HEALTH Action

Understanding Your Health Plan Agreement

The key to understanding your health care coverage is your health plan agreement or contract. This document, often called an "Evidence of Coverage" (EOC) or "Summary Plan Description" (SPD), explains your health care benefits, any limits to your coverage, the health plan's policies and procedures and what costs you will have to pay. The EOC or SPD is your binding agreement or contract with your health plan.

GET A CURRENT COPY

Whether you buy your health care coverage yourself, receive it through your employer, or get coverage through Medicare or Medi-Cal, the EOC or SPD should have been part of the packet of information you received when you signed up with your health plan.

It is important for you to find out whether your EOC or SPD is a summary or a complete contract. Usually, this is stated at the beginning of the document. If you bought an individual policy, the document you received should be your complete contract. If you have coverage through your employer, your employer holds the contract and your copy is probably a summary.

The EOC describes your health plan's policies. It also should describe other legal protections you may have, especially if you are on Medicare or Medi-Cal. If you can't find your EOC or SPD, or if you're not sure if the copy you have is current, contact your insurance agent, your employer, or your health plan to get one.

LOOK AT THE TABLE OF CONTENTS

In the beginning of your EOC or SPD, you will find a Table of Contents that should give you a good idea of the type of information you will find in the document. To understand your health coverage, you should read your EOC.

If you don't understand the medical terms used in your EOC or SPD, or if you can't find the services you are looking for, ask your employer or insurance agent, or call your health plan's customer service department.

Definitions

Because your EOC or SPD has both legal and unfamiliar words, a list of definitions usually is provided to make it easier to read. Mark any terms you do not understand and ask a health plan customer service representative to explain them to you.

"How To" Sections on Providers, Referrals and Using the Plan

These sections of your EOC or SPD should describe:

- The procedures for choosing a doctor or getting referrals to specialists;
- The rules and cost of using doctors, hospitals and other providers that are not part of your health plan;
- The rules and cost of using doctors that are part of your health plan but not part of the medical group you are assigned to;
- What steps to follow to see a specialist, get a second opinion, or obtain emergency treatment.

General Provisions

This section should tell you how the plan pays for care you receive, what is and is not covered, and what to do if you disagree with any decisions made by your health plan. The section should also describe your portion of the cost for your care and what to do if you receive a bill from a hospital or a doctor.

Benefits and Coverage

This very important section of your EOC or SPD should list exactly which services and benefits your health plan provides to its members. It should also tell you the number of visits that are covered (for example, eye exams or mental health appointments) over the course of a year.

The list of services generally is organized by titles such as:

- **Professional Services** *(includes doctors and other health care providers)*
- **Preventive Services** *(such as physical exams or certain tests)*
- **Outpatient Services** *(such as physical therapy, mental health care or treatment at an urgent care center)*
- **Hospital Services**
- **Emergency Services**

Look in the Benefits and Coverage section if you are concerned about a specific medical condition (such as pregnancy) or the availability of certain kinds of treatments (such as mental health services or addiction treatment) or to find out which preventive services are covered.

Even if care appears to be covered you should look at the "Exclusions and Limitations" section to see if there are reasons care may not be covered in all cases.

Exclusions and Limitations

You will find services and supplies that are not covered by your health plan in this section. It also will describe services that are limited under your plan.

Look for treatments that are important to you but may not be covered (such as acupuncture or infertility treatment). You also should find information in this section about how your health plan handles "pre-existing conditions" which are conditions you received treatment for before you joined your health plan. There may be a waiting period before pre-existing conditions are covered by your health plan.

Even if the service or treatment you need appears to be excluded, you may be able to get coverage if the service or treatment is determined to be "medically necessary." You will have to make a case to your health plan, your medical group, or your employer as to why the service or treatment should be covered. Your request should be made in writing and include medical documentation as to why the service or treatment is medically necessary. Ask your doctor for help in making your case.

Copayments, Deductibles, Coinsurance, Maximum Payments

This section should describe your personal responsibility to share costs under your health plan. Your share for copayments, deductibles, and coinsurance may be listed separately or may be noted next to the services described. Sometimes a separate sheet referred to as a "Schedule of Copayments" will be inserted into your packet. Review these figures carefully.

By understanding what your financial responsibilities are, you can avoid being surprised or risking a large, unexpected medical bill. Once you have received services it often is difficult to settle payment disputes. Claiming you didn't know your financial responsibilities usually will not be considered a valid excuse by the health plan. If in doubt, ask your health plan before you seek care.

A ***"copayment"*** *is the amount you pay each time you receive services. In many plans, the copayment is a flat amount, such as $10 or $15 for an office visit with a doctor or for a prescription drug.*

"Coinsurance" *is the amount you pay for services after your health plan has paid its share. A typical coinsurance amount is 10% or 20% of the amount the plan allows for the services you received. Most PPOs require you to pay a percentage of the cost of your care.*

A ***"deductible"*** *is the amount you must pay each year before the plan will start paying for services you receive. Most HMOs do not have deductibles; most PPOs do. A typical deductible amount is $250 per year for an individual.*

Many plans limit the amount you have to pay each year. This is called the ***"Out-of-Pocket Maximum."*** *When you have reached the maximum amount, you do not have to pay any more for covered services.*

WHERE TO GET HELP OR ANSWERS TO QUESTIONS

If you receive health coverage from your employer, your benefits manager or human resources department should be able to help you understand your benefits as well as your responsibilities. If your employer can't help, ask if there is an insurance agent you can call. If you don't want to ask your employer because of privacy concerns, call the customer service phone number listed in your EOC or SPD. Ask the health plan representative to explain the specific policy, benefit, or limitation.

Don't be afraid to ask questions or to have the information repeated until you understand.

If you get your coverage through Medicare, call your health plan, or the Health Insurance Counseling and Advocacy Program (HICAP) at (800) 434-0222. HICAP is an independent consumer advocacy group which has trained peer counselors who can help you. You can also get information about Medicare benefits by calling Medicare at (800) 633-4227.

If you get your coverage through Medi-Cal, call your health plan, or Health Care Options at (800) 430-4263. Health Care Options assists Medi-Cal members with enrollment and eligibility problems. If you live in Placer County, call the Managed Care Network for help with enrollment or eligibility at (800) 895-7479. If you live in Yolo County, call Partnership Health Plan of California at (800) 863-4155. No matter where you live, if you are having a problem with your health plan you can call the Medi-Cal Managed Care Ombudsman at (888) 452-8609.

If you purchase your own health insurance, call the insurance broker who sold you the policy or ask your health plan for help in understanding what is covered and not covered.

If you have special language or hearing needs, have a friend help you with the telephone call or tell the health plan's representative that you need special assistance.

CALL THE HEALTH RIGHTS HOTLINE

Health care coverage can be complicated, but you do have rights. The HEALTH RIGHTS HOTLINE is here to assist you. The HEALTH RIGHTS HOTLINE is a totally independent, free service which provides information and assistance about your rights as a health care consumer. Experienced counselors will answer your questions and help you resolve issues with your medical group or health plan. If you need assistance, give us a call.

HEALTH RIGHTS HOTLINE
INDEPENDENT ASSISTANCE FOR HEALTH CARE CONSUMERS

519 - 12TH STREET, SACRAMENTO, CA 95814

SACRAMENTO: (916) 551-2100 • TOLL FREE: (888) 354-4474 • TDD: (916) 551-2180 • FAX: (916) 551-2158

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Serving El Dorado, Placer, Sacramento and Yolo Counties

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