

TIPS for ACCESSING & USING HEALTH INSURANCE

Health Insurance can be a complicated and confusing subject. Many health insurance plans are available with all sorts of varying coverage, exclusions, deductibles, co-pays, and so on. Following are generally accepted tips for accessing and utilizing any health insurance plan.

- Carry your insurance plan card(s) with you at all times. You may have more than one card for your medical plan, prescription plan, dental plan, and so forth.
- Carry some form of photo identification with you at all times.
- Review your health insurance benefits before you need them. By doing so, you will know what to expect at the time of need.
- Review your health insurance plan limitations and exclusions before you need the coverage. Again, this will help you know what to expect at the time of need.
- Know your deductible amount.
- Know your co-pay amount.
- Know your stop loss amount.

DEFINITIONS

Benefit - Reimbursement for covered medical expenses as specified by the plan.

Brand-Name Drug - Prescription drug which is marketed with a specific brand name by the company that manufactures it. May cost insured individuals a higher co-pay than generic drugs on some health plans. (see "generic.")

Claim - A formal request made by an insured person for the benefits provided by a policy.

COBRA (Consolidated Omnibus Budget Reconciliation Act) - Federal legislation that requires group health plans to provide health plan members the opportunity to purchase continued coverage in the event their insurance is terminated. Applies only to employer groups with 20 or more employees.

Co-Insurance - The percentage of covered expenses an insured individual shares with the insurance carrier. (i.e., for an 80/20 plan, the health plan member's co-insurance is 20%.) If applicable, co-insurance applies after the insured pays the deductible and is only required up to the plan's stop loss amount. (see "stop loss.")

Co-Pay / Co-Payment - The amount an insured individual must pay toward the cost of a particular benefit. For example, a plan might require a \$10 co-pay for each doctor's office visit.

Deductible - The dollar amount an insured individual must pay for covered expenses during a calendar year/policy year before the plan begins paying co-insurance benefits.

Exclusions - Expenses which are not covered under an insurance plan. These are listed in the Certificate Booklet or brochure.

Explanation of Benefits (EOB) – An insurance carrier's written response to a claim for benefits. Sometimes accompanied by a benefits check.

Generic Drug → The chemical equivalent to a "brand name drug." These drugs cost less, and the savings is passed onto health plan members in the form of a lower co-pay.

Health Maintenance Organization (HMO) - HMOs are the oldest form of managed care plan. HMOs offer members a range of health benefits, including preventive care, for a set monthly fee. There are many kinds of HMOs. If doctors are employees of the health plan and you visit them at central medical offices or clinics, it is a staff or group model HMO. Other HMOs contract with physician groups or individual doctors who have private offices. These are called individual practice associations (IPAs) or networks.

HMOs will give you a list of doctors from which to choose a primary care doctor. This doctor coordinates your care, which means that generally you must contact him or her to be referred to a specialist. With some HMOs, you will pay nothing when you visit doctors. With other HMOs there may be a co-payment, like \$5 or \$10, for various services. If you belong to an HMO, the plan only covers the cost of charges for doctors in that HMO. If you go outside the HMO, you will pay the bill. This is not the case with point-of-service plans.

HIPAA - Health Insurance Portability and Accountability Act of 1996, P.L. 104-91. This law relates to underwriting, pre-existing limitations, guaranteed renewal, COBRA and certification requirements in the event someone terminates from the plan. The law establishes new requirements for self-funded, fully-insured group plans (including church plans), and Individual Health policies. The purpose of the law is to:

- Improve portability and continuity of health insurance coverage in the group and individual markets
- To combat waste, fraud and abuse in health insurance and health care delivery
- To promote the use of medical savings accounts
- To improve access to long-term care services and coverage
- To simplify the administration of health insurance

ID Card / Identification Card - Card given to insured individuals which advises medical providers that a patient is covered by a particular health insurance plan.

In-Network - Describes a provider or health care facility which is part of a health plan's network. When applicable, insured individuals usually pay less when using an in-network provider.

Indemnity Plan - With an indemnity plan (sometimes called fee-for-service), you can use any medical provider (such as a doctor and hospital). You or they send the bill to the insurance company, which pays part of it. Usually, you have a deductible—such as \$200—to pay each year before the insurer starts paying.

Once you meet the deductible, most indemnity plans pay a percentage of what they consider the "Reasonable and Customary" charge for covered services. The insurer generally pays 80 percent of the Reasonable and Customary costs and you pay the other 20 percent, which is known as co-

insurance. If the provider charges more than the Reasonable and Customary rates, you will have to pay both the co-insurance and the difference.

The plan will pay for charges for medical tests and prescriptions as well as from doctors and hospitals. It may not pay for some preventive care, like checkups.

Lifetime Maximum Benefit - the maximum amount a health plan will pay in benefits to an insured individual.

Limitations - a restriction on the amount of benefits paid out for a particular covered expense.

Managed Care - The coordination of health care services in the attempt to produce high quality health care for the lowest possible cost. Examples are the use of primary care doctors as gatekeepers in HMO plans and pre-certification of care.

Medicare - Americans age 65 or older and people with certain disabilities can be covered under Medicare, a Federal health insurance program. In many parts of the country, people covered under Medicare now have a choice between managed care and indemnity plans. They also can switch their plans for any reason. However, they must officially tell the plan or the local Social Security Office, and the change may not take effect for up to 30 days. Call your local Social Security office or the State office on aging to find out what is available in your area.

Medicaid - Medicaid covers some low-income people (especially children and pregnant women), and disabled people. Medicaid is a joint Federal-State health insurance program that is run by the States. In some cases, States require people covered under Medicaid to join managed care plans. Insurance plans and State regulations differ, so check with your State Medicaid office to learn more.

Network - A group of doctors, hospitals, and other providers contracted to provide services to insured individuals for less than their usual fees. Provider networks can cover large geographic markets and/or a wide range of health care services. If a health plan uses a preferred provider network, insured individuals typically pay less for using a network provider.

Out-of-Network - Describes a provider or health care facility which is not part of a health plan's network. Insured individuals usually pay more when using an out-of-network provider, if the plan uses a network.

Out-of-Pocket Maximum - the total of an insured individual's co-insurance payments and co-payments.

Pre-Certification - Pre-admission review and approval of appropriateness and medical necessity of hospitalization or other medical treatment.

Pre-Existing Condition - An illness, injury or condition for which the insured individual received medical advice, treatment, services or supplies; had diagnostic tests done or recommended; had medicines prescribed or recommended; or had symptoms of typically within

12 months (time periods may vary depending on state laws) prior to the effective date of insurance coverage.

Preferred Provider Organization (PPO) - A PPO is a form of managed care closest to an indemnity plan. A PPO has arrangements with doctors, hospitals, and other providers of care who have agreed to accept lower fees from the insurer for their services. As a result, your cost sharing should be lower than if you go outside the network. In addition to the PPO doctors making referrals, plan members can refer themselves to other doctors, including ones outside the plan.

If you go to a doctor within the PPO network, you will pay a co-payment (a set amount you pay for certain services—say \$20 for a doctor or \$15 for a prescription). Your co-insurance will be based on lower charges for PPO members. If you choose to go outside the network, you will have to meet the deductible and pay co-insurance based on higher charges. In addition, you may have to pay the difference between what the provider charges and what the plan will pay.

Premiums - Payments to an insurance company providing coverage.

Pre-Notification - An insurance company requirement that an insured obtain pre-approval before being admitted to a hospital or receiving certain kinds of treatment.

Provider - Any person or entity providing health care services, including hospitals, doctors, home health agencies, and nursing homes. Usually licensed by the state.

"Reasonable and Customary" means the charge, fee or expense which is the smallest of: (a) the actual charge; (b) the charge usually made for a covered service by the provider who furnishes it; (c) the negotiated rate, if any; and (d) the prevailing charge made for a covered service in the geographic area by those of similar professional standing.

“Geographic area” means the three digit zip code in which the services, procedure, devices, drugs, treatment or supplies are provided or a greater area, if necessary, to obtain a representative cross-section of charge for a like treatment, service, procedure, device, drug or supply.

Referral - Within many managed care plans, transfer to specialty doctor or specialty care by a primary care doctor.

Rider - A modification to a Certificate of Insurance regarding clauses and provisions of a policy. A rider usually adds or excludes coverage.

Risk - Uncertainty of financial loss.

Stop-Loss - The dollar amount of claims filed for eligible expenses at which the insurance begins to pay at 100% per insured individual. Stop-loss is reached when an insured individual has paid the deductible and reached the out-of-pocket maximum amount of co-insurance.