

Understanding Your Health Insurance Plan

By Jacques Chambers

Health insurance is all too frequently taken for granted. Most people get it through their employment; they sign up for it, pocket the ID card, and regularly misplace the book of benefits, assuming the employer gave them one in the first place.

People who purchase health insurance individually are at the mercy of their agent, because health insurance plans are not uniform in design and can be very confusing to try to read and understand.

When it comes to what the insurance company pays, that seems as mysterious as how the internet works. The plan receives a medical bill and may deny it entirely or pay only a portion. Was it processed correctly?

Even people with an HMO plan, which is supposed to be simple to understand, have problems with unpaid medical bills. Not understanding a health plan may not be a major problem for people who are generally healthy, but if you are dealing with a potentially catastrophic illness such as HCV and incurring frequent and expensive medical charges, you should have at least a basic understanding of your health insurance and know how to make sure they are paying all they should be paying of your medical bills.

Types of Health Plans

Health insurance plans can vary in their design. While many plans have combinations and hybrids that can blur the distinction, the most commonly encountered types of plans in use today are:

- **Preferred Provider Organizations (PPO)** – These plans will generally provide some coverage for any licensed physician or provider that you use, however, the benefits are designed to pay more if you use a *Network Provider*, a doctor or hospital that the plan has contracted with. In addition to providing broader coverage for these Network Providers, you also cannot be overcharged because the contract between the plan and the provider limits what the doctor can charge both you and the plan.
- **Health Maintenance Organizations (HMO)** – HMOs typically require you to go to one of their *Network Providers* in order to receive coverage. If you go outside their network the plan will not pay anything, unless it is a life-threatening emergency. HMOs further limit your choice by insisting that all your care come through a Primary Care Physician, who decides when and if you should see one of their contracting specialists.
- **Point-of-Service Plans (POS)** – This is really just a combination of the other two, an HMO and PPO. Benefits are determined by which provider you use. If you see a provider that is in their “HMO” network, benefits are paid the broadest, with less going to one of their “PPO” providers and even less benefits for going out of their network entirely.

Obtaining Your Plan Documents

You don't have to become a benefits expert to get a good idea of how your insurance plan works. Your plan covers some things, doesn't cover others, and often has special requirements to get certain medical charges covered. While you don't need to memorize every one of them, you should have access to the information should it be necessary. To do this, you need a complete copy of your coverage.

If you purchased your health insurance individually, that information is in your insurance policy or certificate of coverage. If you can't locate yours, call the insurance company or the agent that sold it and get a fresh copy.

If you get your health insurance from your employer, they are required by federal law to provide you with a complete copy of all the provisions of the plan in a document called a Summary Plan Description. This is not a page or two highlighting the benefits. It is usually a booklet of 20 to 40 pages. Very large employers will often put all benefits literature into one binder with the health insurance being the largest section. If you didn't get one or have misplaced the original, your employer should be willing to give you another; in fact, they're required to by law.

However, many people are concerned about "raising a red flag" to their employer by asking for such a document. The best way to avoid having them suspect you need it due to a medical problem is to have an explanation ready and request more than just the health insurance.

The easiest way to get the Summary Plan Description is to go to whoever handles the personnel issues for your company, not your immediate supervisor. It may be the Benefits Office, the Human Resources Office, or, if a small employer, it may be the owner's wife who runs the office.

Tell them you are doing some estate planning. ("I saw a TV special on estate planning" or "I read an article about estate planning" or "I have an insurance agent who is trying to sell me something I don't think I need") Tell them that Step One in any estate planning review is to know what you already have. To help with that, you would like to get copies of Summary Plan Descriptions for all of the employee benefit plans, life insurance, disability, health, dental, vision, retirement, etc.

You should always have copies of all your plans anyway, in case you need to use them.

Reading Your Health Plan

Do not be intimidated by the size and complexity of your health plan document. You do not have to read and understand everything in it. Initially you just need to become familiar with its layout and have an idea of where to find things in it.

Look first for a *Summary of Benefits* or *Benefits Schedule*. It is often toward the front of the plan, but not always. It will give you an outline of the main provisions of the plan. Details of these provisions can be found further in the document.

The Summary should tell you the basic provisions of the policy which may include some or all of the following:

- **Maximum Benefit** – This is the most the policy will pay out for any one person. It is not a major issue today since most policies have maximums of at least one million dollars and are often Unlimited.
- **Deductible** – This is the amount you must pay out of your pocket before the plan begins to pay. It may apply to all medical charges, or a particular set of charges such as a Hospital Deductible or a Prescription Drug Deductible. General Deductibles are usually assessed only once each calendar year, but specific deductibles are often per event, per hospitalization or per prescription.
- **Co-Insurance** – This is the percentage that the insurance plan will pay of the medical bills, frequently 75 – 80% of the *usual and customary medical charges*, although often less for out-of-network providers.
- **Co-Pays** – This is a fee that you are expected to pay for a specific service. Many plans will cover, for example, all physician charges except for a **co-pay** of \$5 to \$40 that you pay the doctor at the time of the appointment. Plans may also charge a **co-pay** to receive medications such as \$5 for generic drugs and \$15 for brand name drugs.
- **Stop-Loss or Out-of-Pocket Maximum** – Most plans limit the amount that you will have to pay out of your own pocket for covered charges after which the plan will cover 100% of the charges for the remainder of the calendar. This effectively caps the amount you would have to pay in any one year for **deductibles, co-insurance, and co-pays**.

Also, in the Summary Outline, you may find other terms used:

- **Usual & Customary** – This is the phrase insurance companies use to avoid paying for charges they consider to be higher than they should be. This allows them to limit their payment; unfortunately, it can leave you having to pay the entire remainder of the bill. This is becoming less of an issue as insurance companies increasingly encourage the use of *Network Providers* with whom they contract so that the charges are limited.
- **Network Providers** – Almost all health plans now use some type of network, groups of medical providers with which they contracted to set limits on charges and agree on medical protocols.

There are several other sections of the plan document that you may find helpful:

- **Covered Services** – This is a listing of the major services covered under the plan, hospital charges both in- and -out-patient, physician services, diagnostic studies and lab tests. It may also give specific limits and requirements for some types of coverage, such as special requirements to have coverage in a skilled nursing facility, or require pre-authorization by the insurance company to cover hospitalizations, MRIs or other expensive procedures.
- **Exclusions** – This is a list of the items that are specifically excluded from coverage. Health plans typically refuse to provide coverage for services performed by a family member, medical charges as the result of participating in a

felony, or services that are experimental or are not generally accepted medical practice.

- **Limitations** – This lists the items that may be covered but have special limits or requirements. Typically charges for mental conditions are more limited than those for physical disorders. Also, newly covered persons may not be covered immediately for a condition they had prior to becoming insured, a “pre-existing condition.”
- **Definitions** – Some documents define terms as they use them. Others will **bold** terms that are defined elsewhere in the document, usually in a separate Definitions section. It is important that you understand how the plan defines its terms as that is the definition that will apply. For example, the plan will define what it considers to be a “pre-existing condition” as well as limit coverage for them.

Health insurance can be complicated; however, anyone dealing with a serious medical condition should take the time to get an idea of exactly how their plan works. No one is as interested in the accuracy of how your claims are handled as you are, so you should know enough about your plan to be able to assure that your medical bills are being processed completely and accurately.