Know your medical insurance benefits.

If you have health insurance coverage, it's essential that you understand the details of your plan. Unless you've got a grasp on, for instance, what services are covered and what procedures you must follow to get the coverage you deserve, you can count on disputes arising with your health insurance company. Besides, you might want to take maximum advantage of all the benefits the plan offers, such as support groups or classes.
This article tells you what you need to know about your health insurance plan and how to find the information you need.

The Costs of Not Understanding Your Health Insurance Coverage

Far too often, when insurance companies deny payment for medical services, it's because the consumer didn't follow the required procedures or failed to understand the limits of coverage. Here are some examples of common (and costly) mistakes:

- A consumer with an HMO visits an orthopedic surgeon. The health plan refuses to pay for the visit because the consumer needed to obtain a referral from his primary care physician first.
- A PPO participant sees a doctor who is not within the PPO network. The participant must pay 80% of the charges. The participant would have paid only 20% if the doctor had been within the network.
- A consumer has surgery without getting the required pre-authorization from the health insurer. None of the costs of the surgery are covered -- it would have been covered in full if the consumer had gotten the pre-authorization.
- A consumer appeals her health plan's decision to deny coverage for a certain procedure. The consumer fails to file the internal appeal within the time limit required and, as a result, automatically loses the appeal.

In order to avoid these and other pricey mistakes, here's what you need to know about your health plan.

What Type of Health Plan Do You Have?

Most plans are one of the following:
Preferred Provider Organization (PPO). In a PPO, the plan contracts with physicians and hospitals to provide services at reduced cost. If you use these in-network medical providers, the plan pays all or most of the cost of treatment. Participants can use out-of-network health care providers, but must pay a larger portion of the cost.
Health Maintenance Organization (HMO). An HMO is a group plan in which members prepay a flat fee and are given access to the services of participating doctors, hospitals, and clinics. Members typically make copayments, but do not need to pay deductibles.
Fee-for-Service (traditional indemnity). This is the traditional plan in which the participant can visit any doctor or health facility (for the most part). The participant pays for the service, and then submits a claim to the insurance company for reimbursement.

Is Your Plan Self-Insured or Employer-Sponsored?

Whether you are self-insured or participate in an employer-sponsored health plan is also important. The type of plan you have determines your rights to appeal a denial of coverage or other negative decision by the health plan.

Self-Insured or Individually Purchased

If you enrolled in a health plan on your own (not through an employer) and pay the premiums entirely yourself, then you are self-insured.

Employer-Sponsored Health Insurance

If you are enrolled in a health plan through work, you have employer-sponsored health insurance.

There are two types of employer-sponsored plans. The type you have is key to your appeal rights if you disagree with a health plan decision to deny coverage. (To learn more about your right to appeal a health plan decision, see Nolo's article Health Plan Disputes: An Overview.) The two types of employer-sponsored plans are:

- **Insured plans.** Your employer has an insured plan if it buys health coverage from an insurance company (such as Blue Cross) or from an HMO.
- **Self-funded plans.** Your health plan is self-funded if the employer pays for the health care costs of its employees directly, rather than by purchasing insurance from an insurance company.

Ask your employer's benefits administrator which type of plan you have, since it's not always obvious from the plan's title. Some employers with self-funded plans use a health insurance company to serve as a third party administrator. So, for example, if your plan documents say "Aetna," your plan may be insured through Aetna or it may self-funded by your employer and merely administered by Aetna.

Once you determine the basic type of plan, it's time to delve into the details. You need to understand what is covered, what procedures must be followed, how payment works, and your appeal rights if you have a dispute.

The best place to get this information is from the insurance policy itself. Don't just read the glossy brochure! Carefully read the Summary Plan Description. In addition, read the Evidence of Coverage -- this is the detailed description of the plan (not just the summary) that lays everything out. If you have purchased your own insurance policy, the company will have already provided you with this document. If you have an employer-sponsored plan, ask your employer for a copy. The Evidence of Coverage may be available online as well.

Covered Services

Read your policy to find out what services, treatments, and procedures are covered. Even more important, take note of what is *not*covered. Excluded services might include infertility treatments, acupuncture, cosmetic treatments, treatment of obesity, mental health care, nursing home care, and substance abuse treatment. Here's a look at some common coverage limitations:

- **Preexisting conditions.** Self-insured plans often exclude preexisting conditions.
- **Service limits per calendar year**. Health plans may also limit certain services in a calendar year. For example, your plan may cover only eight mental health visits or up to $400 for speech therapy per year.
- **Lifetime maximums.** Some plans limit the total amount of money the insurance company will pay for the entire time you have coverage under that plan. Once you reach that limit, your plan will not pay for any more of your medical expenses. Lifetime maximums often range between $1 million and $5 million.

Required Procedures

Many health plans require the consumer to follow certain steps in order to get coverage for services. If you don't follow the health plan's requirements to a "T," you can be sure it will deny coverage. Here are some things to look out for:

- **Referral Procedures (HMO).** Most HMOs do not cover services from specialists unless the patient first receives a referral to that specialist from the patient's primary care doctor. For example, if you have allergies, you must see your primary care doctor and get a referral to see an allergist (who is part of your HMO network of doctors). Only when your health plan approves the referral can you see the allergist and get the services covered.
- **Payment for Out-of-Network Services (PPO).** PPOs give consumers more flexibility in choosing doctors. But PPO participants usually pay more if they visit a doctor who is not part of the plan's network of health care providers. For example, some plans will cover 80% of services performed by an in-network physician, but only 20% of services performed by an out-of-network physician. Always check to see if a doctor is part of your health plan's network, to avoid surprises. If you use an out-of-network provider, there may be another hidden cost. PPO plans determine the rates they will pay to in-network providers for certain services. This is usually called the "allowable" or "approved" charge. Even if an in-network provider generally charges $100 for a service, if your PPO's allowable charge for that service is $80, your portion is based on $80, not $100. So, if you must pay 20%, you pay 20% of $80 (or $40). However, out-of-network providers are not subject to allowable charges, so your percentage would be based on the entire fee of $100.

- **Pre-Authorization for Certain Services.** Many plans require patients to get pre-authorization from the health plan before receiving certain kinds of medical treatment. If you fail to get pre-authorization, your plan may deny coverage for an otherwise covered service.
- **Using Emergency Services.** Most health plans allow you to use out-of-network doctors or hospitals in an emergency, assuming you follow certain procedures. Become familiar with those procedures ahead of time. For example, if you are out of town and must visit the emergency room, you may have to contact your health plan within 24 hours of the visit. It's often wise to write down the steps you must take, phone numbers you must call, and deadlines to make those calls, and then keep this information where you can access it quickly in an emergency (for example, by the kitchen phone or in your wallet).

Payment

A key to understanding your health plan -- and avoiding surprises when the bill comes -- is knowing what your payment obligations are, including:

- **Copayments.** These are often between $10 and $50 per office visit. Copayments for hospital visits, surgery, and other procedures are often higher.
- **Deductibles.** Some PPOs require participants to pay the full cost of medical services until they reach a certain dollar figure (say, $500). This is called the deductible. Once you have spent the amount of the deductible in any given calendar year, the health plan coverage kicks in.

It's wise to keep track of your deductible status, especially if your deductible is high. If you meet the deductible amount in a given calendar year, think about getting other costly procedures or treatments done within the same year rather than waiting until the next year when you have to meet your deductible all over again.

Your Rights If You Have a Dispute

If you disagree with a decision or action by your health plan -- a denial of coverage, refusal to authorize treatment by a specialist, or any other adverse action -- you may have the right to a review of that decision. Most states and most health plans allow a plan participant to ask for an internal review. That means that you make a formal request to have the health plan reconsider a decision related to your coverage. (To learn more about the internal review process for health plan disputes, see Nolo's articleHealth Plan Disputes: Internal Reviews.) You may also have the right to an external review (an appeal that's heard by an organization or panel that's not affiliated with the health plan).

Review is often limited to certain types of health plan disputes. Be sure to know the time limits within which you must file for review as well as any forms and documents you must submit. (To learn more about your right to an internal or external review of a health plan's negative decision, see Nolo's article Health Plan Disputes: An Overview.)

To learn about managing health care expenses and dealing with other pressing financial issues, get *The Busy Family's Guide to Money*, by John Waggoner, Kathy Chu, and Sandra Block (Nolo).

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