

*What Cancer Survivors Need To Know About*  
**HEALTH INSURANCE**

Types of Health Insurance



Know Your Rights and Their Limits



Using Your Health Coverage



Where to Find Help and Information

*A publication of the*



NATIONAL COALITION  
FOR CANCER SURVIVORSHIP

*The power of survivorship. The promise of quality care.*

## **Legal Disclaimer**

This publication has been created by the National Coalition for Cancer Survivorship (NCCS) to provide cancer survivors and their loved ones general information about health insurance. This publication represents the authors' opinions regarding the subject matter covered. This publication is not designed to provide individual legal advice nor to substitute for professional counsel.

### **Sixth Edition**

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## **ABOUT THE NATIONAL COALITION FOR CANCER SURVIVORSHIP**

**T**he National Coalition for Cancer Survivorship (NCCS) is the oldest survivor-led cancer advocacy organization and a highly respected authentic voice at the federal level, advocating for quality cancer care for all Americans and empowering cancer survivors. NCCS focuses on advancing public policy issues that affect cancer survivors on the federal level and providing tools and publications to individuals that address many important survivorship issues, especially the role of advocating for oneself.

In 2004, NCCS launched a legislative grassroots advocacy network, Cancer Advocacy Now!™, to assure that cancer survivors, their families, friends, and caregivers have a voice in advocating for quality cancer care in Washington, D.C. and in forums where health-care policy is decided.

To learn more about NCCS, visit [www.canceradvocacy.org](http://www.canceradvocacy.org). To learn more about or to join the Cancer Advocacy Now! network, visit [www.canceradvocacynow.org](http://www.canceradvocacynow.org).

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The National Coalition for Cancer Survivorship defines “cancer survivor” as anyone with a history of cancer from the point of diagnosis and for the remainder of life, whether that is for months, years, or decades.

## WHAT CANCER SURVIVORS NEED TO KNOW ABOUT HEALTH INSURANCE

**W**hen cancer strikes, you may start thinking about health insurance in a new light. Chances are, you will use your health insurance more than ever before. You also may have more problems with insurance than ever before. Therefore, it is critical that you know and understand your rights and responsibilities under your health insurance plan.

In this booklet we discuss several aspects of health insurance that are important to cancer survivors. First, we describe the many different types of health insurance that are available and what you should look for when considering a health insurance policy. Then, we look at the rights you have under state and federal law that can help you buy and keep health insurance coverage. We will also discuss things you need to keep in mind when using your coverage. Finally, we list places you can turn to for information on how to solve your health insurance problems.

## TYPES OF HEALTH INSURANCE

**I**t is important for cancer survivors – like everyone else – to have adequate and dependable health insurance. There are many kinds of policies on the market, though not all offer the same protection.

It is best to have **comprehensive health coverage** that will pay for all of your basic health-care needs such as hospital and doctor care, lab tests, medical equipment, and prescription drugs. When evaluating a policy to see if it meets your needs, in addition to looking at the **premium**, you need to consider:

- What services are covered?
- How much will I have to pay for covered services?
- What type of policy is it and from whom can I get care?

## What services are covered?

Look at the list of services the policy covers. Look also at what services are explicitly excluded from the policy. For example, many policies exclude coverage for care in clinical trials, drugs that are not on a formulary or approved list, and other important services. Many policies also temporarily exclude services related to a **pre-existing condition**. (See page 13 for more information on pre-existing conditions.) And some add “riders” that permanently exclude services relating to a specific condition, organ system, or body part. When considering a policy, it is important that you find out whether the services you may need during your cancer treatment are covered by the plan. If you are considering joining a **managed care plan**, you should also find out whether your current doctors belong to the plan’s network. Many cancer patients have developed a strong relationship with their doctors and may want to continue receiving treatment from them. Remember, however, that just because your doctor is a member of a certain network today does not guarantee that he or she will remain in that network forever. Also, it is important for you to review the policy to find out what steps you will have to take in order to see a specialist.

## How much will I pay for covered services?

The amount of money you pay to purchase health insurance is called a premium. When considering a health insurance policy, look also at the annual **deductible** (the amount you pay each year before coverage kicks in). Some policies also have separate deductibles for certain services, such as hospitalization or drugs. Look, too, at the **copayment** (a flat fee, such as \$10 or \$20, that you pay the **provider** at the time of service) and **coinsurance** (a percentage of the bill that you pay) that apply to covered services. Also, watch out for **balance billing** – something that happens when the plan limits its payment to the part of the fee that it considers reasonable, leaving you responsible for the rest. See if your policy requires doctors and hospitals to accept the plan’s payment as payment-in-full. Most policies have an **out-of-pocket limit** or “**stop-loss**” **feature** that caps the amount you have to pay in deductibles, coinsurance, or copayments. After that, the plan pays 100 percent. However, the out-of-pocket limit usually does not apply to balance billing. Finally, policies often have a **lifetime limit** or **lifetime maximum** on covered **benefits** (such as \$1 million). Some also impose annual limits on what they will pay.

## What type of policy is it and from whom can I get care?

**Fee-for-service**, or **indemnity** policies, are what people think of as traditional insurance. Under these policies you choose your own doctor or hospital and the insurance company pays a portion of your bill after you meet your deductible. **Managed care** policies, by contrast, usually require you to get care from their network of participating providers, including doctors, hospitals, and pharmacies. In addition, managed care plans often require their members to designate

a **primary care provider (PCP)** or “gatekeeper” who must provide a referral for any visits to a specialist, even a specialist in the plan’s network. These types of plans are most commonly referred to as **health maintenance organizations** or **HMOs**.

There are advantages and disadvantages to managed care plans. These include:

### Advantages

- Lower cost to you (premiums and out-of-pocket costs).
- No claims for you to file.
- Coverage for preventive and routine care.

### Disadvantages

- Limited choice of health professionals, pharmacies, and hospitals.
- Care from specialists may require a referral from your primary care provider (PCP).
- Limited or even no coverage for out of network care.

There are hybrid policies, sometimes called **preferred provider organizations (PPOs)** or **point-of-service options (POS)**, that offer more flexibility than traditional managed care plans by allowing you to have a choice of getting care from in- or out-of-network providers, often without pre-approval. You should be aware that you usually pay more – sometimes a great deal more, including balance billing – for care received out of network.

In addition to the types of comprehensive coverage described above, there are other kinds of health insurance policies. Cancer survivors should be especially careful to understand what these policies are about:

### Catastrophic Insurance

Catastrophic policies are limited policies that cover very high medical expenses. Catastrophic policies have very high deductibles. Some people who buy catastrophic policies also open tax-favored **health savings accounts (HSAs)** to put aside funds to cover these high deductibles. These policies usually are not a good deal for cancer patients.

### Long-Term Care Insurance

Long-term care insurance provides you with a daily benefit when you can no longer take care of yourself. Whether you live at home, in an alternate care facility, or even a nursing home, a good policy will cover skilled, intermediate, or custodial care. However, the companies that sell these policies require that you be in fairly good health when you purchase them. For cancer survivors, that generally means at least five years past treatment. Companies may also consider the type of cancer you had when deciding whether you qualify for coverage. Premiums depend on your age and health.

## **Short-Term, Non-Renewable Policies**

Short-term, non-renewable policies, as the name implies, offer coverage only for a limited time (e.g., for 6 months). If you get sick during that time, the insurer can refuse to renew your coverage. Short-term policies can help bridge a gap in insurance coverage and may be a good idea if you are fairly certain that another, more stable source of coverage will be available in the near future. However, these policies should not be mistaken for comprehensive coverage that is guaranteed renewable.

## **Cancer Insurance**

Cancer insurance or other limited benefit policies only pay for costs related to treatment for cancer or other specific diseases. Insurers generally will not sell these policies to cancer survivors and many states have banned or restricted their sale. Most insurance experts recommend buying a good comprehensive policy instead of cancer insurance for the following reasons:

- Comprehensive insurance usually covers the cost of cancer treatment; additional cancer policies usually duplicate coverage from other policies and are an unnecessary expense.
- The premiums for cancer policies are high and the benefits are limited. Cancer policies often do not cover complications from cancer treatment.
- Some insurance companies and agents try to mislead consumers and prey on their fears about cancer.
- Sales and administrative expenses for cancer policies tend to be much higher than for other policies.

## **Accident-Only Policies**

Accident-only coverage, as the name implies, pays only for care that you need as a result of an accident, not care that is due to illness. Since a good comprehensive policy will cover costs associated with accidents as well as costs related to illness, accident-only policies are not a good value.

## **Supplemental or Hospital Indemnity Insurance**

Supplemental insurance or hospital indemnity policies pay a cash benefit for each day you are in the hospital. The cash benefit will be nowhere near the cost of hospital care, though. These policies are relatively inexpensive and simple to buy and may be appropriate if you want them to cover “extras” that come up when you get sick. But they should never be confused with comprehensive coverage.

## **Public Coverage**

Sometimes you can get health insurance from the government, instead of a private employer or insurance company. Usually you can only get public coverage if you qualify based on your

age, your income, or your **health status**. **Medicare** and **Medicaid** are the biggest public programs and are available in every state. In a few states, there are other smaller programs that might be able to help you buy affordable health insurance.

## **Medicare**

Medicare is health insurance provided by the federal government. You qualify for Medicare coverage if you are 65 or older and eligible for Social Security benefits, if you are disabled (regardless of age) and have collected Social Security benefits for 2 years, or if you have been diagnosed with permanent kidney failure or Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease) regardless of your age. Medicare will not refuse you coverage or charge you more because of where you live, your age, or how sick you are.

There are several parts to Medicare, as well as options for arranging one's Medicare benefits. The program has expanded significantly since its inception in 1965, and Medicare beneficiaries can be confused by its many rules and limitations for good reason. The addition of Medicare Prescription Drug Coverage, known as Part D, added new options and potential combinations of benefits, outlined below. Anyone soon to become eligible for Medicare or interested in maximizing their rights and responsibilities as a Medicare beneficiary at any time would be wise to carefully review their needs and options in light of the costs and consequences of each.

Medicare Part A covers care you receive in a hospital, skilled nursing facility, home health agency, or other facility. For most people who qualify for Medicare, there is no premium for Part A. You will, however, have to pay a deductible. In 2006, the deductible was \$952 per **benefit period**. (A benefit period starts the day you go to the hospital or skilled nursing facility and ends when you have not received hospital or skilled nursing care for 60 days in a row.) Also, for longer stays in a hospital or nursing home, you will have to pay coinsurance. Note: Medicare Part A covers chemotherapy drugs and the costs of administering them when given in hospital outpatient departments, chemotherapy clinics, or doctors' offices.

Medicare Part B covers 80 percent of approved medical expenses, such as doctors' charges, lab fees, durable medical equipment, ambulance services, and certain other supplies. In 2006, the monthly premium for Part B was \$88.50, which is deducted directly from your Social Security check. In addition to your 20 percent coinsurance, there is also a \$124 annual deductible for covered services.

Physicians participating in Medicare "accept assignment" on all Medicare beneficiaries. That means they may charge only what Medicare approves. Physicians who do not accept assignment cannot charge patients more than 15 percent above what Medicare approves. Some states have outlawed balance billing for Medicare beneficiaries at even lower percentages.

If you are eligible for both Medicare and an employer's group policy (either yours or your spouse's) the group insurance is usually primary and Medicare is secondary. That is, the group

plan covers the costs first, and if some are not covered, then Medicare may cover those costs. There are exceptions to this rule, so you should verify the coordination of your benefits with the administrator of your group benefits.

**Medicare Part B covers some specific cancer-related services. These are:**

- Annual screening mammograms (starting at age 40).
- Routine pap smear every three years, with no deductible.
- Screening pelvic exams every two years, or every year for women considered at “high risk” for ovarian cancer, with no deductible.
- Annual colorectal cancer screening for people age 50 and older.
- Annual prostate cancer screening for men age 50 and older.
- Limited physical, speech, and occupational therapy.
- Limited prosthetic devices, including breast prostheses and surgical bras.
- Ostomy products.
- Routine healthcare costs for beneficiaries involved in a clinical trial, including hospital and physicians’ visits, routine lab tests, and costs resulting from problems associated with participation in the trial.
- Clinical laboratory procedures—such as blood tests, urine tests, and cultures.
- Chemotherapy drugs that are injected intravenously or by intravenous pump, chemotherapy drugs you can take in pill form if they are also available as injectable or infusible drugs, and certain anti-nausea drugs.

**Part B does not cover:**

- Routine annual physicals unless you have a specific diagnosis. However, as of 2006, Medicare now covers 80% of the approved amount of an initial preventive physical exam during the first six months after enrollment in Part B.
- Private duty nursing.
- Any services provided outside of the United States, unless you are close to the border of Canada or Mexico and the closest hospital is in one of those countries.
- Prescription drugs, with a few important exceptions that are mentioned above. Medicare coverage of prescription drugs is described in the section on Part D.
- Syringes or insulin for diabetic patients.
- Custodial care, such as help with bathing, eating, and getting dressed.

## **Medicare Managed Care (Medicare Advantage)**

Another option for some Medicare beneficiaries who are looking for ways to lower their out-of-pocket costs is to enroll in a Medicare managed care plan under a program called Medicare Advantage (formerly known as Medicare + Choice, also known as Medicare Part C). These are private managed care plans that contract with the government to cover Medicare services and sometimes additional services, such as check-ups. Significantly, some Medicare Advantage plans include Medicare prescription drug coverage, (known as Medicare Advantage Prescription Drug Plans or MAPDs) and some do not. Medicare Advantage plans cannot turn you down or charge you more because of your health or your age. These plans must provide all of the benefits that traditional Medicare provides, but all plan options are not available everywhere or to everyone. To be eligible for a Medicare Advantage plan, you must:

- Be enrolled in Medicare Part B and continue paying your Part B premium,
- Live in the plan's service area,
- Not be receiving care from a certified Medicare hospice, and
- Not be diagnosed with permanent kidney failure.

You should carefully consider the pros and cons before enrolling in a Medicare managed care plan. (See advantages and disadvantages of managed care on page 3.) Just like all other managed care plans, you will have limited coverage if you choose to get your healthcare from doctors, hospitals, and other providers NOT in the plan's network. If you choose a Medicare HMO, you will receive no coverage for services obtained outside the network. If you are considering a managed care plan because your current doctor or hospital is in its network, keep in mind that these doctors and hospitals may not be able to provide you with the same services in a managed care plan as in traditional Medicare. Often, doctors must follow the managed care plan's rules on care and obtain approval for referrals and costly services. Additionally, your doctor may leave the network at any time. Health plans have been known to leave the Medicare Advantage market, forcing members to choose different coverage. If you become dissatisfied with your Medicare managed care plan, or the plan makes changes, you can return to traditional Medicare. As of 2005, however, you are only able to make this switch during specific enrollment periods. Also, whenever you leave a managed care plan to return to traditional Medicare, you may have only a limited choice of Medigap plans available to you.

Some plans offer a Preferred Provider Organization (PPO) option to Medicare beneficiaries, allowing members to choose care from out-of-network providers at an increased cost. When looking into this option, find out what extra premiums and fees you would be responsible for and what limits the health plan puts on out-of-network coverage.

You can get more information about Medicare from the federal agency that runs this program – the Centers for Medicare & Medicaid Services (CMS), formerly known as the Health Care

Financing Administration or HCFA. They can also provide more information about Medigap and Medicare Advantage plans. To speak with a customer representative, call the Centers for Medicare & Medicaid Services at 800.MEDICARE or visit the agency's Internet site at [www.cms.gov](http://www.cms.gov). A separate government Web site can help you compare plans at [www.medicare.gov](http://www.medicare.gov). Other helpful resources include your state health insurance program, or SHIP. (See page 21 for state health insurance regulator contact information.) Additionally, the Medicare Rights Center, a not-for-profit organization, helps ensure that older adults and people with disabilities have access to quality, affordable healthcare. The Medicare Rights Center can be reached at [www.medicarerights.org](http://www.medicarerights.org).

### **Medicare Prescription Drug Coverage (Part D)**

Medicare Part D was added to the program by Congress to help beneficiaries obtain limited coverage for prescription drugs through private health plans approved by Medicare. Part D is an optional benefit for anyone eligible for Parts A and B, although those with prescription drug coverage from an employer or retiree group plan that is just as good as or better than a Medicare plan probably do not need to enroll in Part D. By law, your current health plan must notify you if your prescription drug coverage meets this criterion (known as **creditable coverage**). As of 2006, Part D plans are not required to cover all drugs; but they do require cost-sharing with beneficiaries including monthly premiums, coinsurance, and copayments. Individuals who qualify for Part D Low Income Assistance (with separate application and enrollment procedures administered by the Social Security Administration) pay much less. Note that the Medicare Part D plans only began to offer coverage in 2006, and the range of plan options and specific provisions of the program may change over time.

Part D selection and enrollment requires many informed choices by beneficiaries choosing to take best advantage of them. All beneficiaries may enroll in a Part D plan when they first become Medicare eligible. All beneficiaries will have a choice of plans. Although plans will vary in numerous ways, all must be approved by Medicare and meet standards of equivalency in overall value as determined by Congress. Medicare's Web site, [www.medicare.gov](http://www.medicare.gov), contains comprehensive information to help beneficiaries review details about plan options available to them.

All beneficiaries are given the opportunity to enroll in a Part D plan when they first become Medicare eligible. Like Part B, delaying enrollment will result in a premium penalty if one signs up later. Beneficiaries who delay enrolling or wish to change plans may do so once a year during the Annual Coordinated Election Period (November 15 to December 31).

It is important for Medicare beneficiaries to be aware that if they enroll in a Medicare Part D plan, they cannot also get coverage from a Medigap policy (H, I, or J). Medigap H, I, or J policyholders who purchased those policies before January 1, 2006 may still have the policies in place, but Medigap policies no longer include drug benefits.

## **Medicare Supplemental or Medigap Insurance**

Because of Medicare's high cost sharing and what it does not cover you may want to supplement your Medicare coverage with a private supplemental insurance policy (also known as Medigap insurance). Congress has regulated the Medigap market to make it easier for Medicare beneficiaries to shop among different companies offering the same selection of plans. Insurance companies that sell these policies can only sell the standard Medigap policies (Plans A through L, with A offering the fewest benefits at the lowest premium, and J offering the most benefits at the highest premium). The table on the next page displays the twelve Medigap plans currently available and lists the benefits that each plan provides. As stated above, as of 2006, Medigap policies no longer cover prescription drugs, although Medicare Part D enrollees may still benefit from the added coverage that Medigap provides for other healthcare needs. It is wise to carefully consider their benefits and costs before purchasing one of these plans. Each state's insurance commissioner decides which of the twelve plans are made available for sale in their state. Insurance companies are not allowed to change the labels of the various Medigap policies (A-L). They may, however, add names or titles to the labels. Although companies are not required to offer all of the plans that the state approves for sale, they must make Plan A available if they sell any of the other nine policies.

Congress has set a six-month **open enrollment** period for buying Medicare supplemental insurance. The law guarantees that, for a period of six months following enrollment in Medicare Part B, persons age 65 and older cannot be denied Medigap insurance due to a health condition or medical history.

## **Medicaid**

Medicaid is a government program that provides health insurance for low-income people and families. Each state has its own Medicaid program with its own rules about whom and what it covers. However, because the federal government helps states fund their Medicaid programs, there are some national rules that apply everywhere.

In most states, in addition to having very low income, you must be a child, a parent of dependent children, elderly, or disabled to qualify for Medicaid. Some states, though, do cover low-income adults who are not elderly, disabled, or parents.

Since 1991, each state has the option to make uninsured women with breast and cervical cancer eligible for Medicaid, and all 50 have done so. To be eligible for Medicaid in this way, women must have been screened through the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP) – services generally provided through clinics or community health centers – and found to have breast or cervical cancer, including precancerous conditions. When states elect this option, coverage for the full range of Medicaid services will be available to these women as long as they are in

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## Medigap Plan Benefits 2006



Medicare Rights Center

	A	B	C	D	E	F	G	H	I	J	K	L
<b>Hospital Coinsurance</b> Coinsurance for days 61-90 (\$238) and days 91-150 (\$476) in hospital; Payment in full for 365 additional lifetime days.	•	•	•	•	•	•	•	•	•	•	•	•
<b>Part B Coinsurance</b> Coinsurance for Part B services, such as doctors' services, laboratory and x-ray services, durable medical equipment, and hospital outpatient services.	•	•	•	•	•	•	•	•	•	•	50%*	75%*
<b>First three pints of blood</b>	•	•	•	•	•	•	•	•	•	•	50%*	75%*
<b>Hospital Deductible</b> Covers \$952 in each benefit period		•	•	•	•	•	•	•	•	•	50%*	75%*
<b>Skilled Nursing Facility (SNF) Daily Coinsurance</b> Covers \$119 a day for days 21-100 each benefit period			•	•	•	•	•	•	•	•	50%*	75%*
<b>Part B Annual Deductible</b> Covers \$124.			•			•				•		
<b>Part B Excess Charges Benefits</b> 80% or 100% of Part B excess charges. (Under federal law, the excess limit is 15% more than Medicare's approved charge when provider does not take assignment; under New York State law, the excess limit is 5% for most services.)						100%	80%		100%	100%		
<b>Emergency Care Outside the US</b> 80% of emergency care costs during the first 60 days of each trip, after an annual deductible of \$250, up to a maximum lifetime benefit of \$50,000.			•	•	•	•	•	•	•	•		
<b>At Home Recovery Benefit</b> Up to \$40 each visit for custodial care after an illness, injury, or surgery, up to a maximum benefit of \$1,600 a year.				•			•		•	•		
<b>Preventive Medical Care</b> Up to \$120 a year for non-Medicare covered physicals, preventive tests and services.  100% of coinsurance for Part B-covered preventive care services after the Part B deductible has been paid.	•	•	•	•	•	•	•	•	•	•	•	•
<b>Hospice Care</b> Coinsurance for respite care and other Part A-covered services.											50%*	75%*
<b>Outpatient Prescription Drugs</b>												
<b>*Out-of-Pocket Maximum</b> Pays 100% of Part A and B coinsurance after annual maximum has been spent											\$4,000	\$2,000

Plans A-L are standardized by the federal government. Not all plans may be available in your area. Consider the benefits offered by each plan and look for one that best meets your individual needs.

treatment for breast or cervical cancer. For more information about eligibility for Medicaid for women with breast and cervical cancer, see the CMS Web site at [www.cms.hhs.gov/medicaidspecialcovcond/](http://www.cms.hhs.gov/medicaidspecialcovcond/).

Note also that you may be eligible for both Medicare and Medicaid. If you are eligible for the Qualified Medicare Beneficiary (QMB) or “Medicare Buy-in” program, Medicaid will pay for all Medicare premiums, deductibles, and coinsurance. If you are eligible for the Specified Low-Income Medicare Beneficiary Program (SLMB), Medicare Part B premiums will be covered.

For more information about the Medicaid program in your state, check the government pages of your phone book or visit the Centers for Medicare & Medicaid Services at [www.cms.gov](http://www.cms.gov).

### **Children’s Health Insurance Program**

In addition to Medicaid, the State Children’s Health Insurance Program (S-CHIP) offers health insurance coverage to low income, uninsured children under the age of 19. Children can qualify for this free or subsidized health insurance if their family’s income is twice as high as the federal poverty level, although in some states, kids in families with incomes up to 400% of the federal poverty level can qualify. (In 2006, the poverty level for a family of 3 was \$16,600 except in AL and HI.) Typically, children cannot be in S-CHIP if they are eligible for private health insurance. However, the eligibility requirements vary from state to state. In all states, children who are eligible for both Medicaid and S-CHIP must be enrolled in Medicaid. In some states, the S-CHIP program is part of the Medicaid program; in others, it is a separate program. To learn more about S-CHIP, contact your state public welfare or social services department or your county welfare board.

### **Other Public Coverage**

A few states offer other help for people who cannot afford health insurance. Some offer government-sponsored health insurance that you can buy at discounted premiums if you have low income. A few states have programs that will help you buy coverage from a private insurance company. Thirty-one states have **high-risk pools** where you might be able to buy coverage if a private insurer turns you down. In several of these states, a modest premium subsidy is available if you have low income.

When it comes to health insurance, the key to remember is read the policy. Whether it is coverage you already have or are thinking of getting, look at the policy carefully to make sure you know what it entails.

## KNOW YOUR RIGHTS AND THEIR LIMITS

**Y**ou have rights under federal and state law to help you buy and keep coverage, as well as protections when you use your coverage. But these rights are not comprehensive, and they may vary depending on where you live, what kind of coverage you have or seek, and other factors.

To find out about your rights, it helps to know who regulates your kind of health insurance. This is not always easy to find out. States regulate many health insurance plans, including many group plans sponsored by small employers and most individual coverage you buy on your own. If you have or are trying to buy coverage under these kinds of plans, it is best to call your state insurance commissioner. (See page 21 for contact information.)

The federal government regulates some coverage including most health plans offered by very large employers. In this case, you need to contact the Employee Benefits Security Administration of the United States Department of Labor to find out about your rights. Visit [www.dol.gov/ebsa](http://www.dol.gov/ebsa) or call EBSA's Employee and Employer Hotline at 866.444.EBSA (3272). When in doubt, though, your state insurance commissioner is usually a good place to start.

Your rights to get and keep private coverage are greatest in group health plans that are usually provided through employers. You tend to have far fewer protections when buying an individual policy on your own. In the next section we discuss the protections and rights you can expect from group, individual, or public insurance programs.

### What Kind of Protections Might I Have When Buying Private Coverage Through a Group Health Plan?

Employers are not required to offer health insurance benefits to their employees. However, if you are offered group health coverage, you have rights under federal and, for state regulated plans, state law.

*Nondiscrimination.* Your eligibility for coverage under a group health plan cannot be conditioned on your health status, which includes how healthy you are now or have been in the past. This means you cannot be refused health benefits under an employer's health plan or charged a higher premium simply because you are a cancer survivor. You might be ineligible for other reasons unrelated to your health status, such as if you only work part time.

*Special enrollment periods.* You must be offered a special enrollment period of at least 30 days when you get married, divorced or widowed, have a baby or adopt a child, lose other health insurance (for example, coverage that another family member had through his or her employer), or your employer stops contributing to your premium. In addition, you get a special enrollment if you meet or exceed a lifetime limit of all benefits under the plan. If your employer provides family coverage, all of your dependents must be offered this special enrollment opportunity as well.

*Coverage for pre-existing conditions.* Sometimes group health plans will temporarily exclude coverage for a health condition you already have when you join. This is called a **pre-existing condition exclusion period**, or pre-ex, for short. If your group health plan does this, you will have insurance coverage, but it will not pay for any care related to your pre-existing condition during the exclusion period. Group health plans cannot impose a pre-ex longer than 12 months, or 18 months if you are a late enrollee. Also, there are limits on what can be subject to a pre-ex. In group health plans, a pre-existing condition is one for which you actually received a diagnosis, treatment, or medical advice in the 6-month period – known as the look back period – prior to joining the group health plan. (In some state-regulated group plans, the maximum pre-ex or look back period may be shorter.) So, if your cancer treatment ended some time in the past and you have received no related care in the past 6 months, your group insurer cannot say that cancer is a pre-existing condition for you. In addition, group insurers cannot consider pregnancy or genetic information as a pre-existing condition. So if you have a family history of cancer or a positive genetic test indicating you are at risk for getting cancer, this alone cannot be the basis for a pre-ex.

*Credit for prior coverage.* When a group plan imposes a pre-ex, it has to give you credit for other health coverage you may have had in the past. Whenever you leave a health plan, you should be given a **certificate of creditable coverage** as proof of the coverage that you had. To be **creditable**, your prior coverage must have been **continuous**, which means it cannot have been interrupted by a lapse of 63 days in a row or longer. In some state regulated group plans, the maximum lapse of coverage may be longer than 63 days. Most kinds of health insurance are creditable toward a group health plan pre-ex, including other group plan coverage, individual coverage, state high-risk pool coverage, Medicare, Medicaid, and military healthcare (TRICARE). So if you join a new group health plan with a 12-month pre-ex, but you have just left a job last week where you had health benefits for a year, your prior coverage will cancel out the pre-ex. Your new group health plan will cover your pre-existing condition immediately.

*COBRA continuation coverage.* A federal law, the Consolidated Omnibus Budget Reconciliation Act (known as COBRA) lets you and your family stay covered under your group health plan even if you no longer are connected to that employer due to certain circumstances. All employers with 20 or more employees must offer this COBRA continuation coverage option. In addition, some states require similar continuation coverage for people when they leave smaller employers. Employees and beneficiaries are given 60 days from the date they lose coverage to make a decision about continued coverage through COBRA. Continued coverage must be offered regardless of any health condition, including cancer, and must extend to surviving, divorced, or separated spouses and to dependent children. If you quit, retire, or lose your job, you and your covered dependents can remain in your employer group health plan for up to 18 months. However, if your spouse or children lose access to your group benefits because of your death or divorce or because you drop coverage when you become eligible for Medicare, they can remain in the plan for up to 36 months. In addition, your children can stay on your group plan

for up to 36 months after they reach the age when they no longer qualify as your dependent. When you take COBRA coverage, you have to pay the entire premium (including the portion the employer used to pay on your behalf). This will probably seem like a big rate increase for you, but it may turn out to be less expensive than other coverage you can buy elsewhere as a cancer survivor.

The Employee Benefits Security Administration (EBSA) of the United States Department of Labor enforces COBRA for most employers in the private sector. The Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services regulates COBRA compliance by state and local government employers. Should you encounter a problem, the first step to resolving a COBRA complaint is to try to work it out with the employer. If that fails, you should contact the appropriate federal agency. (See page 18.)

## **What Kind of Protections Might I Have When Buying Individual Coverage?**

In most states, buying individual coverage can be harder if you are a cancer survivor – especially if it has been less than 5 years since your treatment ended. Where not prohibited by law, individual insurers can turn you down, charge you more, or permanently exclude coverage for cancer – though not all insurers will do so. Also, unless state law requires otherwise, individual health plans can use a much broader definition of pre-existing conditions, in some cases barring coverage for any condition you ever had. You may also have trouble buying a policy that includes specific services you need, such as prescription drugs or mental healthcare.

The rights you have when buying individual health insurance depend on where you live. State laws regulating individual health insurance vary a lot. Consult your state insurance commissioner for more information. (See page 21 for a listing of state insurance departments.) Or, you could consult free consumer guides that are published by Georgetown University and available on the Internet at [www.healthinsuranceinfo.net](http://www.healthinsuranceinfo.net).

Some states have very comprehensive laws that require health insurance companies to sell you any individual policy they offer. This is called guaranteed issue. Some other states require insurers to hold open enrollment seasons. In these states insurers cannot turn you down during open enrollment, but you might be turned down at other times during the year. In about a dozen states, your right to buy individual coverage from an insurance company is protected only if you qualify as “federally eligible” or “HIPAA eligible.” (HIPAA stands for the Health Insurance Portability and Accountability Act.) This means that you must have had at least 18 months of prior continuous credible coverage, your most recent coverage was under a group health plan, a government plan, or a church plan, you used up any available or state COBRA continuation coverage, and you meet other requirements.

Some states prohibit insurers from charging you more because of your health. Some other states let insurers charge higher premiums to cancer survivors and others based on their current health status or health history, but only within limits. However, in most states there are no limits on how much you can be charged for individual health insurance. In these states, premiums can vary significantly due to health status.

Some states limit the use of pre-exclusion periods in individual policies. However, pre-ex rules for individual coverage usually are not as protective as the rules for group coverage. For example, in many states, individual health insurance policies can *permanently* exclude coverage for a pre-existing condition. This is called an **elimination rider**. Also, individual insurance policies often are not required to give you credit for prior coverage against any pre-ex they might impose.

Finally, in some states that do not offer you many protections when buying private coverage, you can buy coverage from a state high-risk pool, a program that sells health insurance to people who need to buy health coverage but can't because they are considered "medically uninsurable" by insurance companies. High-risk pools also vary a lot from state to state. Some offer very comprehensive coverage for relatively affordable rates. Other high-risk pools are more expensive, cover fewer benefits, and have waiting lists to enroll. A few are closed to new enrollees. (See page 20 for a list of states with high-risk pools.)

## Are There Any Special Protections for Small Employers?

If you own a small business or are self-employed, you have special protections when buying coverage for yourself and your employees. If you have 2 to 50 employees, you cannot be turned down for any small group health plan that insurers sell to other small employers. In addition, all group health plans are guaranteed renewable. Your group's coverage cannot be canceled because someone in the group gets sick.

If you are self-employed with no other employees, in most states you are not eligible to buy group coverage on your own (though you may be able to get coverage under a family member's group health plan). However, in a few states, you are considered to be a small employer and are protected by state laws governing other small group health plans. Contact your state insurance commissioner to see if you qualify for a small group health plan. (See page 21 for a listing of state insurance departments.)

## Where Can I Get Help with Paying for Prescription Drugs?

Paying for prescription drugs can be very expensive. Some options do exist. As mentioned earlier for Medicare beneficiaries, Part D plans offer limited coverage for prescription drugs. (See

page 8 for more information on Medicare Part D.) Retiree health benefits often include good prescription drug coverage, so try to keep those benefits as long as possible. Private pharmacy discount programs, which operate like clubs with benefits for their members, provide discounted prescription drugs through their network of participating pharmacies for a flat fee per year. AARP (formerly the American Association of Retired Persons) operates the best known of the programs, but has competitors around the country.

Many states have created special programs for low-income elderly or disabled persons. Contact your state department for the aging or social services to see if you qualify.

Finally, drug companies offer some of their products to patients in need. Eligibility for these programs varies by company. Ask your provider or office staff to help you find out if you qualify for no or low-cost drugs directly from the manufacturer, or contact Cancer Care, Inc. at 800.813.HOPE or [www.cancercare.org](http://www.cancercare.org). You can also obtain a directory of prescription drug patient assistance programs by contacting the Pharmaceutical Research and Manufacturers of America (PhRMA) at 800.762.4636 or [www.phrma.org](http://www.phrma.org).

## USING YOUR HEALTH COVERAGE

**W**hen you need to make a claim on your health insurance, it is important to remember a few things.

*Read your policy*, if possible, before you go for care in the first place. You may need to get permission (a referral) to see a specialist or to get a lab test. You might be restricted to a network of doctors or hospitals. Going out of network might mean you pay more or that the plan will deny your claim. You might need to submit the claim within a certain number of days following the service in order for it to be paid. Reading your policy is important to understanding what coverage you have and how to use it.

*Keep good records*, including copies of all bills and correspondence. Ask for names, addresses, and phone numbers of people you talk to, and note the dates of your conversations. It is a good idea to keep all original bills for follow-up purposes unless your insurance carrier is one of the few that insists you send the originals. In that case, you should keep very good copies for your records.

*Submit your claims on time and in the right order*. Your insurer will pay some bills directly to the appropriate parties if you request that on the claim form. Other bills you must pay yourself and then send copies of the bills to your insurer who then reimburses you directly. Most insurance companies have a time limit for submitting claims. It could be one year from the date of service or by the end of the calendar year. Make sure you know what your policy defines as the time limit. If you have more than one policy, you must send the right bills to the right company in the right order. Remember that the patient's insurance is always primary, the spouse's is secondary.

*If a claim is denied, appeal it.* Send the claim back again and again if necessary. Ask your doctor to help make your case. Keep records of all your correspondence. And again, be aware of any time deadlines that might apply. Sometimes you can only appeal a denial within a certain number of days following the decision. In a growing number of states, if you are in a state-regulated plan and you appeal and your plan says no again, you can appeal to an outside panel of experts, also known as an external appeal. (See page 26 for a list of states with external appeal programs and contact information.) These panels overturn plan denials about half of the time, so it is worth it to hang in there. Contact your state insurance commissioner for more information about your appeal rights. In addition, the Henry J. Kaiser Family Foundation and Consumers Union have developed "A Consumer's Guide to Handling Disputes with Your Employer or Private Health Plan." This guide will help you understand the type of coverage you have, what rules apply, and where to call for more information. To learn more about your appeal rights, visit [www.kff.org/consumerguide](http://www.kff.org/consumerguide).

*Understand your coverage for experimental therapies and clinical trials.* Sometimes an insurer will deny coverage for care they say is experimental. Insurers generally regard drugs, devices, and courses of treatment still under study as experimental. In other cases, some patients may want to enroll in a clinical trial. A cancer clinical trial is a study designed to determine the effects of a particular therapy or drug against cancer. Although Medicare and some state laws now mandate coverage for costs associated with cancer clinical trials, many other plans still deny coverage for care provided as part of a clinical trial. If this happens, appeal the denial. It may help if your doctor can call or write the medical director of your health plan. If the plan upholds the denial, you may be able to appeal to an outside panel of experts. At the time this booklet was published, Congress was debating a law that would require health insurers to cover some of the cost of care in clinical trials. A few states have passed similar laws already. If your appeal fails, tell your insurer that you are hiring an attorney to settle the dispute in court. The courts have generally sided with cancer patients in these circumstances, and most insurers would rather cover the cost than go to court. If you do have to hire an attorney, however, make sure he or she is an expert in insurance law.

*Know how you can protect the privacy of your medical information.* Under federal privacy protections, information related to the treatment of your cancer is treated the same as any other health information. Federal law restricts how your health information can be used by your health-care provider, health plan, and other related organizations. However, these restrictions are limited and generally permit your health information to be used fairly freely for purposes related to treatment, payment, and many other transactions by health-care related organizations, including by insurers in the underwriting process. In addition, if you are covered under an employer sponsored group plan, your employer may have access to your health information. However, federal law does prohibit your health plan from sharing your health information with your employer for employment related activities. To learn more about the rules protecting the privacy of your

medical information under federal law contact the U.S. Department of Health and Human Services, Office of Civil Rights at 866.627.7748 or visit [www.hhs.gov/ocr/hipaa/](http://www.hhs.gov/ocr/hipaa/). Additionally, some states have protections that go beyond those provided under federal law. To learn more about your protections under state law, contact your local consumer protection office. The Federal Citizen Information Center of the U.S. General Services Administration has a list of state, county, and city government consumer protection offices at [www.consumeraction.gov](http://www.consumeraction.gov). Finally, under federal law, you have the right to inspect, copy, and add information to your medical records to make it more correct or complete. These protections vary state to state. Georgetown University, Center of Medical Rights and Privacy has written consumer guides for most states that review these protections. To read or download the free guide for your state visit <http://hpi.georgetown.edu/privacy/records.html>.

The Medical Information Bureau (MIB) is a databank that has medical and non-medical information on many people who have ever applied for health, life, or disability insurance from any of the MIB's 600 insurance company members. MIB receives information collected by insurers during the underwriting process. This includes medical conditions, test results, and other information that represents your past, present, and future health status. Although the MIB's database seems like an invasion of privacy, it prevents fraud and abuse of the nation's private insurance system. If you have ever been denied life or disability insurance and you wonder why, your file at the MIB may be the answer. You have the right to make sure the information in your MIB file is correct. Call the bureau and ask for a copy of your records. MIB will provide consumers a copy of their record once annually without charge. The bureau will also tell you how to correct your records if you find an error. You can contact the MIB at 866.692.6901 or visit [www.mib.com](http://www.mib.com).

## **WHERE CAN I TURN FOR HELP AND INFORMATION?**

It is always best to ask your insurance company or your employer for help answering your questions or solving your insurance problems. If this does not work, though, there are other resources.

Your state insurance commissioner is always a good place to begin. They can help you understand state laws and programs and direct you to other sources of assistance. They also can help you figure out whether your plan is one that they regulate. (See page 21 for contact information.)

The United States Department of Labor, Employee Benefits Security Administration (EBSA) regulates group health plans sponsored by employers in the private sector. EBSA's Web site and publications provide consumers with important information about protecting personal rights to health-care coverage. Visit [www.dol.gov/ebsa/consumer\\_info\\_health.html](http://www.dol.gov/ebsa/consumer_info_health.html) or call EBSA's

Employee and Employer Hotline at 866.444.EBSA (3272) for free copies of these booklets:

- Health Benefits Under the Consolidated Omnibus Budget Reconciliation Act (COBRA)
- Questions and Answers: Recent Changes in Health Care Law
- Pension and Health Care Coverage Questions and Answers for Dislocated Workers
- Health Benefits for Women

The Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services regulates HIPAA and COBRA compliance by group health plans sponsored by state and local governments. In addition, it runs the Medicare program and works with states on Medicaid programs. For more information contact CMS at 877.267.2323 or visit [www.cms.gov](http://www.cms.gov).

Researchers at Georgetown University have written health insurance consumer guides for getting and keeping health insurance for every state. To read or download the free guide for your state visit [www.healthinsuranceinfo.net](http://www.healthinsuranceinfo.net).

Finally, many consumer groups such as the National Coalition for Cancer Survivorship may offer assistance. For very complicated problems, you may need to consult a lawyer or another expert for professional advice and help. Or you may want to ask a friend to help you make some of these calls, gather information, and keep track of the paperwork. If a professional is needed, however, make sure he or she has expertise in health insurance (not all lawyers or accountants do). Health insurance can be complicated and frustrating, but you are not alone. Be persistent and take advantage of the help that is available for you.

## **STATES WITH HIGH-RISK POOLS (AS OF JULY 2006)**

Alabama (open to “HIPAA-eligible” individuals, only)

Alaska

Arkansas

California

Colorado

Connecticut

Florida (closed to new enrollees)

Illinois

Indiana

Iowa

Kansas

Kentucky

Louisiana

Maryland

Minnesota

Mississippi

Missouri

Montana

Nebraska

New Hampshire

New Mexico

North Dakota

Oklahoma

Oregon

South Carolina

South Dakota

Texas

Utah

Washington

West Virginia

Wisconsin

Wyoming

## STATE HEALTH INSURANCE REGULATORS

Every effort has been made to provide accurate information. Call your state office first because many offices have separate mailing addresses for correspondence and complaints.

### Alabama Department of Insurance

201 Monroe Street  
Suite 1700  
Montgomery, AL 36104  
Phone: 800.433.3966 (in state)  
334.241.4141  
Fax: 334.240.4409  
www.aldoi.org

### Alaska Department of Community and Economic Development

Division of Insurance  
550 W. 7th Avenue  
Suite 1560  
Anchorage, AK 99501-3567  
Phone: 800.467.8725 (in state)  
907.269.7900  
Fax: 907.269.7910  
E-mail: insurance@commerce.state.ak.us  
www.dced.state.ak.us/insurance

### Arizona Department of Insurance

2910 North 44th Street  
Suite 210  
Phoenix, AZ 85018-7256  
Phone: 800.325.2548 (in state)  
602.364.2499  
Fax: 602.364.2505  
E-mail: consumers@id.state.az.us  
www.id.state.az.us

### Arkansas Insurance Department

1200 West Third Street  
Little Rock, AR 72201-1904  
Phone: 800.282.9134 (in state)  
501.371.2600  
www.insurance.arkansas.gov

### California Department of Insurance

Consumer Communications Bureau  
300 South Spring Street, South Tower  
Los Angeles, CA 90013  
Phone: 800.927.4357 (in state)  
213.897.8921  
Fax: 213.897.5961  
www.insurance.ca.gov

### Colorado Division of Insurance

1560 Broadway  
Suite 850  
Denver, CO 80202  
Phone: 800.930.3745 (in state)  
303.894.7499  
Fax: 303.894.7455  
www.dora.state.co.us/insurance

### Connecticut Insurance Department

153 Market Street, 7th Floor  
Hartford, CT 06103  
Phone: 800.203.3447 (in state)  
860.297.3900  
Fax: 860.297.3872  
www.state.ct.us/cid

### Delaware Department of Insurance

841 Silver Lake Boulevard  
Dover, DE 19904  
Phone: 800.282.8611 (in state)  
302.739.4251  
Fax: 302.739.6278  
www.state.de.us/inscom

### District of Columbia

Department of Insurance and Securities  
Regulation  
810 First Street, NE  
Suite 701  
Washington, DC 20002  
Phone: 202.727.8000  
Fax: 202.535.1196  
www.disr.washingtondc.gov

### Florida Department of Insurance

Bureau of Consumer Affairs  
200 East Gaines Street  
Tallahassee, FL 32399-0300  
Phone: 800.342-2762 (in state)  
850.413-3100  
Fax: 850.488-2349  
www.fldfs.com

### **Georgia Department of Insurance**

Office of Insurance and Safety Fire  
Commissioner  
2 Martin Luther King, Jr. Drive  
Floyd Memorial Building  
7th Floor, West Tower  
Atlanta, GA 30334  
Phone: 800.656.2298 (in state)  
404.656.2070  
Fax: 404.657.8542  
www.gainsurance.org

### **Hawaii Division of Insurance**

Department of Commerce and Consumer  
Affairs  
335 Merchant Street  
Honolulu, HI 96813  
Phone: 808.586.2790  
Fax: 808.586.2806  
www.state.hi.us/dcca/ins

### **Idaho Department of Insurance**

700 West State Street  
P.O. Box 83720  
Boise, ID 83720-0043  
Phone: 208.334.4250  
800.721.3272 (in state)  
Fax: 208.334.4398  
www.doi.idaho.gov

### **Illinois Department of Insurance**

320 West Washington Street  
Springfield, IL 62767-0001  
Phone: 877.527.9431 (in state)  
217.782.4515  
Fax: 217.782.5020  
www.idfpr.com

### **Indiana Department of Insurance**

311 West Washington Street  
Suite 300  
Indianapolis, IN 46204-2787  
Phone: 800.622.4461 (in state)  
317.232.2385  
Fax: 317.232.5251  
www.ai.org/idoi

### **Iowa Insurance Division**

330 Maple Street  
Des Moines, IA 50319-0065  
Phone: 877.955.1212 (in state)  
515.281.5705  
Fax: 515.281.3059  
www.iid.state.ia.us

### **Kansas Insurance Department**

420 SW 9th Street  
Topeka, KS 66612-1678  
Phone: 800.432.2484 (in state)  
785.296.3071  
Fax: 785.296.2283  
www.ksinsurance.org

### **Kentucky Department of Insurance**

215 West Main Street  
Frankfort, KY 40602-0517  
Phone: 800.595.6053  
502.564.6088  
Fax: 502.564.1453  
www.doi.state.ky.us

### **Louisiana Department of Insurance**

Office of Health  
1702 N. 3rd Street  
Baton Rouge, LA 70802  
Phone: 800.259.5300 (in state)  
225.342.0895  
Fax: 225.342.5711  
www.lidi.la.gov

### **Maine Bureau of Insurance**

Department of Professional & Financial  
Regulation  
Consumer Health Care Division  
#34 State House Station  
Augusta, ME 04333-0034  
Phone: 800.300.5000 (in state)  
207.624.8475  
Fax: 207.624.8599  
www.state.me.us/pfr/ins/ins\_index.htm

### **Maryland Insurance Administration**

525 St. Paul Place  
Baltimore, MD 21202-2272  
Phone: 800.492.6116  
410.468.2000  
Fax: 410.468.2020  
www.mdinsurance.state.md.us

### **Commonwealth of Massachusetts**

Division of Insurance  
One South Station  
5th Floor  
Boston, MA 02110-2208  
Phone: 617.521.7777  
Fax: 617.521.7575  
[www.state.ma.us/doi](http://www.state.ma.us/doi)

### **Michigan Division of Insurance**

Office of Financial and Insurance Services  
Ottawa Building  
611 West Ottawa Street  
2nd Floor  
Lansing, MI 48933-1070  
Phone: 877.999.6442  
517.373.0220  
Fax: 517.335.4978  
[www.michigan.gov/cis](http://www.michigan.gov/cis)

### **Minnesota Department of Commerce**

Enforcement Division  
85 7th Place East, Suite 500  
Saint Paul, MN 55101  
Phone: 800.657.3602 (in state)  
651.296.2488  
Fax: 651.296.4328  
[www.commerce.state.mn.us](http://www.commerce.state.mn.us)

### **Mississippi Insurance Department**

1001 Woolfolk State Office Building  
501 N. West St.  
Jackson, MS 39201  
Phone: 800.562.2957 (in state)  
601.359.3569  
Fax: 601.359.1077  
[www.doi.state.ms.us](http://www.doi.state.ms.us)

### **Missouri Department of Insurance**

Division of Consumer Affairs  
301 West High Street  
P.O. Box 690  
Jefferson City, MO 65102-0690  
Phone: 800.726.7390 (in state)  
573.751.4126  
Fax: 573.751.1165  
[www.insurance.mo.gov](http://www.insurance.mo.gov)

### **Montana Department of Insurance**

840 Helena Avenue  
Helena, MT 59601  
Phone: 800.332.6148 (in state)  
406.444.2040  
Fax: 406.444.3497  
<http://sao.state.mt.us/>

### **Nebraska Department of Insurance**

Terminal Avenue  
941 "O" Street  
Suite 400  
Lincoln, NE 68508-3639  
Phone: 877.564.7323 (in state)  
402.471.2201  
Fax: 402.471.4610  
[www.nol.org/home/ndoi](http://www.nol.org/home/ndoi)

### **Nevada Department of Business & Industry**

Division of Insurance  
788 Fairview Drive  
Suite 300  
Carson City, NV 89701  
Phone: 888.872.3234 (in state)  
775.687.4270  
Fax: 775.687.3937  
[www.doi.state.nv.us](http://www.doi.state.nv.us)

### **New Hampshire Insurance Department**

Consumer Affairs  
21 South Fruit Street  
Suite 14  
Concord, NH 03301  
Phone: 800.852.3416 (in state)  
603.271.7973  
Fax: 603.271.0248  
[www.nh.gov/insurance/index.htm](http://www.nh.gov/insurance/index.htm)

### **New Jersey Department of Banking and Insurance**

20 West State Street  
Trenton, NJ 08625-0325  
Phone: 609.292.5360  
Fax: 609.292.5865  
[www.njdobi.org](http://www.njdobi.org)

### **New Mexico Public Regulation Commission**

Insurance Division  
P.E.R.A. Building  
1120 Paseo De Peralta  
P.O. Box 1269  
Santa Fe, NM 87504-1269  
Phone: 800.947.4722 (in state)  
505.827.4601  
Fax: 505.827.4734  
www.nmprc.state.nm.us

### **New York Department of Insurance**

25 Beaver Street  
New York, NY 10004  
Phone: 800.342.3736 (in state)  
212.480.6400  
Fax: 212.486.2312  
www.ins.state.ny.us

### **North Carolina Department of Insurance**

1201 Mail Service Center  
Raleigh, NC 27699-1201  
Phone: 800.546.5664 (in state)  
919.733.2032  
Fax: 919.733.6495  
E-mail: consumer@ncdoi.net  
www.ncdoi.com

### **North Dakota Department of Insurance**

State Capitol, Fifth Floor  
600 East Boulevard Avenue  
Bismarck, ND 58505-0320  
Phone: 800.247.0560 (in state)  
701.328.2440  
Fax: 701.328.4880  
www.state.nd.us/ndins

### **Ohio Department of Insurance**

Consumer Services Division  
2100 Stella Court  
Columbus, OH 43215-1067  
Phone: 800.686.1526 (in state)  
614.644.2658  
Fax: 614.644.3743  
www.ohioinsurance.gov

### **Oklahoma Department of Insurance**

2401 NW 23rd Street  
Suite 28  
P.O. Box 53408  
Oklahoma City, OK 73152-3408  
Phone: 800.522.0071 (in state)  
405.521.2828  
Fax: 405.521.6635  
www.oid.state.ok.us

### **Oregon Division of Insurance**

Department of Consumer and Business Services  
350 Winter Street, NE  
Room 440  
Salem, OR 97301-3883  
Phone: 503.947.7980  
Fax: 503.378.4351  
www.cbs.state.or.us

### **Pennsylvania Insurance Department**

Bureau of Consumer Services  
1326 Strawberry Square  
13th Floor  
Harrisburg, Pa 17120  
Phone: 877.881.6388 (in state)  
717.787.2317  
Fax: 717.787.8585  
www.insurance.state.pa.us

### **Rhode Island Insurance Division**

Department of Business Regulation  
233 Richmond Street  
Suite 233  
Providence, RI 02903-4233  
Phone: 401.222.2246  
Fax: 401.222.6098  
www.dbr.state.ri.us

### **South Carolina Department of Insurance**

Consumer Services Division  
300 Arbor Lake Drive  
Suite 1200  
Columbia, SC 29223  
Phone: 800.768.3467 (in state)  
803.737.6160  
Fax: 803.737.6231  
E-mail: cnsmmail@doi.sc.gov  
www.doi.sc.gov

### **South Dakota Division of Insurance**

Department of Commerce and Regulation  
445 East Capitol Avenue  
Pierre, SD 57501  
Phone: 605.773.3563  
Fax: 605.773.5369  
[www.state.sd.us/dcr/insurance/](http://www.state.sd.us/dcr/insurance/)

### **Tennessee Department of Commerce and Insurance**

500 James Robertson Parkway  
Davy Crockett Tower  
Nashville, TN 37243  
Phone: 800.342.4029 (in state)  
615.741.2218  
Fax: 615.532.7389  
[www.state.tn.us/commerce](http://www.state.tn.us/commerce)

### **Texas Department of Insurance**

333 Guadalupe Street  
Austin, TX 78701  
Phone: 800.578.4677 (in state)  
512.463.6169  
Fax: 512.475.2005  
[www.tdi.state.tx.us](http://www.tdi.state.tx.us)

### **Utah Insurance Department**

State Office Building, Rm 3110  
Salt Lake City, UT 84114-6901  
Phone: 800.439.3805 (in state)  
801.538.3805  
Fax: 801.538.3829  
[www.insurance.utah.gov](http://www.insurance.utah.gov)

### **Vermont Division of Health Care Administration**

Department of Banking, Insurance, Securities  
and Health Care Administration  
89 Main Street  
Drawer 20  
Montpelier, VT 05620-3101  
Phone: 800.631.7788 (in state)  
802.828.2900  
Fax: 802.828.2949  
[www.bishca.state.vt.us](http://www.bishca.state.vt.us)

### **Virginia Bureau of Insurance**

Tyler Building  
1300 East Main Street  
Richmond, VA 23219  
Phone: 800.552.7945 (in state)  
804.371.9741  
Fax: 804.371.9944  
[www.state.va.us/scc/division/boi](http://www.state.va.us/scc/division/boi)

### **Washington Office of the Insurance Commissioner**

P.O. Box 40255  
Olympia, WA 98504  
Phone: 800.562.6900 (in state)  
360.725.7080  
Fax: 360.407.0186  
[www.insurance.wa.gov](http://www.insurance.wa.gov)

### **West Virginia Insurance Commission**

Greenbrooke Building  
1124 Smith Street, Room 309  
Charleston, WV 25301  
Phone: 800.642.9004 (in state)  
304.558.3386  
Fax: 304.558.4965  
[www.wvinsurance.gov](http://www.wvinsurance.gov)

### **Office of the Commissioner of Insurance State of Wisconsin**

125 South Webster Street  
Madison, WI 53702  
Phone: 800.236.8517 (in state)  
608.266.3585  
Fax: 608.266.9935  
[www.oci.wi.gov](http://www.oci.wi.gov)

### **Wyoming Department of Insurance**

Herschler Building, 3rd Floor East  
122 West 25th Street  
Cheyenne, WY 82002-0440  
Phone: 800.438.5768 (in state)  
307.777.7401  
Fax: 307.777.5895  
<http://insurance.state.wy.us>

## STATES WITH EXTERNAL APPEAL PROGRAMS (AS OF JULY 2006)

State	Where to contact for more information
Alaska	Your health plan
Arizona	Arizona Department of Insurance, 800.325.2548 <a href="http://www.id.state.az.us/consumermore.html">www.id.state.az.us/consumermore.html</a>
Arkansas	Arkansas Insurance Department, 800.852.5494
California	California Department of Managed Health Care, 888.HMO.2219 <a href="http://www.hmohelp.ca.gov">www.hmohelp.ca.gov</a>
Colorado	Colorado Division of Insurance, 303.894.7490, 800.930.3745 toll free <a href="http://www.dora.state.co.us/insurance">www.dora.state.co.us/insurance</a>
Connecticut	Connecticut Insurance Department, 800.203.3447 <a href="http://www.state.ct.us/cid">www.state.ct.us/cid</a>
Delaware	Delaware Office of Health Facilities Licensing and Certification, 800.942.7373
DC	DC Department of Health, Grievance and Appeals Coordinator, 202.442.5979 <a href="http://www.dchealth.dc.gov">www.dchealth.dc.gov</a>
Florida	Agency for Health Care Administration, 888.419.3456 <a href="http://www.fdhc.state.fl.us">www.fdhc.state.fl.us</a>
Georgia	Georgia Department of Community Health, 404.657.4563 <a href="http://www.communityhealth.state.ga.us">www.communityhealth.state.ga.us</a>
Hawaii	Hawaii Department of Commerce and Consumer Affairs, Insurance Division Health Insurance Branch, 808.586.2804 <a href="http://www.state.hi.us/decca/ins">www.state.hi.us/decca/ins</a>
Illinois	Illinois Financial and Professional Regulation, Division of Insurance, 217.558.2309 <a href="http://www.idfpr.com">www.idfpr.com</a>
Indiana	Indiana Department of Insurance, 800.622.4461 <a href="http://www.state.in.us/idoi">www.state.in.us/idoi</a>
Iowa	Iowa Insurance Division, 877.955.1212 <a href="http://www.iid.state.ia.us">www.iid.state.ia.us</a>
Kansas	Kansas Insurance Department, 800.432.2484 or 800.462.2081 (Hearing Impaired) <a href="http://www.ksinsurance.org">www.ksinsurance.org</a>
Kentucky	Kentucky Department of Insurance, 800.595.6053 <a href="http://www.doi.state.ky.us">www.doi.state.ky.us</a>
Louisiana	Louisiana Department of Insurance Help Desk, 800.259.5300 <a href="http://www.lidi.la.gov">www.lidi.la.gov</a>
Maine	Maine Bureau of Insurance, 800.300.5000 <a href="http://www.maineinsurancereg.org">www.maineinsurancereg.org</a>
Maryland	Maryland Insurance Administration, 800.492.6116 <a href="http://www.mdinsurance.state.md.us">www.mdinsurance.state.md.us</a>
Massachusetts	Office of Patient Protection, 800.436.7757 <a href="http://www.state.ma.us/dph/opp">www.state.ma.us/dph/opp</a>
Michigan	Michigan Office of Financial and Insurance Services, 877.999.6442 <a href="http://www.michigan.gov/cis">www.michigan.gov/cis</a>
Minnesota	Minnesota Department of Health, 800.657.3916 <a href="http://www.health.state.mn.us/divs/hpsc/mcs/external.htm">www.health.state.mn.us/divs/hpsc/mcs/external.htm</a>

## STATES WITH EXTERNAL APPEAL PROGRAMS (CONTINUED)

Missouri	Missouri Department of Insurance, 800.726.7390 <a href="http://www.dss.mo.gov/pr_health.htm">www.dss.mo.gov/pr_health.htm</a>
Montana	Montana Department of Public Health and Human Services, 800.332.2272 <a href="http://www.dphhs.mt.gov">www.dphhs.mt.gov</a>
Nevada	Governor's Office for Consumer Health Assistance, 888.333.1597 <a href="http://govcha.state.nv.us/">http://govcha.state.nv.us/</a>
New Hampshire	New Hampshire Department of Insurance, 800.852.3416 <a href="http://www.state.nh.us/insurance">www.state.nh.us/insurance</a>
New Jersey	New Jersey Department of Health and Senior Services, 888.393.1062 <a href="http://www.state.nj.us/health/index.shtml">www.state.nj.us/health/index.shtml</a>
New Mexico	Managed Health Care Hotline, 877.673.1732 <a href="http://www.nmprc.state.nm.us/">www.nmprc.state.nm.us/</a>
New York	NY State Insurance Department Hotline, 800.400.8882 <a href="http://www.ins.state.ny.us">www.ins.state.ny.us</a>
North Carolina	NC Department of Insurance, 877.885.0231 <a href="http://www.ncdoi.com/consumer/consumer.asp">www.ncdoi.com/consumer/consumer.asp</a>
Ohio	Ohio Department of Insurance Consumer Hotline, 800.686.1526 <a href="http://www.ohioinsurance.gov">www.ohioinsurance.gov</a>
Oklahoma	Oklahoma Health Department Hotline, 800.522.0203, 405.271.5600 <a href="http://www.health.state.ok.us">www.health.state.ok.us</a>
Oregon	Department of Consumer and Business Services, Insurance Division, 503.947.7269 <a href="http://www.oregoninsurance.org">www.oregoninsurance.org</a>
Pennsylvania	Bureau of Managed Care, 888.466.2787 <a href="http://www.health.state.pa.us">www.health.state.pa.us</a>
Rhode Island	Rhode Island Department of Health, 401.222.6015 <a href="http://www.health.state.ri.us">www.health.state.ri.us</a>
South Carolina	South Carolina Department of Insurance, 800.768.3467, 803.737.6180 <a href="http://www.doi.sc.gov/">www.doi.sc.gov/</a>
Tennessee	Tennessee Department of Commerce and Insurance, 800.861.1270, 615.741.2825 <a href="http://www.state.tn.us/commerce">www.state.tn.us/commerce</a>
Texas	Consumer Help Line, 800.252.3439 <a href="http://www.tdi.state.tx.us">www.tdi.state.tx.us</a>
Utah	Utah State Insurance Department, 800.439.3805, 801.538.3805 (Salt Lake City) <a href="http://www.insurance.utah.gov">www.insurance.utah.gov</a>
Vermont	Division of Health Care Administration, 800.631.7788 <a href="http://www.bishca.state.vt.us/">www.bishca.state.vt.us/</a> The Vermont Office of Health Care Ombudsman, 800.917.7787
Virginia	Bureau of Insurance, 800.552.7945 <a href="http://www.state.va.us/scc/division/boi">www.state.va.us/scc/division/boi</a>
Washington	Office of the Insurance Commissioner Consumer Hotline, 800.562.6900 <a href="http://www.insurance.wa.gov">www.insurance.wa.gov</a>
West Virginia	Office of the Insurance Commissioner, Consumer Services Division, 888.879.9842 <a href="http://www.wvinsurance.gov/consumer/hmo_grev.htm">www.wvinsurance.gov/consumer/hmo_grev.htm</a>
Wisconsin	Office of the Commissioner of Insurance, 800.236.8517 <a href="http://www.oci.wi.gov">www.oci.wi.gov</a>

## **GLOSSARY OF INSURANCE TERMS**

**Balance Billing**—The practice of billing a patient for the amount that remains after the insurer's payment and patient's copayment have been made.

**Benefit**—An amount payable by the insurance carrier.

**Benefit Period, Medicare**—The period of time that begins the first day a person enters a hospital or skilled nursing facility and ends 60 days after discharge without being readmitted to either type of facility.

**Catastrophic Insurance**—A type of limited health insurance that serves the purpose of covering very high medical expenses. The deductibles are very high (\$2,000 or above) and the premiums are low.

**Certificate of Creditable Coverage**—A document provided by your health plan that lets you prove you had coverage under that plan. Certificates of creditable coverage will usually be provided automatically when you leave a health plan. You can obtain certificates at other times as well.

**Coinsurance**—The portion of the bill for which the insured is responsible.

**Comprehensive Coverage**—Insurance is either comprehensive or limited. Comprehensive means broader coverage and/or higher indemnity payments than limited coverage.

**Continuous Coverage**—Health insurance is continuous if it is not interrupted by a break of 63 or more consecutive days. In some

state regulated plans, the maximum lapse in coverage may be longer than 63 days.

**Copayment**—In managed care plans, the amount the insured must pay directly to the provider of the service. Copayments typically range between \$5 to \$25.

**Creditable Coverage**—Health insurance coverage under any of the following: a group health plan; an individual health plan; Medicare; Medicaid; State Children's Health Insurance Program, CHAMPUS and TRICARE (health coverage for military personnel, retirees, and dependents); Federal Employees Health Benefits Program; Indian Health Service; Public Health Plan (any plan established or maintained by a State, the U.S. government, a foreign country); the Peace Corps; or a state health insurance high risk pool. See also Continuous Coverage, Group Health Plan, Individual Health Plan.

**Deductible**—The amount of money the insured must pay out of pocket before benefits begin. Deductibles are usually on a calendar year or policy year basis. Some policies have deductibles per diagnosis—the least desirable—or family deductibles. A policy may have a \$250 deductible per individual with a \$500 deductible per family. This means that when two individuals have each satisfied a \$250 deductible, the remaining family members will not have to meet any deductible.

**Elimination Rider**—A feature permitted in individual health plans that excludes coverage for a pre-existing condition. Unlike pre-existing condition exclusion periods, which

are temporary, elimination riders can last indefinitely. Elimination riders cannot be imposed if you are HIPAA eligible.

**Explanation of Benefits (EOB)**—One of these forms comes with or without an insurance check to explain what portion of the submitted bill was covered and why. If the patient has more than one policy, this is proof of what his or her primary coverage paid.

**Exclusions**—Specified illnesses, injuries, or conditions listed in the policy that are not covered. Experimental therapies, cosmetic surgery, and eyeglasses are common exclusions.

**Fee-for-Service**—See indemnity insurance.

**Health Maintenance Organization (HMO)**—The first and most traditional type of managed care plan. Like other types of managed care, HMOs are organizations that both finance healthcare (provide insurance) and provide the care by collecting fees in advance.

**Health Savings Account (HSA)**—A tax-favored savings account available to eligible individuals that are covered by a federally qualified high deductible health plan. Funds accumulated in a HSA can be used to pay for certain health-care costs.

**Health Status**—Refers to your medical condition (both physical and mental illness,) claims experience, receipt of healthcare, medical history, genetic information, evidence of insurability, (including conditions arising out of acts of domestic violence,) and disability.

**High-Risk Pool**—A program offered in 31 states that sells health insurance to people who need to buy coverage on their own but can't because insurance companies consider them "medically uninsurable." A cancer diagnosis or history can render someone uninsurable in the individual health insurance market unless state laws require health insurers to sell coverage to everyone.

**Indemnity Insurance**—Traditional insurance that pays providers on a fee-for-service basis.

**Lifetime Limit or Maximum**—Total benefits that the insurance company will pay per individual over a lifetime.

**Managed Care Plan**—Organization that functions as both insurer and provider of healthcare simultaneously. HMOs were the first type, but variations include preferred provider organizations (PPOs) and independent practice associations (IPAs). HMOs tend to operate with stricter rules than other types of managed care plans.

**Medicaid**—A joint federal and state health insurance program that assists individuals with low incomes and limited resources. Medicaid programs vary from state to state.

**Medicare**—The federal health insurance program for people 65 years of age or older, certain younger people with disabilities, and people with permanent kidney failure.

**Open Enrollment**—The period of time in which eligible individuals may enroll in, or transfer between, health-care insurance programs. Plans must accept all individuals who enroll during open enrollment.

**Out-of-Pocket Limit**—A cap or limit placed on a patient’s out-of-pocket costs, after which the plan provides full coverage for all costs for the remainder of the year.

**Participating Provider**—A health-care provider who has joined a managed care plan and is willing to accept its contracts.

**Portability**—Insurance that can be retained even if one leaves employment or the group plan.

**Pre-Existing Condition**—A health condition that existed before a policy was purchased. Companies’ definitions of pre-existing conditions vary, but usually anything for which a patient has seen a doctor during the previous 6 months is a pre-existing condition and will not be covered during the waiting period, which is typically six to twelve months after the effective date of coverage.

**Pre-Existing Condition Exclusion Period**—The first days of an illness that are not covered by insurance.

**Preferred Provider Organization (PPO)**—A PPO is a type of managed care plan that allows members to access service both from in-network providers and out-of-network providers. Members pay higher out-of-pocket costs when they receive care outside the PPO network.

**Premium**—The amount paid to an insurance company for providing insurance coverage.

**Point-of-Service (POS) plan**—A type of managed care plan that gives the insured the option of seeing providers within the plan’s network and paying the copayment amount

only, or seeing providers out of the network and getting reimbursed as one would under an indemnity policy. Although these plans are increasingly popular because they allow for choice of providers, the premiums are higher than plans that provide no coverage for providers outside the network.

**Primary Care Provider (PCP)**—Sometimes referred to as “gatekeepers,” PCPs are non-specialty physicians that enrollees choose to serve as their coordinator for all the services they may need. In many managed care plans, PCPs must pre-approve referrals to specialists and use of services, including emergency room care.

**Provider**—The supplier, physician, psychologist, pharmacist, or other health-care professional providing a service to the insured.

**Stop-Loss**—The point during a calendar year when your insurance policy pays 100 percent of costs for the remainder of the year. Thus, your out-of-pocket expenditures, or losses, stop. Most policies pay 80 percent and the individual pays 20 percent. If the policy has a \$5,000 stop-loss point, 20 percent of that equals \$1,000. This means that when you have spent \$1,000 out of your pocket plus your deductible, the policy will pay 100 percent rather than 80 percent.

**Waiting Period**—The time after the beginning date of a policy when benefits are not payable.

## PUBLICATIONS ON OTHER SURVIVORSHIP ISSUES

*A Cancer Survivor's Almanac: Charting Your Journey*, edited by Barbara Hoffman, J.D., John Wiley & Sons (Hoboken, NJ). 2004 Edition. Available from the National Coalition for Cancer Survivorship and bookstores nationwide.

*Cancer Survival Toolbox*<sup>®</sup>, developed by NCCS in collaboration with the Oncology Nursing Society, the Association of Oncology Social Work and the National Association of Social Workers, with support from the Amgen Foundation, the Bayer Healthcare Foundation, the Eli Lilly and Company Foundation, Novartis Oncology, and the sanofi-aventis Foundation. Available free of charge 877.TOOLS.4.U (877.866.5748) in English and Spanish. Chinese transcript also available. May be downloaded from [www.cancersurvivaltoolbox.org](http://www.cancersurvivaltoolbox.org).

*Facing Forward Series: Life After Cancer Treatment*, (No. 02-2424) and *Ways You Can Make A Difference in Cancer* (No. 02-5088) by the National Cancer Institute (content assistance from NCCS), (2002). Available from Cancer Information Service (1.800.4CANCER); [www.cancer.gov](http://www.cancer.gov).

*Self-Advocacy: A Cancer Survivor's Handbook*, Published by the National Coalition for Cancer Survivorship. First Edition (2003), 26 pp. Currently available in English only.

*Teamwork: The Cancer Patient's Guide to Talking with Your Doctor*, by Elizabeth J. Clark, Ph.D., Editor. Published by the National Coalition for Cancer Survivorship. Fourth Edition (2006), 58 pp. Available in English and Spanish.

*Working it Out: Your Employment Rights As a Cancer Survivor*, by Barbara Hoffman, JD. Published by the National Coalition for Cancer Survivorship. (2003), 22pp. Available in English and Spanish.

*You Have the Right to Be Hopeful*, by Elizabeth J. Clark, Ph.D. Published by the National Coalition for Cancer Survivorship. Third Edition (2003), 24 pp. Available in English and Spanish.







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