Look inside for money saving tips, key terms and FAQs.

Making The Most *of your* Insurance 365 Days a Year

Essential Health Benefits

Defined by the Affordable Care Act

These categories of coverage ensure comprehensive care in new plans.

- **Emergency services and hospitalization**
- **Laboratory services**
- **Ambulatory or outpatient services**
- **Pregnancy, maternity and newborn care**
- **Pediatric services, including pediatric dental and vision**
- **Preventive and wellness services**
- **Chronic disease management**
- **Mental health and substance abuse treatment**
- **Prescription drugs, including brand name and generic medications**
- **Rehabilitative, habilitative services and medical devices**

GET YOUR RECOMMENDED —HEALTH SCREENINGS— *and* ANNUAL CHECKUPS

Health Insurance Matters

If you are healthy it is difficult to foresee potential illness or injury, and even more difficult to predict the costs of future health problems. But it's important to remember that health insurance—unlike car or home insurance—does not *just* help you to pay for an unexpected disaster. Health plans provide vital benefits intended to help you maintain good health and enjoy life on an ongoing basis.

Health insurance is ultimately a contract between you and a health insurer to pay some or all of your healthcare costs in exchange for a monthly premium payment. The kind of coverage you have—that is, the amount your insurance company is willing to pay for certain healthcare expenses—will vary depending on the insurance policy you've selected.

With a health insurance policy, you are *not* penalized for using your coverage throughout the year—and are actually encouraged to seek regular checkups and preventive care during the year.

Unlike other types of insurance, your rates are not determined by annual usage and claims cannot affect future benefits.

Keep your coverage current by paying your premiums on time. If you allow your coverage to lapse, your medical costs will not be covered.

Patient Advocate Foundation
patientadvocate.org
(800) 532-5274

The Ins and Outs of Comprehensive Insurance

In order to satisfy the legal requirement for adequate health insurance, individuals must have what's defined as "comprehensive insurance." Comprehensive insurance guarantees you a minimum amount of healthcare coverage for each area and type of medical service that you may encounter, including doctor visits, prescription drugs, hospital stays, chronic medical care and/or surgery.

Treatment for specific complaints are not covered under the preventive care benefit, even if addressed during an otherwise preventive appointment.

Certain key elements appear in all comprehensive healthcare plans:

PRIMARY CARE

Includes basic healthcare services, usually delivered by physicians and trained medical personnel who practice family medicine, pediatrics or internal medicine. A primary care physician is your main healthcare provider and usually your first point of contact. This physician will deliver preventive services and may refer you to specialists.

SPECIALTY CARE

Extends beyond primary care to medical fields such as surgery, cardiology or oncology. Specialists are doctors who have trained more deeply in specific medical or treatment areas to gain a more detailed level of expertise.

URGENT CARE

Same-day clinics that can handle a variety of injuries and conditions that require care but are not serious enough to require an emergency room. They offer a wide range of services for common illnesses that are not considered a true emergency, including severe sore throats, minor sprains and cuts requiring stitches.

EMERGENCY CARE

Is required for any medical condition that poses an immediate danger to a person's life or health. Head injuries, weakness, paralysis or persistent chest pain are true emergencies and are among those conditions that require emergency care.

PREVENTIVE CARE

Includes testing, screenings and immunizations. Well-baby care, children's vision exams, periodic prostate exams, pap smears and mammograms are all examples of commonly covered preventive care services. The ACA requires that most insurance plans provide preventive services without deductibles, co-payments, or co-insurance payments from you, allowing you to participate in these services without an expense.

How is My Plan Structured?

Whether you are enrolled in a group or individual plan, understanding the way your plan works can help you use your benefits.

Health Maintenance Organization (HMO) or **Exclusive Provider Organization (EPO)** plans provide medical services in a specific geographic area, based on contracted rates with the providers paying a fixed and predetermined fee. HMOs require that you select a primary care physician (PCP) who is responsible for managing your healthcare. If you need a diagnostic service or care from a specialist, your PCP must provide you with a referral to a network provider. If you choose to go to a doctor outside of your HMO's network for scheduled care, you may have to pay all of the cost (with the exception of emergency care which requires that you notify the insurance company after the fact).

Preferred Provider Organizations (PPO) and Point of Service (POS) plans provide coverage to members similarly through a pre-defined network of healthcare providers but are generally more flexible than HMOs. For example, you are not required to have a referral to see an in-network specialist. However, if you choose to go out-of-network for services, you are responsible for paying the difference between what the plan has determined to be their negotiated rate and what the provider charges.

High Deductible Health Plans (HDHP) have lower premiums and a higher yearly deductible than a traditional health plan. These plans appeal to healthy people who cannot or don't want to pay large monthly premiums for benefits. Preventive care is covered at no cost, but other services must be paid by the insured until the deductible is met before the insurance company contributes.

One advantage of a HDHP is the ability to contribute a certain amount of pre-tax dollars to a **Health Savings Account (HSA)** in your name. Money deposited into your HSA that is unused for medical expenses remains in the account, earns tax-free interest and can roll over year to year. Most people use the savings from lower monthly premiums and deposit them regularly into their HSA so they accumulate money to pay for the costs of medical care until the deductible is met and insurance coverage begins.

Government-sponsored plans like Medicare, Medicaid or military benefits frequently operate under alternate or a combination of structures. Many Medicare Advantage plans are structured as HMOs or PPOs. Medicaid can also have a lot of variety in its plan types, but numerous states are implementing an HMO structure.

Words That Impact Your Bill

Deductible

The amount you pay for medical expenses before the insurance plan begins to cover any additional expenses. For example, if you have a $1,000 deductible, this means you will have to pay $1,000 in out-of-pocket costs before your insurance company pays its portion for a covered service. Premiums do not count toward meeting your deductible.

Premium

The amount you must pay for your health insurance plan to remain active. If you have insurance through the workplace, your employer may pay a portion of your premium on your behalf as part of your employee benefits package.

Out-of-Pocket Maximum

This is the highest amount of money you will have to pay during your plan period. It includes the money you spent within the deductible amount, co-insurance, co-pays. Once you reach this limit, the insurance company will pay 100% of the allowable amount of costs for all covered benefits. Out-of-pocket maximum is higher than your deductible and does not include medication costs or services that are listed as excluded within your plan language. Today, most plans have separate medication and medical out-of-pocket maximums.

Formulary

A list of pharmaceutical drugs covered by a plan's prescription drug benefits. The formulary is usually divided into tiers or levels of coverage based on the type or usage of the medication. Each tier will have a defined out-of-pocket cost or percentage that the patient must pay before receiving the drug. Not all medications will be covered under the formulary for a specific plan.

Allowed Amount

The negotiated rate your insurance company and provider have agreed upon for a particular service when completed within your insurance network. Your co-payments and co-insurance will be based on this amount.

Preauthorization

Your insurance plan may require prior approval for certain services, drugs or equipment to consider any charges. Preauthorization is not a guarantee that the insurance plan will cover the cost of the service.

Know Your Plan, Save Your Wallet

Reading and understanding your insurance plan's key words and phrases will help you uncover ways to control costs.

- **Covered Benefits** A comprehensive medical policy contains several areas of coverage; however, no plan will cover every available health service or product. Before you seek care, become familiar with the covered services identified in the plan language. You may be surprised to find some services you need are not covered or are only covered with approved pre-authorization.

- **Non-Covered Benefits & Exclusions** It's important to read and become familiar with the section of your health policy that lists the limitations and exclusions. These are the services your insurance will not contribute towards. Typical limitations or exclusions include eye exams and contacts, dental care, fertility treatment, cosmetic surgery and alternative or complementary care (such as massage therapy). Some plans will limit coverage for treatments the insurer considers unproven. This can include supplies, procedures, therapies or devices considered experimental or investigational.

- **Pharmacy Benefits** In order to fill a prescription drug, most insurers require a co-pay (a fixed cost) or co-insurance (a percentage of the cost) paid beforehand. These costs can vary greatly depending on which tier level the medication is classified on within the plan drug formulary. The higher the tier level (tier levels usually range from 1 to 5), the higher the out-of-pocket cost associated with that medication. You may also have to meet a pharmaceutical deductible amount before your insurance begins paying its share toward your medications. Generics are usually on lower tiers and can save you money, if available.

If you need a medication that is not included on the formulary, you can request that your doctor contact the health plan to explain the medical need for you to take a specific medication. If your request is denied, you have the right to appeal your health plan's decision.

NO INSURANCE PLAN *will pay* for EVERYTHING

Keep in mind that it's OK to ask about costs when you're considering treatment options. Some treatments may be more costly and just as effective as others.

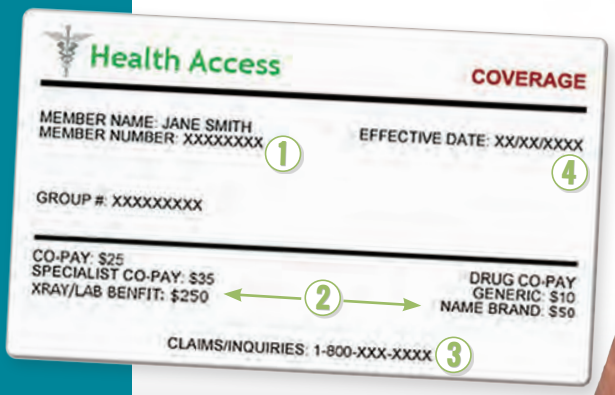
What are Specialty Pharmacies?

If you have a chronic, rare or long-term illness that requires medication, you may be required to have certain prescriptions filled by a specific pharmacy network or a mail-order prescription program. Medications that require special storage or handling, are given by injection or infusion, need to be taken on a strict schedule, or require close monitoring for side effects are typically filled by specialty pharmacies. **Specialty medicines cost more than more common medicines and often require prior authorization from the insurance company.** All prescriptions require you to pay the total amount owed prior to receiving the medication. If you are required to use a specialty pharmacy, a billing coordinator will work with you and your providers to streamline the process.

Reading Your Insurance Card

Take your insurance identification card with you whenever you seek care. This ID card will come in the mail or will be available electronically after you enroll in a health benefit plan.

1. The health policy member number (this number is unique to your policy) will be referenced on all correspondence.
2. Brief out-of-pocket cost breakdown, which may include the required co-payments for office visits, specialty, urgent or emergency care and prescriptions. This information does not take into consideration your deductible.
3. Telephone numbers and addresses to use when you have questions, need help filing claims or seek prior authorization.
4. Effective date of coverage.



Frequently Asked Questions

Q What is a grandfathered plan and how do I know if I have one?

A The Affordable Care Act passed in 2010 included the requirement that all *new* insurance plans created after January 1, 2014, had to follow certain rules. However, health insurance plans which existed before the ACA passed do not have to implement some of these new regulations. These plans are known as grandfathered plans. For example, one benefit the plans were not required to offer involved providing preventive care outlined in the 10 essential health benefits with no cost-sharing.

If you are uncertain if your insurance plan is considered a grandfathered plan, ask your employer's human resources department. If your insurance plan makes significant changes to the policy as it is currently written, the plan may lose its grandfather status.

Q What if I have more than one health benefit plan?

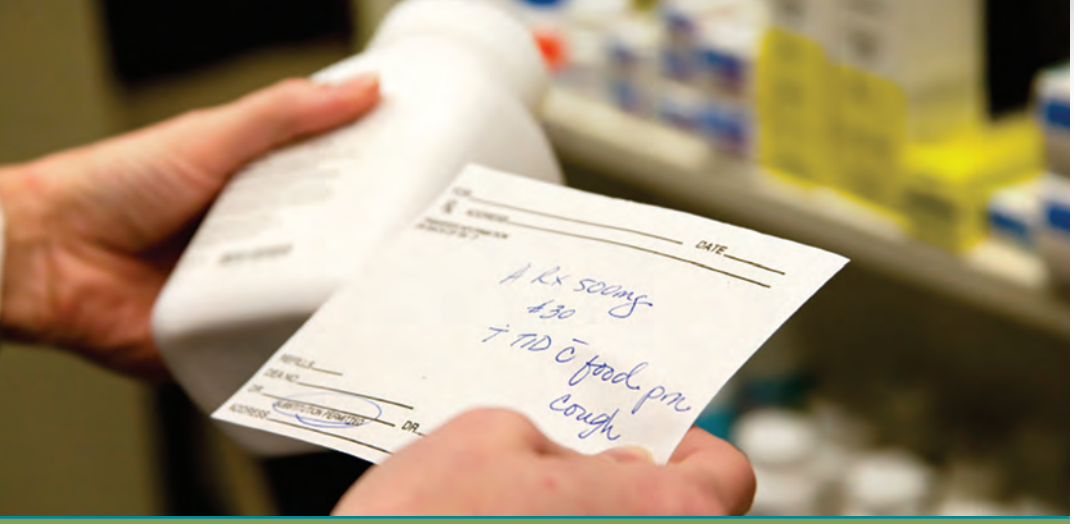
A You may have coverage from more than one health insurance plan. For example, spouses may have coverage for themselves and each other under their workplace plans. Older employees who are still working may have both Medicare and employer-sponsored coverage. Retired employees may have both retiree insurance through their final employer and Medicare coverage.

If you have more than one active policy, every claim filed will undergo a review process to determine which health insurance company should be the primary or secondary payer. Once the primary plan pays its portion of the allowable charges on covered services the remaining balance is submitted to the secondary payer for consideration under their benefit plan.

Q Should I get a second opinion?

A It is your right to seek a second opinion when you feel it is necessary. It can be especially useful when facing a serious or life-threatening disease, when the diagnosis is not clear or you are unsure which treatment option you want to pursue. Most insurers will pay for a second visit to an in-network provider; however, it is not guaranteed. Speak to a customer service representative from your insurer to be sure. If you feel the best options for a second opinion exist outside of the network, then you need to be persistent in advocating for yourself.

Know what services are approved *before* accessing your second opinion and contact your insurance plan if you have any questions. Diagnostic tests can be very costly and many insurance providers will not pay for them a second time if they were recently completed. However, you have the right to have copies of any tests you have already completed, allowing you to provide them to the second doctor or medical provider for their review before or during your appointment.



Understanding Your Explanation of Benefits (EOB)

Every time you receive care from a provider or file a claim for services received, your insurer will send you an "Explanation of Benefits." This form *is not a bill.* It explains what medical treatments and/or services were provided and the amount the insurance company will pay towards any covered charge. It is important to take note of the following information on your EOB:

Explanation of Benefits (EOB)

Customer service: 1-800-123-4567

Statement Date: XXXXXX
Document Number: XXXXXXXXXXXXXXXXX
THIS IS NOT A BILL

Member Name:
Address:
City, State, Zip:

Subscriber number: XXXXXXXXX **ID:** XXXXXXXXX **Group:** ABCDE **Group number:** XXXXXX

(1) **Patient Name:**
Date Received:

(1) **Provider:**
Payee:

Claim Number: XXXXXXXXXX
Date Paid: XXXXXXXX

Claim Detail				What Your Provider can Charge You		Your Responsibility			Total Claim Cost		
(2) Line No.	(2) Date of Service	(3) Service Description	Claim Status	(4) Provider Charges	(4) Allowed Charges	Co-Pay	Deduct-ible	(5) Co-In-surance	(5) Paid by Insurer	(5) What You Owe	(6) Remark Code
1	3/20/14–3/20/14	Medical Care	Paid	$31.60	$2.15	$0.00	$0.00	$0.00	$2.15	$0.00	PDC
2	3/20/14–3/20/14	Medical Care	Paid	$375.00	$118.12	$35.00	$0.00	$0.00	$83.12	$35.00	PDC
			Total	$406.60	$120.27	$35.00	$0.00	$0.00	$85.27	$35.00	

Remark Code: PDC — Billed amount is higher than the maximum payment insurance allows. The payment is based on the allowed amount.

1. **Verify that the names of the patient and provider seen are accurate**
2. **Verify date for the service performed**
3. **Review the procedure code and brief description of the service performed**
4. **Review the billed amount as well as the allowed amount for the service**
5. **Review the amount the insurance paid as well as the amount the patient is responsible for paying within plan structure**
6. **Review the remark code explaining more about costs, charges and paid amounts for your visit**

The information presented within the EOB should make it easy to match bills from providers and ensure accuracy.

Save Money Through Prior Authorizations

Your health plan may require you or your medical provider to get a prior authorization or precertification *before* you receive some services. Services that often require prior authorization include routine or planned hospital admissions, home health or infusion therapy and certain outpatient services. **If you don't get prior authorization, the service or medication may cost you more or may not be covered at all.** If you are in doubt about whether a service or treatment is covered, call the customer service number listed on your health insurance card.

If you are in doubt, contact your insurance company in advance to ask questions about your coverage. You are responsible for knowing what your policy requires.

Always submit preauthorizations and pre-approval paperwork!

Starting the Conversation on Billing Issues

The first step to dealing with problems is to keep your medical and financial paperwork organized. That way, if you experience problems, you'll be able to provide a complete description of the problem you're facing. Always **keep written notes with the date, name, title, and phone number of the person** that you spoke with. *Remember your goal is to get them to help you.* Stay calm; be polite and patient, but also persistent. If you don't understand, ask for clarification and continue until you fully understand.

Keep all of your health information and documents in one place.

Six of the Best Health Insurance Money Saving Tips

1. **Choose In-Network Providers** – Know where to go for care. Use the emergency department for a life-threatening situation but use your in-network providers for all other health-related issues.

2. **Call Your Insurance Company with Questions** – Read Your EOB, ask questions and take notes. Pay attention to codes you don't understand and ask for definitions. Be sure to compare your EOB to your bill and double-check the dates of service to make sure the amounts match, and previous payments are documented.

3. **Take Advantage of Preventive Services** – Most plans must cover certain preventive services without requiring payment from you. This is true even if you have not yet met your deductible, as long as you see a network provider for services.

4. **Practice Ways to Improve Health and Lower Costs** – Good advice tells us all to eat better, exercise more, limit alcohol intake and quit smoking. In addition to these health basics, get immunizations and screenings when recommended, and don't put off seeing a doctor when you need one.

5. **Be Proactive if You are Unable to Afford Your Care** – Stressing about how to pay for healthcare costs can make a chronic condition worse, or cause you to delay seeking care. If you are feeling overwhelmed, inquire about payment plans or charity care programs. Community resources can range from help with practical expenses and medical supplies to co-payment and premium assistance, counseling services and legal help. If you ask for help, many providers will discuss a payment plan or offer solutions that may help you pay for your care.

6. **Choose Generic Medication When Possible** – The U.S. Food and Drug Administration requires that generic drugs be as safe and effective as brand-name drugs. They have the same dosage, intended use, effects, risks, safety and strength as the original drug. The main difference is generic drug manufacturers have fewer costs associated with developing and marketing. The cost savings are passed on to you when you use the generic instead of the name brand.

A New Trend in Treatment: Personalized Medicine

Genetic testing and personalized medicine are rapidly evolving as the future of medical treatment. Genetic testing not only helps identify an individual's risk for developing a certain disease or condition, but it also provides information on how best to treat a condition. In addition to cancer, personalized medicine is driving the development of new treatments for complex diseases such as diabetes, heart disease, hepatitis C and Alzheimer's disease, which are thought to be caused by a combination of genetic and other factors.

While we are still learning about the benefits, personalized medicine allows doctors to prescribe targeted treatment or drugs based on your specific genetic makeup. For example, many unique tumor biomarkers are being studied through clinical trials determining whether a patient's tumor has the characteristics to respond to a specific treatment. This has been shown to provide better health outcomes, save the patient from many unnecessary and unpleasant side effects and avoid additional costs.

Talk to your insurance company about which generic tests and treatment options are covered in your plan.

Featured Resource - My Resource Search

Sometimes even with insurance, you need additional healthcare or financial support. Available in Apple and Android app stores, ***My Resource Search*** can help you identify nonprofit and community organizations that work to help patients overcome challenges surrounding healthcare access and affordability. Download the free app and begin searching for resources today.