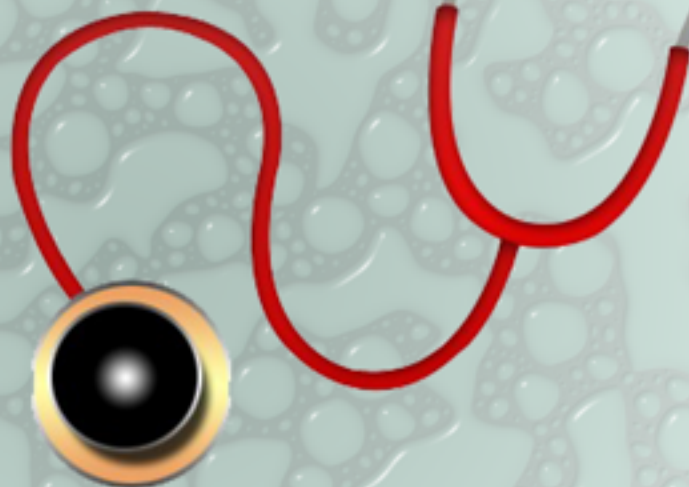


Healthcare Insurance Primer



**A Proactive
Guide Into
Understanding
Your Health
Insurance**



Healthcare. It's a hot topic! Because it is such a huge topic and many don't understand it, I wanted to give a primer of terms. I will be keeping the topic general, not speaking of any one insurance company. But hopefully going over some of the terms used in the health care industry will help you better understand what you need to know when choosing and using your health care.

Disclaimer: I am not a licensed insurance sales person, nor do I profess to be all knowing of health insurance issues. This is only a primer of topics. Please consult your insurance provider or sales person for more details.

Premiums

This term is rather close to people's pocket. This is the cost you pay to have insurance. The old saying, you get what you pay for is so very true in this situation. So you'll want to choose carefully. There are many, many plans to choose from. Find out what they cover, but more importantly, find out what they exclude. And unless you choose a plan, with most likely a very high premium, not everything is covered 100%.

Initial Costs, Applied To Deductible

Deductible – This is the amount some plans ask you to pay first before the plan makes any payments. This could be a low dollar amount or it could be high. The deductible is an annual event. Either starting over at the beginning of the calendar year or the beginning of the policy year. While a high deductible sounds scary, there are some options that can help. Keep reading for more.

Lint In My Pockets

So, you go to your doctor's office and you pay something to the doctor out of your pocket. This is how the term **Out-Of-Pocket** came to be. Under some plans the deductible can be applied toward your out-of-pocket and some plans it does not get counted toward it. This would be something you'd want to look into. The sooner the out-of-pocket is met for the year the sooner the plan would pay at 100% for the remainder of the year. (Read the out-of-pocket section of the plan to see if deductibles and copays go toward it. Also check to see if copays still apply after you have met the out-of-pocket maximum.)

Plans will also have a **lifetime max** as well. This is the most the plan pays for the lifetime of that policy. (This is changing with new legislation. Consult your insurance to see how lifetime max will be changing for your policy.)

May I Have Your Copay Please?

Simply, the **Copay** is the amount you pay upfront when visiting the doctor. Copays can also apply for Urgent Care services, ER visits, and other services under your plan. Read your insurance plan to see if Copays can also be applied to your deductible to help pay it down faster. Most typically do not, but you may find one that does.

Not all plans have copays, so if you don't see any listed don't be worried quite yet. Next topic: co-insurance.

As you're learning these terms either for the first time or refreshing yourself to prepare yourself to be an active insurance policy holder, remember this:

"Knowledge is of no value unless you put it into practice." - Anton Chekhov

Adding Up The Coins

Now that we have gotten through copays and deductibles, we must now consider **co-insurance**. After you satisfy your deductible then you have a portion, shared expenses with the insurance company. Co-insurance is where the plan pays a percentage of the cost and shares the other percentage with you. A few plans will pay 100%, but most look at 90% or 80% with you paying 10% or 20%.

These will be the percentages of the plan until you reach your out-of-pocket maximum, after which the plan pays at 100% for the remainder of that plan year. A few caveats to consider is some plans will still make you pay copays even after the out-of-pocket maximum is met. Co-insurance sounds like you the member are paying even more after paying premiums and deductibles, but the thing to consider is the rising cost of healthcare is making it harder to have all inclusive plans that don't break the bank.

The Ins and Outs of Providers

Some plans get very specific about **In-Network Providers**. So much so, you can only get benefits if you only go to in-network providers. There are other plans that allow for **Out-Of-Network** providers. Depending on the plans, the benefits can be a little less than in-network. But this is to encourage you to staying in-network. Why is this important?

When you go out-of-network there are no contracted rates to keep a provider charging anything. You won't pay anymore than what the in-network rates are for a given eligible service. Where-as when you go out-of-network plans will go off the average cost of services and if the out-of-network provider charges more than the average, the difference usually falls back to you.

Second point I want to bring up is the fact, providers can choose which networks to be part of AND can change at almost any time. So, if you go to a doctor today and then don't see them again for a year, double check to see if they are still in-network. No reason to get a surprise later.

With all the layers of insurance it is important to have an active role in every step.

Coordinating Choices

Coordination of Benefits is probably the biggest thing of the health insurance business that gets confused. What coordination of benefits does is put into order insurance policies when you have two or more insurance policies. Some think, and I've heard this: "Well, my plan is better than my wife, so we will use mine as primary."

Unfortunately, it's not that easy. There are guidelines, most by the government itself, which determine the order of policies. Make sure you are checking this out before getting more insurance. Some plans have their own deductibles or conditions for coordinating, so don't assume, a second insurance will automatically pick up everything the first policy didn't.

Please, please, double and triple check your policies. Don't get caught paying for something that doesn't fit your needs.

Everything Is Covered?

Under some preconceived notion, many assume that once they have health insurance coverage, anything is covered. Or, they assume, their doctor says it's needed, so then the insurance company must cover it. In all reality, policies have **Exclusions** and **Riders** that you should know about and read before getting the coverage.

No two policies are alike. Many plans today are put together for many reasons, for individuals, for employers, etc. For one reason or another certain things get excluded. Yet on another policy, those same things could be included. So if you have certain things you are looking for, read the exclusions to make sure they are not listed there.

Another term that has people confused is **Pre-Existing**. Only certain policies may have this as a condition. Even so, if you do not have break in insurance coverage of more than 62 days, pre-existing does not apply. Let me put it to you a different way. If you are buying into a policy and you haven't had insurance before, if the policy has this pre-existing rider, then the policy will be sending questionnaires for services prior to coverage. But if you did have coverage before the one you are switching to, then a simple **certificate of coverage** from the previous insurance will cover you.

When a policy ends you typically get a letter from the company telling you the start and end dates of that policy. This is a certificate of coverage. Keep this, like you should all your insurance documents. You may need to send a copy of it to your new insurance carrier if the new policy has a pre-existing rider.

Of all the insurance terms, these are the most important ones to keep in mind. Cause if you are looking for coverage because you become sick with certain conditions, check the pre-existing and exclusions to make sure this will not be a problem. Education of insurance is imperative to making sure you are buying something that will actually benefit you and your unique needs.

(With the new legislation, pre-existing will be going away, but not right away. For children, it will with new policies after September 23,2010. For adults pre-existing can still apply until January 1 2014.)

Once A Year Doctor's Visit

When you look at **Preventative** services, be aware there are guidelines that define what these are. Loosely defined, these are the services done during a once a year annual physical you have with the doctor. Make sure you are aware of these services, because many plans will cover this differently than a regular visit to your doctor, also known as a **diagnostic** visit.

The other reason to make sure you know how this benefit works is because even though a doctor may say, for instance, please come to my office every six months for a check up. If the plan says only one visit a year is covered under preventative, the second visit will not be paid the same by the insurance or could not be covered at all.

If you see a recurring theme, it's on purpose. No matter the situation, if you want to get coverage from the insurance company, make sure you are checking your policy, not just going by what you hear from co-workers, friends, blogs, or even your doctor. As well meaning as they all are, no one knows your policy other than you and the insurance company.

HRA And FSA And HSA, Oh My!

Some of the ways you can pay for medical expenses is with pre-tax dollars. A Health Reimbursement Account (**HRA**) is one type which is usually set aside by your employer. Money in this type of account can roll over from year to year until there are no funds left.

A Flexible Savings Account (**FSA**) Is usually a set dollar amount for the plan year. If you don't use it all within that year, you lose what's left. So with this type of account you need to plan your expenses wisely so you don't lose out.

With a Health Savings Account (**HSA**), almost anyone can set one of these up through their own bank. This is money you set aside and it can roll over from year to year, plus you can continue to add to it throughout the year.

So what types of expenses can apply? Usually copays, deductibles, prescriptions, dental, vision, and other medically related items. For the FSA and HSA the guidelines are set by the IRS. You can find what is allowable to be claimed on their website.

HRA's are slightly different and you should check your plan to verify exactly what expenses can be claimed under it.

With the 2011 FSA guidelines from the IRS, double check what is and isn't included. One of the items no longer covered by FSA is over the counter medications unless prescribed by a doctor. (www.irs.gov for more information)

As with all the information, check your plan documents. Does this seem like a lot of work? Yes, but you are paying premiums, much like you pay rent or a mortgage. Make sure you know what you are getting.

Prescriptions

If you are used to the days of brand and generic, with generics falling as your lowest copay. Now's the time to check your prescription drug list. Depending on the plan, costs may not just be based on brand and generic. Also, don't assume every drug out there is covered by your plan. Some may not be.

Now's the time to look at and maybe even print off a copy of your prescription drug list. When you go to the doctor's office, take the list with you. Then the two of you can look to see not only the medicine that will work for you, but possible find the lowest alternatives listed.

Keep checking your list from time to time. Sometimes prescriptions can move levels.

Read, Keep Records, Stay Informed

I hope this information has given you a nice overview of what is all involved. I have not dived into any one topic too deeply, because there is so many differences from policy to policy, these articles would be longer than your insurance documents. So instead, read your documents, whether a printed version or some companies have your benefits listed online. Use these resources so you are not caught off-guard.

Secondly, keep details and records. This is for explanations of benefits, check stubs, receipts, everything. Sometimes a year or two may go by and then someone sends you to collections for not paying a medical bill. You know you did as well as the insurance, but where is the statement? The other reason to keep them, especially if you have FSAs or HSAs, is the IRS can do an audit and documents are your safe ground.

Lastly, keep in mind who you are talking to when calling your insurance company. A customer service representative, who's job it is to help. These are your first line of defense. You have questions, they have answers. The insurance game is a group experience, your doctors, insurance company and you. Can mistakes happen? Yes. But consider this, any insurance company processes hundreds if not thousands of claims a month, some done by automation. Of these numbers, on average, less than 10% have errors. I know that is no comfort when it is your claim, but keep it in mind when you are wanting help to straighten it out. Also by knowing your policy, including exclusions, less errors are made. Treat others how you want them to treat you. Together, the complexity of insurance can move forward to better insurance.

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