

UNDERSTANDING HEALTH INSURANCE



DIVISION OF
SPECIALIZED CARE FOR CHILDREN

Understanding your health insurance coverage can prevent costly mistakes. The purpose of this brochure is to help you identify the benefits and requirements of your health insurance plan. Read your insurance policy benefits booklet. If you do not have one, ask your health insurance representative to send you one. After reading your benefits booklet, answer the questions in this brochure. If you are unable to answer the questions, or if you have additional unanswered questions, contact your health insurance representative. If you would like to discuss your concerns with your DSCC consultant, she/he will be willing to help you. You may keep this brochure for your own use. You don't need to return it to our office.

What type of insurance plan do you have?

- Traditional indemnity plan
- Managed care plan
 - HMO (Health Maintenance Organization)
 - PPO (Preferred Provider Organization)
 - POS (Point of Service)
- Public Insurance (Medicaid, Medicare, CHIP, CHAMPUS)

It is helpful to know the type of insurance you have because each type has certain characteristics and requirements you need to be aware of.

- Traditional indemnity plan - you (or your employer) pays a premium. You have a choice of the providers you use. A basic plan usually covers hospitalizations. A major medical plan is more comprehensive. In addition to hospitalization, it usually covers services such as physician office visits, laboratory and x-ray tests, prescription medications, outpatient services, and mental health services. Major medical plans usually have deductibles, copayments and a lifetime maximum. These plans usually contain a preexisting condition clause.

- Managed care plans - usually provide more comprehensive health care services. The care is monitored and must be preapproved by either a primary care physician or by the insurance company. Each plan has a network of providers. You must use providers in the network to receive maximum benefits from the plan. If you go outside the network, you are assessed a penalty.
- Public programs - such as Medicaid and Medicare use tax dollars to pay for medical care. While they have operated like traditional indemnity plans in the past, more and more states are developing managed care plans.

What is the effective date of your policy? _____

What is the renewal date of your policy? _____

It is important to know the dates your policy is in effect. The insurance company will not pay claims for services obtained outside those dates.

Does your plan have a deductible amount?

	Yes	No	If Yes, Amount
Individual	<input type="checkbox"/>	<input type="checkbox"/>	_____
Family	<input type="checkbox"/>	<input type="checkbox"/>	

Most insurance policies have deductible amounts which must be paid by you for covered services before coverage begins. There is usually an individual deductible and a family deductible. The family deductible usually requires that a specified number of family members meet their individual deductibles. For example: if you have a 4 member family, your policy covers your entire family and there is a \$100 deductible per individual. The policy will probably not require all 4 of you to meet the individual deductible, but will most likely require 3 members of the family to satisfy the individual deductible.

Does your plan have a coinsurance (or co-payment) amount?

Yes No If Yes, how much? _____

Coinsurance is a set amount of money an insured individual must pay toward covered medical expenses after the deductible has

plan, the coinsurance amount may be 20% of the covered medical expenses. Another example would be a \$10 co-payment for each office visit under a managed care (HMO, PPO, POS) plan.

What is covered by your insurance plan?

All policies have a section in their benefits booklet that lists the types of services the insurance will pay for. The following services are frequently covered by health insurance plans. Check to see if your policy has these services listed. List the services covered by your plan that are not on this list

Is service covered?	Yes	No
Inpatient hospital services	<input type="checkbox"/>	<input type="checkbox"/>
Outpatient hospital services	<input type="checkbox"/>	<input type="checkbox"/>
Outpatient surgery	<input type="checkbox"/>	<input type="checkbox"/>
Diagnostic laboratory and x-ray	<input type="checkbox"/>	<input type="checkbox"/>
Outpatient emergency	<input type="checkbox"/>	<input type="checkbox"/>
Physician office visits	<input type="checkbox"/>	<input type="checkbox"/>
Medical equipment (such as wheel-chairs or walkers)	<input type="checkbox"/>	<input type="checkbox"/>
Orthotic or prosthetic devices	<input type="checkbox"/>	<input type="checkbox"/>
Medical supplies (such as bandages, catheters, IV supplies)	<input type="checkbox"/>	<input type="checkbox"/>
Prescription drugs	<input type="checkbox"/>	<input type="checkbox"/>
Well child care services (such as checkups and immunizations)	<input type="checkbox"/>	<input type="checkbox"/>
Physical therapy	<input type="checkbox"/>	<input type="checkbox"/>
Occupational therapy	<input type="checkbox"/>	<input type="checkbox"/>
Speech therapy	<input type="checkbox"/>	<input type="checkbox"/>
Mental health services	<input type="checkbox"/>	<input type="checkbox"/>
Ambulance services	<input type="checkbox"/>	<input type="checkbox"/>
Home nursing services	<input type="checkbox"/>	<input type="checkbox"/>

Is service covered?	Yes	No
Dental services	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Aids	<input type="checkbox"/>	<input type="checkbox"/>
Eye glasses or contact lens	<input type="checkbox"/>	<input type="checkbox"/>
Other (please list) _____		

Does your policy have special requirements?

Most plans have special requirements. For example, you may need to get prior approval before a hospital admission or a second opinion before surgery. Your doctor needs to know about special requirements.

Possible Special Requirements	Yes	No
Second opinion before surgery is performed.	<input type="checkbox"/>	<input type="checkbox"/>
Precertification or preregistration before a hospital admission.	<input type="checkbox"/>	<input type="checkbox"/>
Precertification or preregistration before an outpatient surgery is performed.	<input type="checkbox"/>	<input type="checkbox"/>
Referral by your primary care physician before seeing a specialist physician.	<input type="checkbox"/>	<input type="checkbox"/>
Physicians, hospitals or other health care providers must be selected from the health insurance plan's provider list.	<input type="checkbox"/>	<input type="checkbox"/>
Prior approval for medical equipment rental or purchase.	<input type="checkbox"/>	<input type="checkbox"/>
Services not covered or excluded due to a preexisting condition.	<input type="checkbox"/>	<input type="checkbox"/>
Age a child must be to be covered by the plan.	<input type="checkbox"/>	<input type="checkbox"/>

Is there a specified procedure or timeframe for filing a medical claim?

If you do not follow the plan's claims filing procedures and file the claim in the timeframe specified, your claim will not be paid.

If you have more than one health insurance policy, which one is the primary payer?

In order to maximize all benefits available to you, it is important to identify the primary plan for payment of claims and learn how to coordinate the policies to your advantage.

If you have more questions about your insurance coverage, who can you ask?

Insurance companies or employers usually have someone available to answer questions about the insurance plan or assist with claims. Check your booklet.

Who is your insurance representative or who should you contact with questions about your benefits?

Name: _____

Phone Number: _____

TIPS to help you get what you need from your insurance benefits:

- When submitting claims to your insurance company, include copies (not originals) of bills, doctor's letters stating need for equipment, and pharmacy receipts. Originals should not be sent because they could be lost by the insurance company.
- Keep all your receipts, bills and completed claims forms in a folder for each family member. When you need them you will know where to go to find them.
- If your initial claim is denied, file an appeal if you feel the denial is unjust. Follow the appeals process described in your benefits booklet. Appeal decisions are based on medical information, not on your desire to argue the situation. Ask your physician to write a letter detailing the reasons why the care was necessary.

- If you feel your insurance company is treating you unjustly, contact the:
 Illinois Department of Insurance
 Assistant Deputy Director, Life Accident and Health Compliance Section
 320 West Washington
 Springfield, IL 62767
 Phone: (217) 782-4254

If your employer is “self-insured,” however, the Department of Insurance may not be able to help you. Call the Department of Labor office nearest you to see if they can help. You can find that number by looking in the phone book under “Government, U.S., Department of Labor.” Another helpful resource could be your State Representative or State Senator.

- Because of “preexisting condition” clauses, insurance could be difficult to obtain for your child with special health care needs. Therefore, if your child is covered by private insurance, it is probably in your child’s best interests to continue it as long into adulthood as possible.

Most insurance companies will continue to insure your children as long as they remain in school. Some companies will cover children up to age 23.

The Illinois Insurance Code states insurance companies must continue to provide coverage if an insured’s dependent (child or adult) continues to be both incapable of self-sustaining employment (by reasons of mental retardation or physical handicap) and dependent on the insured individual for support and maintenance.

You will need to request an extension to keep the child on your policy. Make your request at least one year before your child’s dependent status expires. This may be a lengthy process and you may need to appeal.

- **Health Insurance Portability and Accountability Act**

A preexisting condition is a medical condition diagnosed or

treated before joining a new plan. In the past, health care given for a preexisting condition often has not been covered for someone who joins a new plan until after a waiting period. However, a new law—called the Health Insurance Portability and Accountability Act—changes the rules.

Under the law, most of which went into effect on July 1, 1997, a preexisting condition will be covered without a waiting period when you join a new group plan, if you have been insured the previous 12 months. This means that if you remain insured for 12 months or more, you will be able to go from one job to another, and the preexisting condition will be covered—without additional waiting periods—even if it is a chronic illness.

If there is a preexisting condition and you have not been insured the previous 12 months before joining a new plan, the longest you will have to wait before the condition is covered is 12 months.

To find out how this new law affects you, check with either your employer benefits office or your health plan.

- In Illinois, an employer is required by the Consolidated Budget Reconciliation Act of 1985 (COBRA) to provide an opportunity for continued health insurance coverage, at the employee’s expense, to the employee and/or covered dependent(s) when the employee is terminated, laid off, gets divorced or dies. You can elect to continue this coverage for a period of up to 36 months.
- If your medical expenses are large, talk with your doctors and ask them to “accept consignment.” This means they will accept whatever your insurance will pay and not request additional payment from you.
- **To learn more about insurance**, check out your local public library. Some good books about insurance include:

Your Child and Health Care, A “Dollars and Sense” Guide for Families with Special Needs by Lynn Robinson Rosenfeld, L.C.S.W., Ph.D.

Health Insurance: How to Get It, Keep It, or Improve What You’ve Got by Robert Enteen, Ph.D.