Understanding Your Health Insurance Plan

Slide Catalog for Assisters

Updated May 6, 2015

GetCoveredIllinois℠
The Official Health Marketplace

Health Insurance Costs

Terms to Know: Premium

Premium: The monthly bill you pay to your health insurance company.

- Your coverage usually will not begin until you pay your first monthly premium.
- Paying your monthly premium ensures that you continue to have health coverage but does not contribute to your deductible.
- Marketplace plans are paid monthly while employer-provided insurance plans can be paid monthly, quarterly or yearly.
- If you do not pay your premium, your insurance company may cancel your coverage.
- Losing coverage because you did not pay your premium does not qualify you for a Special Enrollment Period.

Terms to Know: Out-of-Pocket Costs

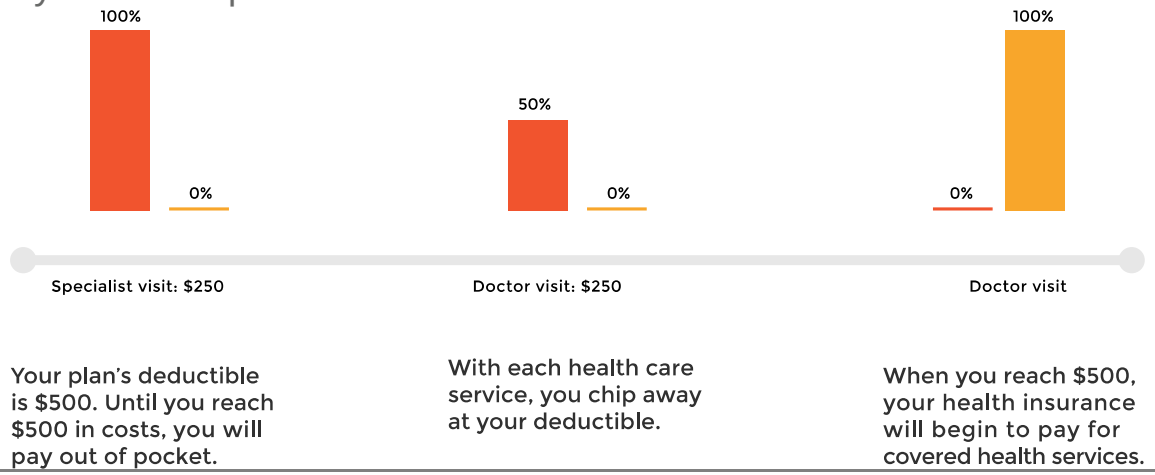
<u>Out-of-Pocket Costs</u>: The costs paid when you receive a health care service.

- The highest possible out-of-pocket (OOP) amount you will have to cover for 2015 is $6,600 for an individual and $13,200 for a family plan. Your plan's limit may be lower.
- If your cumulative OOP costs over the course of the year reach your OOP limit, your health plan will cover your health care costs for the remainder of the year for services covered by the plan.
- OOP costs are important because if you do have a major health issue, surgery or procedure that is covered by your plan, then you will know the absolute maximum you will have to pay.

Terms to Know: Deductible

<u>Deductible</u>: The amount you pay out-of-pocket before your health insurance plan will begin paying for most of your covered health care services.

- Some covered services may be covered before you reach your deductible. For example, many plans offer preventive services without cost-sharing before the deductible is reached. Check your health plan's details.
- For example:



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Terms to Know: Copay

<u>Copay</u>: The fixed amount that you pay for health care services (like a doctor's visit or paying for a prescription) determined by your health plan. Short for *copayment*.

- You usually pay the copay when you receive the service.
  For example:
  - $15 per doctor's visit
  - $25 for specialist's visit
  - $10 for prescriptions

- Your plan's copay amounts can be found on your insurance card or by asking your insurance company.

Terms to Know: Coinsurance

<u>Coinsurance:</u> Cost-sharing where you pay a set percentage of the covered service and your insurance company also pays a set percentage of the covered service, like an x-ray.

- For example, a coinsurance plan of 80/20 means that:
  - Insurance company covers 80% of the cost of a service
  - You cover 20% of the cost of a service

- Many times, coinsurance will begin to take affect after you have reached your deductible.

Insurance Costs: How You Pay

- Your **premium** payment is an important payment to ensure you are continually covered by your health plan. This is your monthly bill.
  - Premiums can be paid a variety of ways. You can choose to pay directly through a bank account, online or by mailing a check.
  - Individuals without bank accounts can also pay by paper check, cashier check, money order or pre-paid debit cards.

- **Copays** are normally paid at the time the service is provided, such as during doctor's visits.
  - Copay prices are often on your insurance card. Be sure to take this with you whenever you are visiting a doctor of any kind. They will be able to tell you whether the services at their office are covered by your insurance.
  - If your copay is not on your card, you can find out how services are covered ahead of time by contacting your insurance company.

Health Care Providers and Provider Networks

Health Care Providers and Provider Networks

- A health care provider is a medical professional who treats patients.
  - Doctors, physicians, pharmacists, nurses and other health care professionals are often referred to as providers.

- A provider network is a specific list of doctors, hospitals and other providers that your health plan covers.

- The health care providers who are in your provider network are also known as network providers or in-network providers.
  - An out-of-network provider is a provider that your plan does not cover.
    - Always try to find in-network providers when seeking care; depending on the plan you bought, you could be charged more when you use out-of-network providers or not covered at all when you use out-of-network providers.

Differences Between In-Network and Out-of-Network

- In-network: Hospitals, providers and pharmacies that are covered by your specific insurance plan. The insurance company will cover part of your health care services.

- Out-of-network: Hospitals, providers and pharmacies that are not covered by your specific insurance plan. You risk paying the full price for health care services and there is a chance that your insurance will not cover any of the cost of the service.

- Health plans generally cannot require higher copays or coinsurance if you get care from an out-of-network hospital *when it is an emergency*, no matter what plan you have.

Checking to See if Your Doctor is In-Network

- Visit your health plan's website and check the provider directory.
  - A provider directory is a list of in-network providers. Your plan has a standing agreement/contract with providers in its network.

- Call your health insurance company to ask about specific providers and confirm which providers are in-network.
  - The phone number for your insurance company is on your insurance card.
  - You can also visit GetCoveredIllinois.gov to find numbers for insurance companies in Illinois.

- Call your doctor's office to confirm whether your health plan is accepted. Provider networks change frequently. It's important to check if your doctor is in-network before each visit, especially if it has been awhile since your last visit.

Saving Money by Staying In-Network

1. Find out if your doctor or desired doctor(s) are in your health plan's network.
2. Know your health plan's policies on how to access covered services that are not available from in-network providers.
3. Ask your health plan what to do if you want to continue care with a provider who leaves your current network.
4. Know your plan's cost-sharing requirements and how they are different in-network and out-of-network.
5. If you need specialty care, ask your doctor to recommend in-network providers for you and your family. Depending on your health plan, you may need a referral from your primary care provider for your specialty care to be covered.
6. When undergoing treatment in a hospital or other facility, ask to have services performed by in-network providers.

Types of Medical Professionals You May See

There are many types of medical professionals that help manage your care, but they generally fit into two buckets:

- Primary Care Provider (PCP): A medical professional that you will see regularly when you are sick, injured or need a check up. PCPs can generally treat you for a variety of health issues or concerns.

- Specialist: If your PCP cannot treat you or thinks you need specialized attention or care, they will refer you to a medical professional that focuses on a specific issue or therapy.
  - Examples of specialists include surgeons, pediatricians and gynecologists.

Types of Plans

Medicaid and Health Plans

- If you are on Medicaid in the State of Illinois, your health insurance covers the same type of services but functions differently than private insurance plans.

- Medicaid generally does not have premiums, coinsurance or deductibles but you may have a copay for services.
  - You may pay premiums in the All Kids program depending on your income.

Medicaid and Health Plans

- Medicaid copays are:
  - $3.90 for a doctor's visit or specialist's visit
  - $2.00-$3.90 for a prescription
  - $3.90 for an emergency room visit in a non-emergency
  - $3.90 each day to stay in the hospital

- There are no copays for the following:
  - Family planning services and contraceptive supplies
  - Emergency services when your life is in danger
  - Certain medications including insulin, AIDS drugs, chemotherapy drugs, hemophilia drugs, certain cardiovascular drugs and over-the-counter drugs

Medicaid and Health Plans

- If you are deemed eligible for Medicaid:
  - You will receive an approval letter in the mail. Within 10 days of receiving the approval letter, you will receive a piece of paper that includes your Recipient Identification Number (RIN) – that is your medical card, so keep it safe. The RIN is what you give providers and pharmacies when you need care.
  - Soon after getting your medical card, you will receive a client enrollment package in the mail. This will explain your benefits and how to pick a Primary Care Provider (PCP) and, for many enrollees, a health plan. You can continue to access any Medicaid provider until you receive your client enrollment packet and are enrolled with a PCP and Health Plan. In some counties, health plans will not be available, so clients will only enroll with PCPs.

Types of Plans to Choose From on the Marketplace

HMO
(Health Maintenance Organization)

- With an HMO, you may have lower out-of-pocket costs than other plans.
- These plans generally will not pay for out-of-network services or have limited out-of-network coverage, except in emergency situations.
- You will need to pick a regular doctor, called a primary care provider (PCP), who can refer you to see other doctors in your network, like in-network specialists.

POS
(Point of Service)

- On average, POS plans have higher out-of-pocket costs than HMO plans but lower out-of-pocket costs than PPOs.
- Like an HMO, you will need to pick a regular doctor, called a primary care provider (PCP), to help monitor your health care; however, you do not have to get permission before visiting other in-network doctors, like in-network specialists.
- POS plans give you the option of going out-of-network for services, but you will usually have to pay more.

PPO
(Preferred Provider Organization)

- PPO plans usually have higher out-of-pocket costs than other plans.
- With a PPO plan, your insurance company will pay a portion of your out-of-network costs. This means you will have more freedom to choose doctors and hospitals regardless of network but risk paying more for services provided out-of-network.
- You do not usually have to pick a regular doctor or get referrals to see specialists.

Types of Plans: A Quick Breakdown

	Do I need permission to see specialists or go out-of-network?	Does the plan pay for out-of-network care?
HMO Health Maintenance Organizations	**In-network:** Yes. You will probably need to pick a regular doctor who can refer you to see other doctors in your network. **Out-of-network:** You probably will not be able to visit doctors or specialists outside of your network.	**No.** These plans generally will not pay for out-of-network services or have limited coverage, except in emergency situations. This means that your visit will cost as much as it did without insurance.
POS Point-of-Service Plans	**In-network:** No. You can generally see any in-network provider without permission from your regular doctor. **Out-of-network:** Yes. You may be able to see providers out-of-network, but your regular doctor may need to set up the visit.	**Yes.** These plans will probably pay for services from out-of-network providers. This means you have the choice to go outside of the provider network but risk paying more.
PPO Preferred Provider Organizations	**In-network and out-of-network:** No. You can generally see any in-network or out-of-network provider without permission from your regular doctor.	**Yes.** These plans will probably pay for services from out-of-network providers. This means you have the choice to go outside of the provider network but risk paying more.

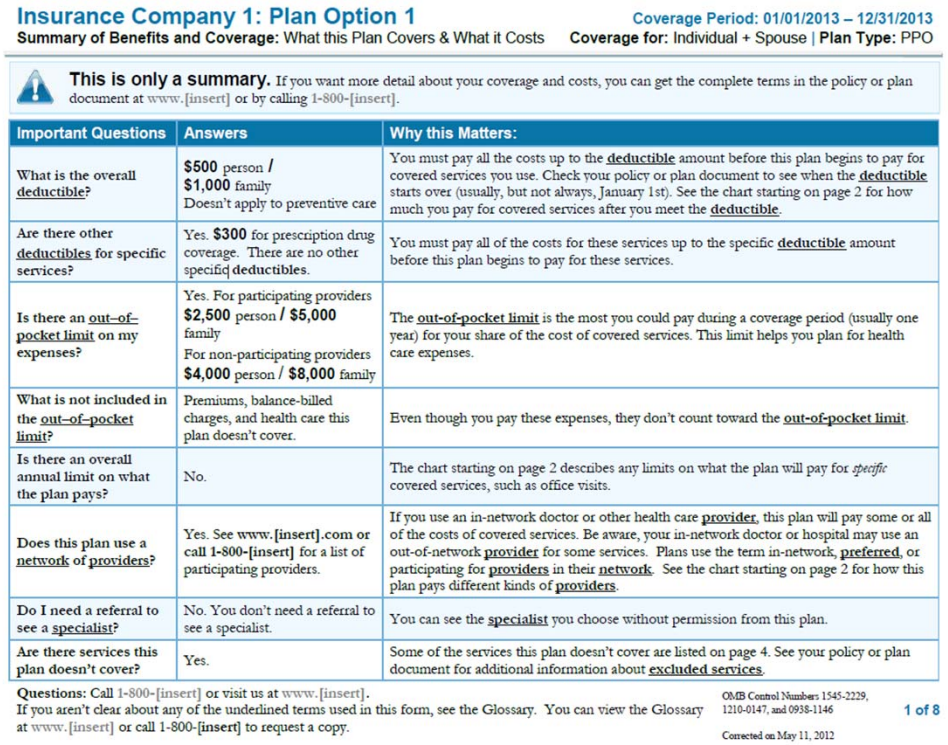
Things to Keep in Mind When Choosing a Plan

- Are your doctors and pharmacy in the plan's network?
  - Is your preferred hospital in the plan's network?
- Where do you generally see the doctor?
  - If you get health services in multiple places or travel often, does the plan cover out-of-network providers or have a national provider network?
- Will the plan require a referral to see a specialist or get other services?
  - Do you prefer having one doctor who refers other providers for your health care?

Understanding Your Health Insurance Plan

Summary of Benefits

- The Summary of Benefits and Coverage (SBC) is a summary of a health plan's benefits and "why this matters" to help you understand what each aspect of your health plan means.
- SBCs are standardized across all insurers and allow you to compare plan specifications side by side.
- The SBC will also give you coverage examples, allowing you to see what would be covered in two possible medical situations:
  - Having a baby, and
  - Managing type 2 diabetes.



Insurance Company 1: Plan Option 1
Summary of Benefits and Coverage: What this Plan Covers & What it Costs
Coverage Period: 01/01/2013 – 12/31/2013
Coverage for: Individual + Spouse | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.[insert] or by calling 1-800-[insert].

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500** person / **$1,000** family Doesn't apply to preventive care	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$300** for prescription drug coverage. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. For participating providers **$2,500** person / **$5,000** family For non-participating providers **$4,000** person / **$8,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.[insert].com** or call **1-800-[insert]** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-800-[insert] or visit us at www.[insert].
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.[insert] or call 1-800-**[insert]** to request a copy.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146
Corrected on May 11, 2012

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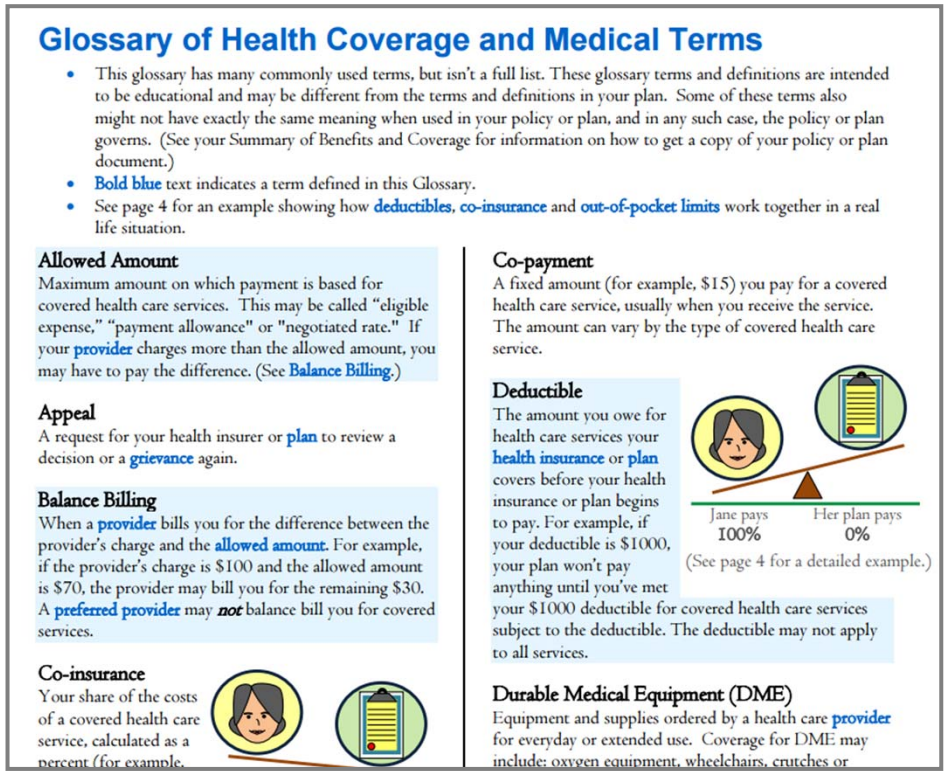
Uniform Glossary

- The Summary of Benefits and Coverage (SBC) is sometimes paired with a Uniform Glossary.
- The Uniform Glossary goes into detail to explain health insurance terms and how cost sharing works.



Glossary of Health Coverage and Medical Terms

- This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- **Bold blue** text indicates a term defined in this Glossary.
- See page 4 for an example showing how **deductibles**, **co-insurance** and **out-of-pocket limits** work together in a real life situation.

Allowed Amount
Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your **provider** charges more than the allowed amount, you may have to pay the difference. (See **Balance Billing**.)

Appeal
A request for your health insurer or **plan** to review a decision or a **grievance** again.

Balance Billing
When a **provider** bills you for the difference between the provider's charge and the **allowed amount**. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A **preferred provider** may ***not*** balance bill you for covered services.

Co-insurance
Your share of the costs of a covered health care service, calculated as a percent (for example,

Co-payment
A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible
The amount you owe for health care services your **health insurance** or **plan** covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

Jane pays 100% | Her plan pays 0%

(See page 4 for a detailed example.)

Durable Medical Equipment (DME)
Equipment and supplies ordered by a health care **provider** for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or

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Preventive Care

- Preventive care and services are routine health care services that include screenings, check ups and patient counseling to prevent illness, disease or other health problems.

- Health plans are required to cover recommended preventive care services at no cost to you. As long as you visit a doctor in your network, you will not have to pay a copay or coinsurance for recommended preventive services. Some examples of recommended preventive care include:
  - Well-woman and well-child visits
  - Recommended vaccines and flu shots
  - Screenings for high blood pressure, high cholesterol, diabetes, etc.
  - Cancer screenings
  - Obesity screening and counseling
  - Alcohol use and tobacco use screenings
  - Recommended services specifically for women, like breastfeeding support
  - Recommended services specifically for children, like vision screening

How to Prepare for Your Doctor's Appointment

Scheduling Your Doctor's Appointment

Once you've determined that your doctor is in-network and covered by your health plan, you can begin scheduling appointments. In order to stay healthy, annual wellness visits are recommended.

- Call your doctor's office and set up a date and time for an annual wellness visit
  - Have your insurance card handy when calling the office.
  - Annual well-woman visits and well-child visits are recommended preventive services, so they are available without cost-sharing.

- Write down the day and time of your appointment on a calendar or planner.

Preparing for Your Doctor's Appointment

- Before your appointment, there is some information you should get together. This includes:
  - A list of all medications you are on, including your recommended dosage.
  - Your family's history of any and all medical conditions.
    - This includes chronic diseases and conditions that a sibling, parent, aunt, uncle or grandparent may have, as well as cancers and other diseases they may currently have or have had in the past.
- Write down any questions you have for the doctor and bring them with you so that you do not forget to ask while you are there.
  - This includes questions about your health, changes to it or anything you are unsure about. It will be helpful to write these down before your visit.
- Bring your insurance card and any other documentation requested by the doctor's office to the visit.
- Find out what to do if you need to cancel or change your appointment.

Having an Effective Doctor's Appointment

- Pay attention to your doctor's recommendations. There are four good questions you may want to ask during your visit or after your doctor gives you a recommendation.
  - How can I improve my health?
  - What do I need to do?
  - Why is it important for me to do this?
  - Do I need to schedule a follow-up appointment?

- You should feel free to take notes and write things down during a doctor's visit.

- You have a right to understand what the doctor recommends. If you don't understand, ask your doctor to repeat it or explain it differently.

Specialists and Referrals

- Most health plans have specialist referrals (meaning that you can be referred to a special doctor for certain needs) but differ in rules and costs on how to get such services.

- There are two ways to go about finding a specialist for your particular situation. You can either go through your Primary Care Provider or through your insurance provider.

- By asking your Primary Care Provider for a referral, you will be more likely to be given a doctor your provider knows and trusts. However, you must also make sure the specialist is in-network.
  - Contact your insurance company to confirm that the specialist is in-network before you schedule an appointment to ensure that you do not pay higher costs for the service.

Finding the Right Prescriptions

- Your doctor might recommend you take a specific medicine or drug. Some medicines are sold over the counter while some can only be purchased if you have a prescription from your doctor.
  - You must have a prescription from your doctor to buy a prescription medicine.

- To find out if your insurance plan will cover your prescriptions, check your health insurance plan's formulary. The formulary is the list of prescriptions your insurance plan covers. You can find the formulary on your insurance company's website or by calling your insurance company. Always remember:
  - The exact name of the medicine.
  - The dose you take.
  - How many pills your doctor prescribes.

- Oftentimes, a generic drug will cost less than a brand name drug.
  - If your doctor writes you a prescription for a brand name drug, you can ask your doctor about generic drug options too.

Finding the Right Prescriptions

- If your prescription is not covered, you can:
  - Talk to your doctor or insurance company about options.
  - Ask about the possibility for a one-time refill.
  - Ask if your health plan will cover a drug if there is a health need.
  - File an appeal with your insurance company.
    - The Illinois Department of Insurance has an Office of Consumer Health Insurance (OCHI) that can talk to you about your rights as a health care consumer and help you file an appeal for free. You can call OCHI toll-free at (877) 527-9431.

How to Get Your Prescriptions

- If you need prescription medicine, your doctor will fill out a prescription and either give it to you or send it directly to your preferred pharmacy.
  - Your doctor may ask what your preferred pharmacy is, including its address. You can bring this information to your appointment. Check that your preferred pharmacy is in-network.

- If the doctor gives you the prescription, take it to a pharmacy that is in your provider network. This will ensure that your out-of-pocket costs are not higher.

- To determine if a pharmacy is in your network, either call the pharmacy or your insurance company.

- Pharmacies can be found in local drugstores and supermarkets in your community, such as:
  - Target
  - Walgreens
  - Wal-Mart
  - CVS Pharmacy

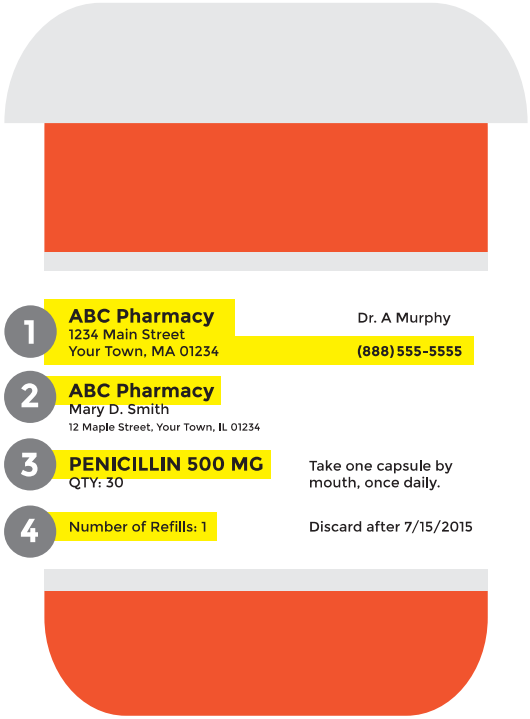
Reading Medicine Labels

1. The name and address of the pharmacy that is filling your prescription.

2. The prescription number, which identifies the medicine as well as the person it is made out to (you).

3. The name of the medicine and the amount, called the dosage. Next to it are the directions for how much to take and when.

4. The number of times you can refill this particular prescription.



Emergency and Urgent Care

Where to Go When You Need Help Fast

- Emergency care is required when your life is in danger. Examples include:
  - Heart attack
  - Bad car accident
  - Uncontrollable bleeding
  - Unconsciousness

- Urgent care is used in situations when you require help but your life is not in immediate danger. Examples include:
  - Minor injuries, like sprains
  - Earaches
  - Coughs
  - Sore throats
  - Backaches

Emergency Care

- In an emergency, call 9-1-1 as soon as possible.
- When emergency workers arrive, they will take you to the closest hospital.
- It does not matter if the hospital is in-network or out-of-network if it is an emergency. They are legally obligated to care for you. Insurance plans cannot require higher copays or coinsurance if you get care from an out-of-network hospital when it is an emergency.
- Once you are no longer in a life-threatening emergency, you may want to change doctors or hospitals to make sure you are in-network. If it is no longer a life-threatening emergency, getting care from in-network doctors and hospitals will help avoid any unexpected costs.

Urgent Care

- If you are sick or hurt and can't wait for a regular appointment, but it is not life threatening, you may want to access urgent care services or an on-call doctor instead of going to the emergency room.

- Urgent care refers to clinics or facilities that take walk-in patients and do not require that you have a Primary Care Provider located there. These can be helpful in medical situations that need quick attention, but are not life threatening, or when you are somewhere that you will not be able to see your own doctor (travelling, on vacation, etc.).

- Emergency room co-pays are typically very high so in situations that are not life threatening, but also cannot wait for a regular doctor appointment, you may save time and money by accessing care from an urgent care office.
  - Check with your insurance company to see which urgent care offices near you are in-network.

Questions?

Visit GetCoveredIllinois.gov or call (866) 311-1119