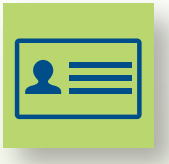
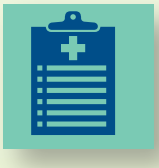
MISSISSIPPI INSURANCE DEPARTMENT

Understanding Your Health Care Benefits

Part 1: Your Guide to Health Insurance





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Put your health first

- Staying healthy is important for you and your family.
- Maintain a healthy lifestyle at home, at work, and in the community.
- Get your recommended health screenings and manage chronic conditions.
- Keep all of your health information in one place.

2

Understand your health coverage

- Check with your insurance plan to see what services are covered.
- Be familiar with your costs (premiums, co-payments, deductibles, co-insurance).
- Know the difference between in-network and out-of-network.

3

Know where to go for care

- Use the emergency department for a life-threatening situation.
- Primary care is preferred when it's not an emergency.
- Know the difference between primary care and emergency care.

4

Find a provider

- Ask people you trust or do research on the Internet.
- Check your insurance plan's list of providers.
- If you're assigned a provider, contact your plan if you want to change.
- If you're enrolled in Medicaid or CHIP, contact Medicaid directly for help:
  - 1-800-421-2408
  - 601-359-6050

Visit mid.ms.gov/healthcare for more information

5 Make an appointment

- Mention if you're a new patient or have been there before.
- Give the name of your insurance plan and ask if they take your insurance.
- Tell them the name of the provider you want to see and why you want an appointment.
- Ask for days or times that work for you.

6 Be prepared for your visit

- Have your insurance card with you.
- Know your family health history and make a list of any medicines you take.
- Bring a list of questions and things to discuss, and take notes during your visit.
- Bring someone with you to help if you need it.

If you want to change your provider, return to Step 4.

7 Decide if the provider is right for you

- Did you feel comfortable with the provider you saw?
- Were you able to communicate with and understand your provider?
- Did you feel like you and your provider could make good decisions together?
- Remember: it is okay to change to a different provider!

8 Next steps after your appointment

- Follow your provider's instructions.
- Fill any prescriptions you were given, and take them as directed.
- Schedule a follow-up visit if you need one.
- Review your explanation of benefits and pay your medical bills.
- Contact your provider, health plan, or Medicaid with any questions.

1 Put your health first.

Staying healthy increases the chances you'll be there for your family and friends for many years to come. Use your health coverage when you are sick and when you are well, to help you live a long, healthy life. While coverage is important, there's no substitute for living a healthy lifestyle.

Here's what you can do to put your health and well-being first:

- Make time for physical activity, healthy eating, relaxation, and sleep.
- Get the preventive services that are right for you.
- Take an active role in your health.
- Learn more about what you can do to stay healthy and share what you learn with your family and friends.

WHAT IS A PROVIDER?

We use the term "provider" throughout this guide to mean a health care professional. This may be a doctor, a nurse practitioner, behavioral health professional, or another health care professional you see.

Your **Primary Care Provider** will be the provider you see the most, and they will get to know you and help you keep track of your health over time.

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2 Understand your health coverage.

Health insurance coverage pays for provider services, medications, hospital care, and special equipment when you're sick. It is also important when you're *not* sick. Most coverage includes immunizations or vaccines for children and adults, annual visits for women and seniors, obesity screening, counseling for people of all ages, and more for free.

Keep your coverage by paying your monthly premiums (if you have them).

Insurance plans can differ by the providers you see and how much you have to pay. Contact your health insurance plan or insurance company to make sure you understand what services and providers your plan will pay for and how much each visit or medicine will cost. Ask them for a Summary of Benefits and Coverage document that summarizes the key features of the plan or coverage, such as the covered benefits, cost-sharing provisions, and coverage limitations and exceptions.

Here are explanations of some key health insurance words that you may hear. Other key words are explained through this book.

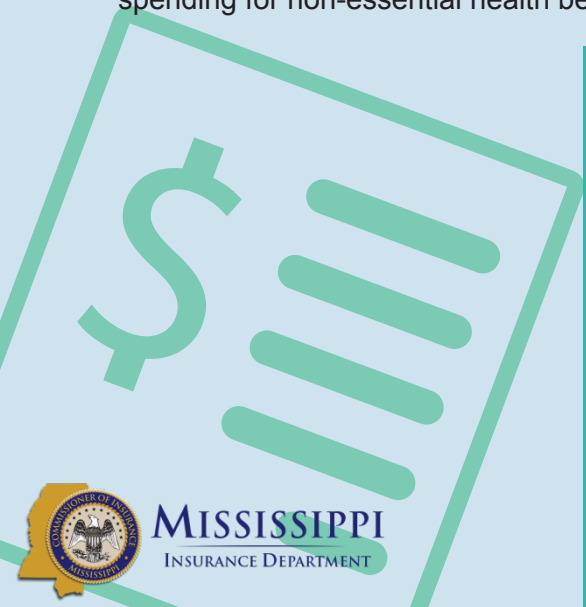
- **A Network** is the collection of facilities, providers, and suppliers your health insurer has contracted with to provide health care services.
  - Contact your insurance company to find out which providers are "in-network." These providers may also be called "preferred providers" or "participating providers."
  - It may cost you more to see a provider who is "out-of-network".
  - Networks can change. Check with your provider each time you make an appointment, so you know how much you will have to pay.
- **A Deductible** is the amount you owe for health care services covered before your health insurance or plan begins to pay.

  For example, if your deductible is $1,000, your plan won't pay anything until you've met your $1,000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.
- **Co-insurance** is your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe.

  For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

- **A Co-payment** or co-pay is an amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or prescription drug. A co-payment is usually a set amount, rather than a percentage.

  For example, you might pay $10 or $20 for a doctor's visit, lab work, or prescription. Co-payments are usually between $0 and $50 depending on your insurance plan and the type of visit or service.
- **A Premium** is the amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly, or yearly. It is not included in your deductible, your co-payment, or your co-insurance. If you don't pay your premium, you could lose your coverage.
- **Out-of-pocket maximum** is the most you pay during a policy period (usually one year) before your health insurance or plan starts to pay 100% for covered essential health benefits. This limit includes deductibles, co-insurance, co-payments, and any other expenditure required of an individual for a qualified medical expense. This limit does not have to include premiums or spending for non-essential health benefits.



REMEMBER: Essential Health Benefits are Outpatient Services (care given outside of a hospital); Hospitalization; Emergency Care; Maternity and Newborn Care; Mental Health; Prescription Drugs; Rehabilitative and Habilitative Care (services to help a person keep, learn, or improve skills for daily living); Laboratory Services; Pediatric Care (children's vision and dental); & Preventive and Wellness Care.

- **Explanation of Benefits (or EOB)** is a summary of health care charges that your health plan sends you after you see a provider or get a service.

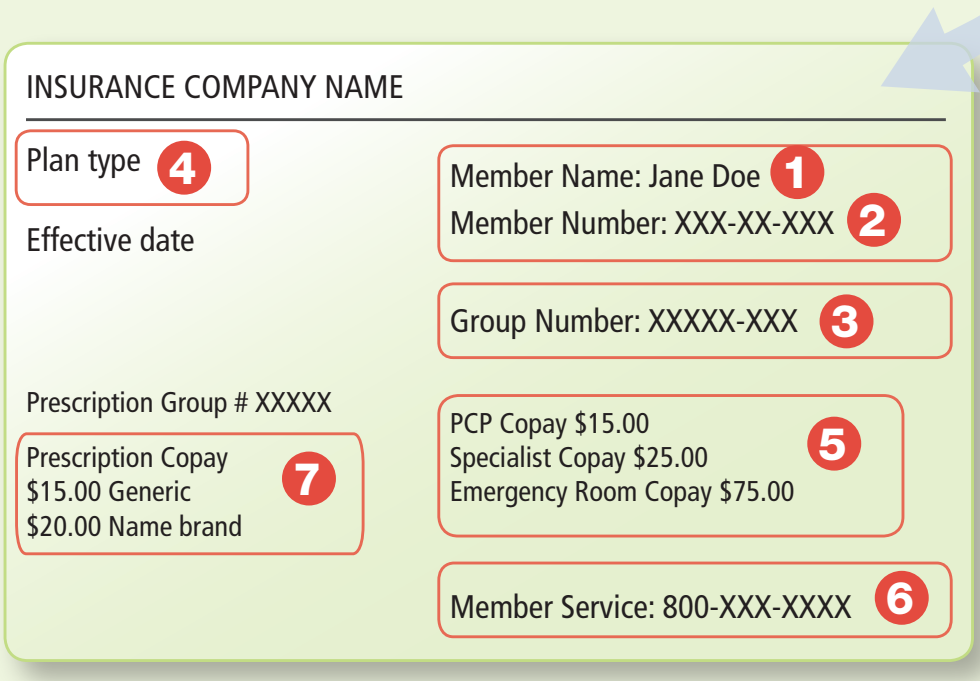
  It is not a bill. It is a record of the health care you or individuals covered on your policy received and how much your provider is charging your health plan.

  If you have to pay more for your care, your provider will send you a separate bill.

Your Insurance Card or Other Document

You probably received a membership package with information about your coverage from either your health plan or program. Read this information because you will need it when you see a provider or if you call your insurance company to ask a question. If you can't read or understand it, call your health plan or program and ask them to explain it to you.

You may also have received a card or other document as proof of your insurance. Your card may look different from this one, but should have the same types of information. Some health plans don't have cards, but you should have received this information in another form. If you didn't receive a card, contact your health plan to see if you should have.



The following information may be included on your insurance card or another document from your health plan or program.

1. **Member name and date of birth.** These are usually printed on your card.

2. **Member number.** This number is used to identify you so your provider knows how to bill your health plan. If your spouse or children are also on your coverage, your member numbers may look very similar.

3. **Group number.** This number is used to track the specific benefits of your plan. It's also used to identify you so your provider knows how to bill your insurance.

4. **Plan type.** Your card might have a label like HMO, PPO, HSA, Open, or another word to describe the type of plan you have. These tell you what type of network your plan has and which providers you can see who are "in-network" for you.

5. **Co-payment.** These are the amounts that you will owe when you get health care.

6. **Phone numbers.** You can call your health plan if you have questions about finding a provider or what your coverage includes. Phone numbers are sometimes listed on the back of your card.

7. **Prescription co-payment.** These are the amounts that you will owe for each prescription you have filled.

The questions below can help you better understand your coverage and what you will pay when you get health care. If you don't know the answers to these questions, contact your insurance plan or provider.

- How much will I have to pay for a primary care visit? A specialty visit? A mental or behavioral health visit?
- Would I have to pay a different amount if I see an "in-network" or "out-of-network" provider?
- How much do I have to pay for prescription medicine?
- Are there limits on the number of visits I can make to a provider, like a behavioral health provider or physical therapist?
- How much will it cost me to go to the emergency room if it's not an emergency?
- What is my deductible?
- Do I need a referral to see a specialist?
- What services are not covered by my plan?

PREVENT HEALTH CARE FRAUD

If someone else uses your insurance card or member number to get prescription drugs or medical care, then they're committing fraud. Help prevent health care fraud.

- Never let anyone use your insurance card.
- Keep your personal information safe.
- Call your insurance company immediately if you lose your insurance card or suspect fraud.

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3 Find a provider.

Choosing the right provider is one of the most important decisions you'll make about your health care, and finding the right one can take a little work.

Remember, you're looking for a partner you can trust and work with to improve your health and well-being, so take time to think about what you need. Depending on how complicated your health care needs are, you may need to see more than one type of provider. Two common provider types are listed below.

A **Primary Care Provider** is who you'll see first for most health problems. They will also work with you to get your recommended screenings, keep your health records, help you manage chronic conditions, and link you to other types of providers if you need them. If you're an adult, your primary care provider may be called a family physician or doctor, internist, general practitioner, nurse practitioner, or physician assistant. Your child or teenager's provider may be called a pediatrician. If you're elderly, your provider may be called a geriatrician.

- *In some cases your health plan may assign you to a provider. You can usually change providers if you want to. Contact your health plan for how to do this.*

A **Specialist** will see you for certain services or to treat specific conditions. Specialists include: cardiologists, oncologists, psychologists, allergists, podiatrists, and orthopedists.

You may need a **Referral** from your primary care provider before you go to a specialist in order to have your health plan pay for your visit. For some services, your health plan may require you to first get **Preauthorization**—a decision by your coverage or health plan that a health care service, treatment plan, prescription drug, or durable medical equipment is medically necessary and will be covered. This is also called prior authorization, prior approval, or precertification.

THE RIGHT PROVIDER

It might take more than one visit to figure out if a provider is the right one for you.

4 Be prepared for your visit.

If this is your first visit to a new provider or you are using new health coverage, you will need to bring a few things with you.

This will help your provider understand your health and lifestyle, and help you work together to improve your health and well-being during your visit and after you leave.

It is important to show up early for your appointment!

When you get to your provider's office, check in with the front office staff.

You may be asked to provide the following:

- Insurance card or other documentation.
- Photo identification (*e.g., driver's license, government or school ID, passport, etc.*).
- Completed forms.
- Your copay, if you have one. *Ask for a receipt for your records.*

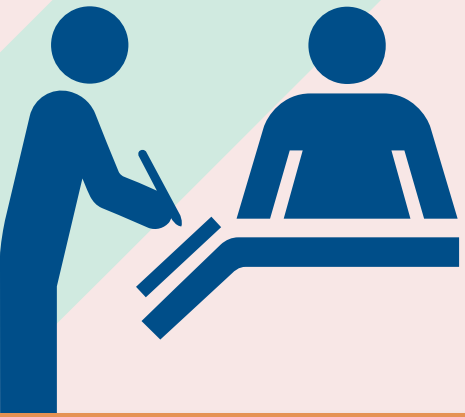
The staff may ask you to fill out additional forms and to read over their privacy policy, which tells you how they will keep your information private. It is required by law.

COST TIP
If you need to change your appointment, contact your provider's office as soon as possible. Many providers charge a fee if you're late, don't show up for your appointment, or cancel less than 24 hours in advance. Most health plans will not pay these fees.

When you see your provider, it is helpful to share:

- Your family health history and medical records, if you have them.
- Medications you are taking (and the bottles so your provider knows what dose you take). If you need a refill, ask for one.
- Questions or concerns you have about your health—write them down so you don't forget to ask.

You may want to bring someone with you, like a friend or family member, to help you talk to the provider.



KNOW YOUR RIGHTS

You should be treated with respect and your information kept private. If you're not happy with how you were treated, ask to speak with an office manager or the provider and tell them your concerns. If things aren't resolved, then this office may not be the right place for you.

5 Decide if the provider is right for you.

Your health and well-being are important and personal and you should have a provider that you can work with, trust, and feel comfortable talking to.

Remember:

- It's important to find a provider that meets your needs.
- If you're not happy with your first visit, consider giving them another try. You can call the provider's office and share your concerns. You may also be able to see another provider in that office.

COST TIP
If you were assigned a provider and you want to try someone else, call your health plan or go to their website to make that change. Make sure you choose a provider in your network or you will pay more for your care.

SPEAK UP
If you're not comfortable with your provider, say something! It is okay to ask for changes or to look for another provider. The right provider for you will meet your needs when you ask.

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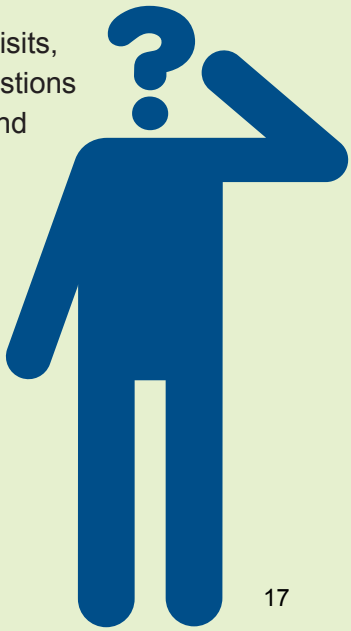
6 Next steps after your appointment.

Now that you have found a provider and had your first visit, where do you go from here?

You'll see your primary care provider for your recommended preventive care and for help managing chronic conditions, as well as when you feel sick. Even if you see a specialist for a specific service or condition, you'll always come back to your primary care provider.

Ask your provider or their staff to notify you when your next visit or recommended health screenings should happen. Make an appointment for that visit as soon as you can and write it down someplace where you'll remember it, or in the back of this book.

If you have questions or concerns between visits, call your provider. They can help answer questions you have about your health and well-being and adjust any medications you are taking.



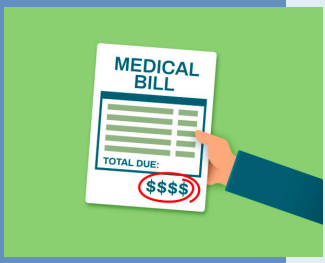
Pay your bills and keep any paperwork. Some providers will not see you if you have unpaid medical bills. You may be able to go online to look up your own health information, such as screening and test results or prescribed medications. This can help you take charge of managing your health.

APPEALS AND GRIEVANCES

If you have a complaint or are dissatisfied with a denial of coverage for claims under your health plan, you may be able to appeal or file a grievance. For questions about your rights, or assistance, you can contact your insurance plan or state program. If you think you were charged for tests or services your coverage is supposed to pay for, keep the bill and call the phone number on your insurance card or plan documentation right away. Insurance companies have call and support centers to help plan members.

1. **Service Description** is a description of the health care services you received, like a medical visit, lab tests, or screenings.
2. **Provider Charge** is the amount your provider bills for your visit.
3. **Allowed Charge** is the amount your provider will be reimbursed; this may not be the same as the Provider Charges.
4. **Paid by Insurer** is the amount your insurance plan will pay to your provider.
5. **Payee** is the person who will receive any reimbursement for over-paying the claim.
6. **What You Owe** is the amount the patient or insurance plan member owes after your insurer has paid everything else. You may have already paid a portion of this amount, and payments made directly to your provider may not be subtracted from this amount.
7. **Remark Code** is a note from the insurance plan that explains more about the costs, charges, and paid amounts for your visit.

Contact your health plan if you have questions about your EOB.



BALANCE BILLING

What is Balance Billing?

Balance Bills are surprise medical bills that charge patients for the difference between what an out-of-network provider charges and what the insurer actually pays the provider.

- Usually this occurs when a consumer inadvertently sees an out-of-network provider in an emergency situation
- Because insurers do not pay out-of-network providers the full amount of the service charges, some providers try to collect from the patients the remaining amount of their fees.

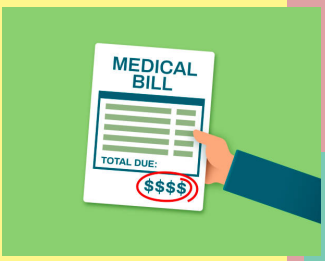
Why is this important?

About 1 in 5 Mississippi adults has medical debt in collections, meaning their past due medical debt has been sold to collection agencies. Once a collection agency is involved, the debt can harm a person's credit score.

EXAMPLE 1:

A patient receives treatment at the Emergency Department at a hospital that participates in his insurance company's network. The total cost of treatment is $100 ($30 in hospital fees and $70 for physician fees). The total cost of treatment is submitted to the patient's insurance company. Insurance pays the in-network hospital fees ($30), but the physician that treated the patient was not a Hospital employee and does not participate in the insurance network. Because the physician is not in-network and there is no assignment to pay him directly, the insurance company will send the patient the in-network physician fee amount ($50) which is a discounted rate.

Even though the hospital was in the patient's network, the physician was not. The patient will receive a $70 bill from the physician for the full amount of his fees. This is a "Balance Bill" - where a healthcare provider bills a patient for the amount of fees that insurance did not cover.



EXAMPLE 2:

A patient visits his usual physician who participates in the patient's insurance network. The physician orders blood work and sends the patient's sample to an out-of-network laboratory for testing. The patient's insurance covers 50% of out-of-network care. The lab's total charges are $500, and the insurance network rate is $300. The patient's insurance pays $150, which is 50% of the network rate, and expects the patient to pay the remaining $150 as outlined in the patient's policy. But the lab adds on the $200 difference between its charge ($500) and the network rate ($300) to the bill sent to the patient.

Even though the physician was in the patient's network, the laboratory was not. The patient receives a bill of $350 from the lab - the $150 usual co-pay plus the $200 (balance) bill for the different rate. This is a "Balance Bill" - where a healthcare provider bills a patient for the amount of fees or charges that insurance does not cover.

Mississippi Prohibits Balance Billing

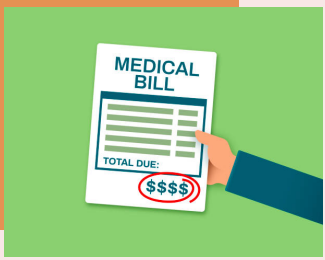
Miss. Code Ann. § 83-9-5(1)(i)

Under this law, if a healthcare provider accepts a patient's insurance assignment, then the insurance company will pay the provider directly for the patient's treatment.

That payment is considered ***payment in full*** to the healthcare provider - this means the provider cannot bill the patient later for any amount more than the payment received from the insurance company, other than normal deductibles or co-pays.

Assignment means that your physician agrees to accept your insurance company's rates as *full payment* for services covered by insurance.

So, in Example 2 above, if the provider (the lab) had accepted the assignment, it could not have billed the patient for the $200 difference.



What Can I Do If I Get a Surprise Balance Bill?

Remember: The Insurance Department enforces the law to protect consumers against surprise balance billing.

If you get a Balance Bill, follow these steps and be sure to reach out to the Insurance Department:

- Make sure it is a Balance Bill (remember your co-pays and deductibles)
- Call your insurance company to make sure it's not a mistake and that the provider has accepted Assignment
- Call the Insurance Department (1-800-562-2957)
- Call the Attorney General's Office - Consumer Protection Division and file a complaint (601-359-4230)
- Call the Mississippi Health Advocacy Program (601-353-0845)
- File a claim in court
- Contact a private attorney

HELPFUL LINKS

Getting Coverage

How to get coverage through the Health Insurance Marketplace

How much will health insurance cost?

What plans are available in my area?

https://www.healthcare.gov/find-premium estimates/

Contact Your Insurance Plan

Contacting your health plan's customer service phone number

http://marketplace.cms.gov/outreach-and education/contact-health-plan.pdf

Value of Prevention

Understanding prevention and the Affordable Care Act

https://www.healthcare.gov/prevention/

Finding a Provider

Reviews and ratings of local providers

Planning Your First Visit

Steps to help you plan your first visit

Questions to Ask Your Provider

Topics and questions to discuss with the provider during your visit

Patient-Provider Relationship

The importance of communicating with your provider

Tracking Your Medicine

Patient guide and wallet card to keep a record of all medications

http://www.ahrq.gov/patients-consumers/diagnosis-treatment/treatments/safemeds/yourmeds.html

YOUR IMPORTANT INFORMATION

Health Plan Name _____

Policy Number_____

Group Number _____

Health Plan Phone Number_____

Primary Care Provider _____

Other Providers _____

Pharmacy _____

Allergies_____

Emergency Contact _____

Medications _____

_____

Other _____

_____

Protect Your Identity: Keep your personal information safe, whether it is on paper, on-line, or on your computers and mobile devices. Store and dispose of your personal information securely, especially your Social Security number.

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Mike Chaney
Commissioner of Insurance
and State Fire Marshal

Mississippi Insurance Department • Life & Health Actuarial Division

1001 Woolfolk State Office Building • 501 North West Street •
Jackson, Mississippi 39201

Main Switchboard: 601-359-3569 • For Consumers Statewide Call:

1-800-562-2957

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