



Putting The Pieces Together: *Your Step-by-Step Guide to Using Health Insurance*

Understanding Your Coverage At A Glance

When you signed up for your insurance plan, you agreed to its rules, but what does that mean? How do you use your insurance? Let's go over insurance rules to help you understand each piece and put them together.

First, you received a summary of benefits and policy documents when you signed up. These are the initial key pieces – keep these documents and make sure you read them. The documents should help answer many of the questions you will have as you navigate using your insurance within the healthcare system. And if you have specific questions about your coverage call your insurance company. The number is on your insurance card.



Review your card and documents.

- Your insurance card provides information about certain cost-sharing responsibilities as well as the number to call if you have questions.
- Your insurance documents provide the details of your insurance coverage, including the do's and don'ts of using services.



Understand the meaning of an in-network vs. out-of-network provider.

- Not all providers participate in an insurance company's network. If a provider is not in the insurance company's network, you may be responsible for additional charges.
- When choosing a provider always check to see if they are in-network.



Identify the services that must be pre-approved by your insurance company, may be excluded from your coverage or may have limits.

- Insurance companies often require certain services to be preauthorized or pre-approved, such as therapy services, MRIs, etc. This means the insurance company verifies that the service is required and appropriate.
- Not every service is covered under an insurance plan. A service may be excluded for various reasons.
- Some services may have limits on the number of times you can receive them. For example, therapy visits often have a limit.



Know what to expect after receiving care.

- You will be billed for a different amount if you choose an out-of-network provider instead of an in-network provider.
- Your insurance company will send an Explanation of Benefits – this is not a bill!
- If you don't agree with your insurance company, you have options, including an appeals process.

Look at your insurance card.

Your insurance card can provide a lot of information before you even read your documents. It is also often a source of information about the type of insurance plan you have. You may find an abbreviation on the identification card that tells you what type of insurance you have. Or you can call the member services number on the card to ask. Additionally, your card will probably list how much you will pay (co-payment) for doctors' appointments and emergency department visits.



TYPES OF PLANS

Below are the main types of plans. It is important to understand that different plans have different rules. Health insurance companies will only pay when you follow all of the health insurance company's rules, such as get pre-approval for certain services and receive care by a provider who is part of your insurance company's network, also known as an in-network or participating provider.

Providers can be doctors, specialists, hospitals or any place or anyone who provides care.

■ HEALTH MAINTENANCE ORGANIZATION (HMO)

- Members are required to choose a primary care provider (PCP)
- Members must get referrals from the PCP for specialty care
- Members must use in-network providers

HMOs generally will not cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be covered.

■ PREFERRED PROVIDER ORGANIZATION (PPO)

- Members are encouraged, not required, to choose a PCP
- Members pay less when using in-network providers, but can go out-of-network
- Members usually do not need a referral before receiving a service

With a PPO plan, you can choose not to be treated by an in-network provider, but then you will have to pay higher deductibles and co-payments (also called cost-share) than if you used an in-network provider.

■ POINT-OF-SERVICE PLAN (POS)

- Members are not required to choose a PCP
- Members pay less when using in-network providers, but can go out-of-network
- Members usually must get referral from the PCP for any other service you need

■ EXCLUSIVE PROVIDER ORGANIZATION (EPO)

- Members are not required to have a PCP
- Members typically do not need referrals for in-network services
- Members are required to use in-network providers

If you choose to seek care outside of the network, the EPO will not pay the bill.

Co-payment

Paying a set upfront fee for a specific service (such as \$20 for an office visit or \$10 for each prescription drug). It is required to be paid each time you receive the healthcare service or supply.

2.

You know what kind of insurance you have and now you need to find a doctor. What do you need to know?

- In-network or out-of-network?
- Do I need a referral?
- Do I need to be preauthorized?
- Is it a covered benefit?
- Are there exclusions or limitations?

■ IN-NETWORK VS. OUT-OF-NETWORK

Most insurance companies sign contracts with certain doctors and hospitals to be in the plan's network, and these in-network providers agree to accept a certain payment rate, called the contracted amount, from the insurance company. You should know that not all doctors will be part of the same insurance plans as the hospital. Your insurer keeps a list of in-network doctors and facilities. These lists are required to be posted on the insurance company's website, or you can call the member phone number on your insurance card to ask for information or a copy.

Out-of-network providers are those that are not contracted with the health insurance company. Since the insurance company doesn't have an established rate with these providers, the providers will bill the insurance company the full cost of the healthcare service. Your insurance company may not pay for you to go to a provider who is not in-network. In that case, you will be responsible for the whole bill. If the insurance company pays for you to use an out-of-network provider, the amount the insurance company pays may be less than what it would pay for an in-network provider. You will likely have to pay the difference between the amount the insurance company pays and the amount of the bill.

Contracted amount

The amount that insurance will pay to healthcare providers in their networks for services. These rates are negotiated and established in contracts with in-network providers.

Out-of-pocket maximum

Once you meet your deductible, you'll be responsible to pay for a portion of the rest of your healthcare costs for the rest of the year. But many insurance plans have an out-of-pocket maximum, and once you spend up to that amount in deductibles plus coinsurance and copays, insurance will pay 100 percent of any other health costs during the policy year. This only applies to covered services. Monthly premiums do not count toward the out-of-pocket maximum.

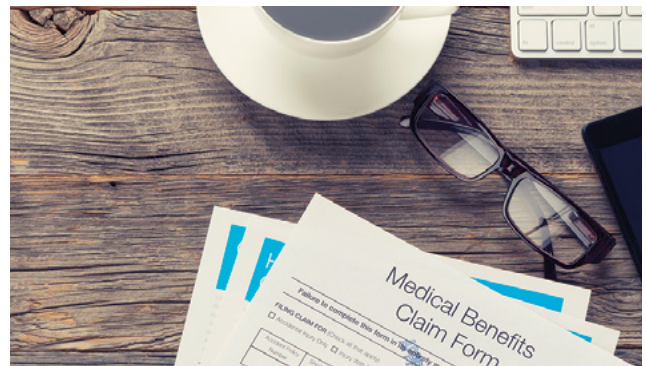
■ MY DOCTOR THINKS I NEED TO SEE A SPECIALIST. CAN I PICK WHOEVER I CHOOSE?

Many insurance plans won't pay for you to see a specialist unless your PCP (usually your family doctor) thinks it is necessary and provides you with a referral. If you see a specialist like a cardiologist or a dermatologist, without a referral, you will likely have to pay more for the care you receive.

Also, don't forget to make sure the specialist you see is in-network, or you could be responsible to pay the entire bill for the visit. Double check with your health insurance company to ensure that the specialist your PCP refers you to is in-network.

■ MY DOCTOR THINKS I NEED A CERTAIN HEALTHCARE SERVICE. CAN I JUST GO GET IT?

If your doctor decides that you need to go to the hospital, have surgery or have certain tests, your insurance company may refuse to pay unless the service is preauthorized. Preauthorization means calling the insurance company ahead of time to have them authorize the service. Sometimes your doctor will do this for you, but make sure you confirm this in advance.



Do I need pre-approval? Know before you go.

■ PREAUTHORIZATION/PRIOR AUTHORIZATION

You may need preauthorization (or pre-approval or prior authorization) from your health insurance company before you receive certain healthcare services. Preauthorization for emergency care is never required.

The preauthorization process verifies medical necessity—in other words, that the service is required and appropriate. Examples of healthcare services that typically require preauthorization include MRIs, home healthcare, therapy services and many more. If you receive the healthcare service without first checking if you are preauthorized, you may be responsible for the entire bill for the service. Carefully review your insurance documents to identify healthcare services that may require preauthorization. If a healthcare service is not listed, check with your health insurance company in advance.

■ *I have preauthorization for my service. Am I set?*

There are many times when your doctor may recommend a particular service or treatment and the service may even be preauthorized by your health insurance company, but the health insurance company still may not pay for it. Below are some of the ways that you could receive a service and be responsible to pay for it out-of-pocket.

■ COVERED BENEFITS VS. MEDICALLY NECESSARY

■ *My doctor thinks I need a shingles vaccine. I have insurance so it's automatically covered right?*

No, insurance companies establish rules to decide what benefits they will cover. Your doctor may think that a shingles vaccine might be medically necessary for many reasons, for example, family history. However, your insurance company may have rules that it won't cover a shingles vaccine until a person is at least 50 years of age. Because of these rules, if you get the vaccine before you turn 50 it will not be covered. This means you will be responsible to pay for the vaccine yourself.

Also, non-covered services don't count toward the annual out-of-pocket maximum under your health plan.

WHAT TO ASK YOUR INSURANCE COMPANY: *Don't just accept the pre-approval as an indicator that payment will be made. ASK: "Is this a covered benefit under my benefits package?"*

■ LIMITATIONS

■ *My doctor recommended 25 therapy visits. Therapy services are a covered benefit. I can schedule all 25 visits, correct?*

No, in some instances, your health insurance will have limitations to covered services or supplies. Usually this refers to the number of times or the circumstances of use for a particular service or treatment. Limits can be a visit limit or a specified number of days allowed per calendar year. Some of the services that commonly have limitations include physical therapy visits, home health visits and skilled nursing facility visits.

Similar to the non-covered benefit, if you go over the service limits you will be responsible for the whole bill and the amount you pay will not apply to your out-of-pocket maximum. Read your insurance documents carefully to identify what limitations may exist.

WHAT TO ASK YOUR INSURANCE COMPANY: *Don't just accept the pre-approval and the fact that it is a covered benefit as an indicator that payment will be made. ASK: "Are there any limitations on the number or amount of this service?"*

■ EXCLUSIONS

■ *My doctor has recommended speech therapy visits for my child. I have pre-approval and know the limit on visits. I won't have any concerns when scheduling the appointments, correct?*

Health insurance companies are not required to cover all services. That is why, when reviewing your insurance documents, pay special attention to the exclusions listing. Some of the more common exclusions include certain ambulance trips, acupuncture, cosmetic surgery and experimental or investigational care.

Less common exclusions can include particular services if another condition exists. For example, certain therapies may be excluded for children with autism. Or when a person is receiving hospice care, therapies for healing the terminal illness are not covered because hospice care is intended to be palliative — meaning it is focused on the comfort of the patient — usually because the patient's condition is incurable. Other therapies for issues not related to the terminal illness may be covered.

If you receive a service that is excluded you will be responsible for the whole bill.

WHAT TO ASK YOUR INSURANCE COMPANY: *Explain any other conditions you may have. Ask: “Are there any conditions or services that would exclude me from getting this service?”*

There are many chances to be exposed to costs that you may not be aware of, which is why it is critical that prior to using your health insurance you look at your policy documents. It will save you money in the long run.

Can't find any of this information? Refer back to the beginning and check your insurance documents.

■ HOW OUT-OF-NETWORK WORKS

Here is an example of how much you could be charged if you go out-of-network. Remember, ***if your insurance plan does not have an out-of-network benefit, you will be responsible for the entire bill!*** If you do have an out-of-network benefit, the charges can still be more than you might realize.

Example: You go to the hospital to have a baby. We assume that the price is the same, \$10,000, at both an in-network and out-of-network hospital. See the chart at right for an example of what you might pay if you used an out-of-network benefit (if you have it).

Deductible

The amount an insured person must pay for health-care services before the health insurance company starts sharing costs. For example, if your deductible is \$1,000, your plan won't pay anything until you pay for \$1,000 of healthcare services or supplies.

Coinsurance

You and the health insurance company share the covered charges in a specified ratio (like 80 percent by the insurer and 20 percent by the enrollee).

Financial risk

Financial risk is the cost of paying medical claims for healthcare services provided to people covered under the insurance plan. Your financial risk is the amount you may need to pay once insurance covers its portion.

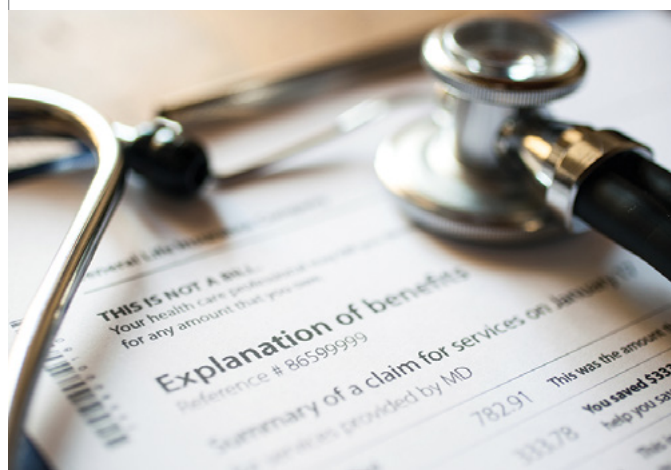
{ PATH 1 - IN-NETWORK }

Hospital Charge	\$10,000
The Insurance Company Pays Its Contracted Rate	\$6,000
You Pay Deductible	\$700
You Pay Copayments	\$100
You Pay Coinsurance	\$950
YOUR TOTAL IS:	\$1,750

{ PATH 2 - OUT-OF-NETWORK }

Hospital Charge	\$10,000
Insurance Company Allowed Amount	\$8,000
Insurance Company Pays 80% of Allowed Amount	\$6,400
You Pay 20% of Allowed Amount	\$1,600
You Pay Balance of \$10,000 – \$8,000	\$2,000
YOUR TOTAL IS:	\$3,600

***When in doubt,
call your insurance
company!***



What happens after my care?

- How much of the cost am I responsible for?
- I received an “EOB” – is it a bill?
- What if I disagree with how my insurance company paid my claim?

■ EXPLANATION OF BENEFITS AND APPEALS

I received in the mail an “Explanation of Benefits” – is this a bill?

No, an Explanation of Benefits (EOB) is a letter from your insurance company that tells you how much the services cost, how much the insurance company paid and how much you might be responsible to pay to your doctor or hospital, and why. The services you received will be grouped, either by who provided the services or the day you received them. These groups of services are called claims, and each claim will have a number. If you have questions about your EOB when it arrives, having the claim number will help you get answers more quickly.

When you receive your bill from your healthcare provider, check it against the EOB. If the provider and the insurance company are telling you to pay two different amounts, call your insurance company before you pay the bill - there may have been an error.

I don't agree with my health insurance company's decision about the cost to me. What can I do?

All health insurance companies are required to have an appeal process. The process varies based on rules for how your health insurance plan is set up. Below are some common examples of how plans are set up and where to go for help.

■ SELF-FUNDED (AKA ERISA) PLANS

Some employers choose to self-fund employees' health insurance. With this type of insurance, your employer assumes the financial risk associated with providing healthcare benefits to employees. In this way, your employer is also your health insurance company.

Sometimes employees do not even realize that their plan is self-funded, because even though the employer pays all the claims, the plan is often administered by a health insurance company. This means most people with self-funded health insurance have insurance identification cards from a well-known health insurance company.

Self-funded plans follow federal requirements, under the Employee Retirement Income Security Act (ERISA). That is why they are also known as ERISA plans.

WHERE DO I GO FOR HELP? If you receive your insurance through an employer and are unsure of the type of product you have, ask your employer, “Is our health insurance self-funded?” If you have a self-funded plan you should contact your human resource department to learn more about the process to file an appeal.

■ FULLY INSURED PLANS

A fully-insured health plan is one where the insurance company assumes all of the risk. This can either be done by an individual purchasing a policy independently or when an employer purchases the insurance from the health insurance company and pays all or a portion of the premiums.

The health insurance company assumes the financial risk and pays for medical claims with the premiums collected. Fully insured health plans must follow all applicable state and federal regulations.

WHERE DO I GO FOR HELP? If you have a fully insured product, you can contact your insurance company or the state Department of Banking and Insurance to learn more about how to file an appeal. In New Jersey, the Office of the Insurance Ombudsman is available to assist consumers. The Ombudsman can be reached at www.state.nj.us/dobi/ins_ombudsman/ombudsfaq.html or by calling 1-800-446-7467.


■ HEALTHCARE SHARING MINISTRY PLANS

Healthcare sharing ministry plans are not insurance plans. They are a cost-sharing mechanism in which people pay a monthly fee, similar to a premium, which is then deposited in an account overseen by the ministry. The ministry then disburses payments for eligible medical bills. If you are part of a healthcare sharing ministry, you are considered a self-pay patient when using healthcare services.

WHERE DO I GO FOR HELP? Because healthcare ministry plans are not actually insurance, whether or not you have any rights is dependent upon the ministry.

PUTTING IT ALL TOGETHER

It's important to be informed about your health insurance. If you have other questions or concerns, call the customer service phone number on your insurance card.



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If you have other questions or concerns, call the customer service phone number on your insurance card.