, not being able to get an appointment with your doctor soon enough), call your health plan's customer department and ask how to register your complaint. In many plans, the grievance procedures will be the same for both coverage denials and other types of complaints. Some plans may have different procedures to handle different types of problems.

WHEN THE DIVISION OF INSURANCE CAN HELP YOU

If you have completed your health plan's review procedures and you are still not satisfied, you can contact the Colorado Division of Insurance. You are also welcome to contact the Division if you believe the health plan did not follow the time frames or requirements in this brochure.

You can file a complaint by sending a brief letter stating the facts of the case to us at the following address:

Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, CO 80202

or complete the complaint form on our website:

www.dora.state.co.us/insurance

It is important for you to complete your health plan's review process before contacting the Division of Insurance with your complaint. If you have not completed the review process, the Division will refer you back to your health plan.

The Division of Insurance can help you -

- Record your complaint against the health plan.
- Thoroughly investigate your complaint.
- Make sure the health plan follows state law.

The Division of Insurance cannot -

- Force a favorable utilization review decision.
- Require your plan to pay for services that are excluded by the policy.
- Provide legal services that are sometimes needed to settle complicated disputes.

TIPS FOR THE SAVVY CONSUMER

Read your policy or member handbook carefully. The key to getting quality health care is being an educated consumer. If you believe you have been wrongly denied coverage, create a paper trail by maintaining the following: your policy; copies of denial letters; copies of any correspondence between you and your health plan, or between your health care provider and your health plan; detailed notes of conversations with your health plan; and copies of correspondence with the Division.

In all correspondence to the Division, please include: your name, address, and telephone number; member ID number; policy number and type of policy.

For all telephone conversations, keep a written record of the date and time of your call, name of the person you spoke with, and what was discussed.

Send a copy of any letter to your employer's benefits manager. Your employer is interested in your satisfaction with the health plan. The benefits manager may have some leverage with the health plan, since employers can consider changing health plans if employees are not satisfied.

What Happens When Your Health Insurance Company Says No

Your Rights Regarding Insurance Pre-Authorization and Grievance Procedures

A publication of the Department of Regulatory Agencies
Colorado Division of Insurance

1560 Broadway, Suite 850
Denver, CO 80202
303-894-7499
800-930-3745
www.dora.state.co.us/insurance

March 2007

Most health plans today carefully evaluate requests to see a specialist or have certain medical procedures performed. A medical professional employed by the health plan reviews the request for covered services made by your health care provider to make sure the requested services are medically necessary, appropriate, efficient, or effective. This process is known as "utilization review".

Any time your health plan denies benefits for covered services that you and your health care provider feel are medically necessary or have medical evidence proving that the services aren't subject to a contractual exclusion, you have the right to challenge that decision. The decision to deny benefits is known as an "adverse determination".

This brochure is a guide to the rights you have when your health plan says "no". It contains summary information about standard and expedited utilization review, emergency services, "peer-to-peer conversations", first level reviews, voluntary second level reviews, expedited reviews, and independent external reviews. Colorado law requires all health plans subject to the state insurance laws to follow the same procedures.*

* State insurance laws do not apply to self-insured (self-funded) health plans. Some self-insured employers use a health insurance company to administer their plans, so it may not be obvious that they are self-insured. Check with your employer to find out if your plan is self-insured. Self-insured plans are regulated by a federal law known as ERISA. For information and assistance with complaints about self-insured plans, contact:

U.S. Department of Labor
Pension and Welfare
1100 Main Street, Suite 1200
Kansas City, MO 64105
866-275-7922 (toll free)

STANDARD UTILIZATION REVIEW

Prospective Review

A prospective review may be performed by your health plan when your health care provider requests pre-authorization for a hospital admission or a course of treatment (such as a procedure or a visit to a specialist). Your health plan must notify you and your provider of its determination within 15 days of receiving the request. Under certain circumstances, this period of time may be extended.

Retrospective Review

A retrospective review may be performed when you or your health care provider submit a claim for services or treatment you've already received. The purpose of this review is to determine whether the services and/or treatment were medically necessary, appropriate, efficient, or effective. Your health plan must notify you and your provider of its determination within 30 days of receiving the request. Under certain circumstances, this period of time may be extended.

EXPEDITED UTILIZATION REVIEW

Sometimes your medical condition may require you to receive treatment or services rather quickly, although an emergency may not exist. If this is the case, your health care provider may submit an urgent care request to your health plan, which would require your health plan to conduct its utilization review in a shorter period of time than that allowed for standard utilization review.

An urgent care request can be made:

1. before hospitalization or treatment begins, or
2. while you are hospitalized or undergoing treatment.

In both of these circumstances, the health plan must take your health condition into account when making its determination.

If hospitalization or treatment has not started, the health plan must notify you and your health care provider of its determination as soon as possible, but no more than 72 hours after receiving the request.

If you are in the hospital or undergoing treatment and your health care provider wants to extend your hospital stay or continue your treatment beyond what was originally authorized, your health care provider should make the request at least 24 hours prior to the time hospitalization or treatment is supposed to end. The health plan must notify you and your health care provider of its determination as soon as possible, but no more than 24 hours after receiving the request.

ADVERSE DETERMINATIONS

Anytime a request for benefits for covered services is denied, your health plan must notify you and your health care provider.

With standard utilization review, the notice may be sent in writing or electronically. With expedited utilization review, the notice may be provided orally, in writing, or electronically. If notice of a denial is given orally, written notice must also be given within 3 days of the oral notification.

All notices of adverse determination must include all of the following:

- The specific reason(s) for the denial, and reference to the plan provision(s) on which the denial is based.
- A description of any additional material or information that may improve the benefit request, and why that material or information is necessary.
- A copy of any internal rule, guideline, etc., that was relied upon by the health plan, or information on how you can request a free copy of what was relied upon.
- An explanation of the clinical or scientific basis for a denial based on medical necessity or experimental treatment, or information on how you can request a free explanation.
- A description of the plan's review (appeal) procedures and the applicable time limits, and notification of your right to appeal.

EMERGENCY SERVICES

Health plans **cannot** require you to get prior authorization for emergency services if a person, having average knowledge of medicine and acting reasonably would have believed that an emergency medical condition or a life or limb threatening emergency existed.

PEER-TO-PEER CONVERSATIONS

Any time a prospective review results in an adverse determination, your health care provider may ask for a "peer-to-peer conversation"; that is, an opportunity to speak with the reviewer who made the adverse determination of behalf of the health plan. The conversation must take place within 5 days of receipt of the request. If this conversation does not resolve the issue, you may appeal the adverse determination. **A peer-to-peer conversation is optional. You can appeal without such a conversation ever taking place.**

APPEALS PROCEDURES

If you are not satisfied with your health plan's decisions, you have the right to appeal them. All health plans subject to state insurance law must have written procedures for handling such requests for review. In this brochure, we summarize the basic process plans must follow. For details of your plan's specific procedures, check your member handbook or call your health plan's customer service department.

FIRST LEVEL REVIEW

You may request a first level review within 180 days of receiving an adverse determination. Most plans will require you to submit your request in writing. The first level review will be conducted by a physician in consultation with clinical peers, none of who were involved in the initial adverse determination. You do not have the right to attend this review, but you do have the right to submit written comments, documents, records, and other material relating to the request for benefits. The plan must notify you of its decision, in writing or electronically, within 30 days of receiving your request.

VOLUNTARY SECOND LEVEL REVIEW

Health plans are required to offer a second level review process for those who are dissatisfied with the first level review decision. You may file a request for one with yo plan within 30 days after receiving the adverse determination from the first level review. The second level review will be conducted by a health care professional or, if offered by the health plan, a panel of health care professionals who have appropriate expertise in relation to the case. You always have the right to appear in person at the review meeting or atten via a teleconference. Procedures for conducting a second level review must include the following:

- the review meeting must be scheduled within 60 day of receiving your request, and you must be notified i writing at least 20 days in advance of the review dat
- you must be given the opportunity to be present and/or given the opportunity to provide additional written comments, documents, records, etc., for review;
- both you and the health plan may have an attorney present;
- the reviewer or the review panel must consider all of the comments, documents, records, etc., submitted for the first level review; and
- the written decision must be issued within 7 days of the review meeting.

EXPEDITED REVIEW

Expedited review is available for urgent care requests c adverse determinations and for someone who has received emergency services but has not been discharged from a facility. Either you or your health care provider may request an expedited review, and the request may be made orally or in writing.

The expedited review will be conducted by clinical peer who were not involved in the initial adverse determination. You do not have the right to attend this review, but you do have the right to submit written comments, documents, records, and other material relating to the request for benefits. The plan must notify you of its decision, as speedily as possible, but not mor than 72 hours after receiving your request. The decisior must be communicated to you or your health care provider by the fastest means. If notice is given orally, written notice must also be given within 3 days of the or notification.

If the expedited review process does not resolve the issue, under some circumstances you or your health care provider may request a voluntary second level appeal or request an independent external review.