

## For More Information Refer To These Resources:

### Division of Insurance

[www.mass.gov/doi](http://www.mass.gov/doi)

Consumer Line: (617) 521-7794

The Division of Insurance provides useful information regarding various types of insurance, and responds to consumer inquiries and claim disputes.

### HealthCare.gov

[www.healthcare.gov](http://www.healthcare.gov)

HealthCare.gov provides a wide range of information on how to find insurance, understanding and managing your insurance, and comparing insurance carriers. It also provides information on the Affordable Care Act.

### Healthcare Blue Book

[www.healthcarebluebook.com/](http://www.healthcarebluebook.com/)

Healthcare Blue Book will provide you cost estimates of various procedures and tests and useful cost-saving tips.

### Health Law Advocates

[www.healthlawadvocates.org/](http://www.healthlawadvocates.org/)

Phone: (617) 338-5241

Health Law Advocates provides free legal assistance to income-eligible individuals who live or work in Massachusetts and are having difficulty obtaining healthcare or insurance coverage.

### Health Care for All

[www.hcfama.org/](http://www.hcfama.org/)

Consumers: (800) 272-4232

Health Care for All provides useful information to consumers on the healthcare system in Massachusetts, and additional information on helping consumers understand their health coverage.

# EMPOWERING HEALTHCARE CONSUMERS

INSURANCE COMPANY NAME	COVERAGE TYPE
MEMBER NAME: JOHN DOE MEMBER NUMBER: XXX-XX-XXXX	EFFECTIVE DATE: XX-XX-XXXX
GROUP #: XXXXXX-XXX-XXX	PRESCRIPTION GROUP #: XXXXX
PCP CO-PAY: \$15.00 SPECIALIST CO-PAY: \$25.00 EMER. ROOM CO-PAY: \$75.00	PRESCRIPTION CO-PAY: \$15 GENERIC \$20 NAME BRAND
MEMBER SERVICES: 1-800-XXX-XXXX CLAIMS/INQUIRIES: 1-800-XXX-XXXX	

## Speaking with Your Insurance Company About Your Healthcare Plan



Consumer Hotline: (617) 973-8787

Toll free: (888) 283-3757

[www.mass.gov/consumer](http://www.mass.gov/consumer)



Deval L. Patrick  
Governor



Barbara Anthony  
Undersecretary



# SPEAKING WITH YOUR INSURANCE COMPANY ABOUT YOUR HEALTHCARE PLAN

- ***Can my health plan delay the internal grievance process?***

**NO**, your insurance carrier or plan administrator must maintain a procedure that allows for a timely resolution.

- ***What if my health plan fails to reach a timely decision on my internal grievance?***

If your insurance carrier or plan administrator does not reach a resolution within the time limits explained above, you may then go directly to an external review process for a decision. In Massachusetts, you should call the Office of Patient Protection at 1-800-436-7757 for more information.

- ***Are there any circumstances under which the health plan has to act more quickly?***

**YES**, the grievance resolution process maintained by your insurance carrier or plan administrator must also provide for an expedited resolution of a grievance concerning the carriers coverage of immediate and urgently needed services.

**Choosing** a health insurance plan is never an easy task. There are many terms in the health insurance industry and differences in plans that are often hard to understand. To make an informed choice when purchasing health insurance, having a general understanding of how health insurance operates is important. This brochure will provide you with information about different service and payment options.

## COMMON TERMS:

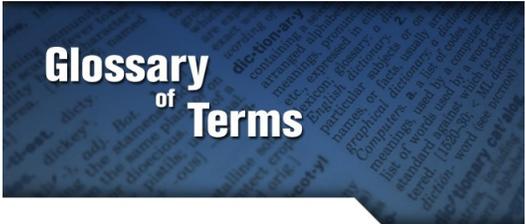
### Adverse Determination

A determination based upon a review of information, made by a healthcare provider or a designated review organization, that a service, prescription or supply is not medically necessary or appropriate.

### Allowable Charge

The allowable charge is the dollar amount typically considered payment-in-full by an insurance company

and an associated network of healthcare providers. It is typically a discounted rate that is negotiated between insurers and providers in their health plan network rather than the actual charge that is set by the provider for a service or supply. Each insurer has its own schedule of allowed charges.

A graphic with a dark blue background featuring faint, overlapping text. The words "Glossary of Terms" are prominently displayed in white, bold font in the center.

## Benefit

A healthcare service, prescription, supply or type of support that is specifically covered under a health insurance plan or government program.

## Benefit Limit

Some health plans have a limit on the number of visits or dollars allowed for a specific covered service, prescription or supply.

## Coinsurance

Coinsurance is a percent of the allowed charge that you pay for a covered service, prescription or supply. For example, your health insurance may cover 80% of the allowed charges for a covered procedure, leaving you responsible for the remaining coinsurance of 20%.

## Copayment

A copayment is a fixed dollar amount that you pay directly to a doctor, hospital or pharmacy at the time you receive a covered service, prescription or supply. For example, you may pay a \$20 copayment for an office visit and the plan pays the rest. A plan may have different copayments for different types of services, prescriptions or supplies.

## Deductible

A deductible is the amount you pay before the plan starts to pay for a covered service, prescription or supply. For some services you may need to meet an annual deductible.



## QUESTIONS TO ASK YOUR HEALTHCARE PLAN:

- Why is my share of the medical bill higher than expected?
- Why did my monthly premiums go up so much?
- Why is it taking so long for my health plan to pay the doctor bills?
- Someone from my health plan told me a particular service was covered, but after I received the service, the plan would not pay. How can this be?
- My health claim was denied. What are my rights?
- Can you explain why my plan is denying coverage for my doctor's recommended treatment?
- What grievance or appeal policy does this health plan practice?
- How much time can it take to decide a grievance or appeal?
- Can someone help me file an appeal?
- What is my timeframe for filing an appeal?

If your plan denies coverage of a particular service or medical device, you may want to file a grievance with your plan. The following questions and answers provide more information about internal grievance procedures.

## GENERAL QUESTIONS AND ANSWERS ABOUT INTERNAL GRIEVANCES AND APPEALS

- ***Is my plan required to have a formal grievance procedure?***

**YES**, your insurance carrier or plan administrator must maintain a formal internal grievance process for your plan that provides adequate consideration for a timely resolution of grievances.

- go to an ER, urgent care center or doctor's office?
- Does the plan include discounts for health club memberships, or other services for wellness maintenance?
- Is there a cost-sharing arrangement for prescription drugs?

### QUESTIONS FOR CONSUMERS ENROLLED IN EMPLOYER PLANS:

- What percentage of the premium do I pay for coverage? What is the price difference for individual vs. family plan?
- Are my spouse and children eligible under the plan?
- Is the premium deducted from my paycheck?
- If your employer changes health plans, ask:
  1. How will my coverage change?
  2. Can I still see my current primary care physician?

**NOTE:** *if your employer offers various plans to choose from, please refer to the sample of questions listed under "General Questions to ask Healthcare Providers" to determine which plan fits your needs.*

Once you purchase a healthcare plan, there will be occasions when you will be required to make certain payments. Furthermore, there may also be situations when your healthcare plan will not provide coverage. In both of these situations, you should ask your plan questions so that you fully understand your rights under the plan.

Before the plan picks up any charges, you must usually pay the deductibles, copayments, and your coinsurance amount, if any.

### Exclusions

Exclusions are specific listed services for which there is no benefit payment provided.

### Healthcare provider

A licensed professional who provides a healthcare service (such as a doctor, nurse, or therapist).

### Insured health plan

A health plan purchased by an individual or an employer from a licensed insurance carrier. Insured health plans are required to include Massachusetts mandated benefits (see mandated benefits below).

### Mandated benefit

A service, prescription or supply, or access to a category of healthcare providers that are required by law in Massachusetts insurance health plans. Self-funded employer-sponsored plans are not subject to the laws requiring the provision of mandated benefits.

### Medical necessity or medically necessary

Health plans will usually only pay for procedures that they deem medically necessary. Medical necessity refers to a decision by your health plan that your treatment, test, or procedure is necessary for your health or to treat a diagnosed medical problem. This criteria must be consistent with generally accepted principles of professional medical practice.

### **Minimum creditable coverage**

The essential healthcare services or benefits that you need to have in your insured health plan or self-funded employer-sponsored plan to meet Massachusetts' minimum coverage standards. If you do not have minimum creditable coverage, you could be subject to fines, unless exempt under state laws.

### **Out-of-pocket maximum (Annual Limit)**

An annual out-of-pocket maximum is the highest or total amount your health plan requires you to pay towards the cost of your covered healthcare. Once you reach your annual limit, in most cases, your health plan will cover 100% of the covered service for rest of the year. It is important to get an explanation of your benefits as health plans account for out-of-pocket costs differently.

### **Preventive health services**

Any periodic, routine, screening or other services designed for the prevention and early detection of illness that a carrier is required to provide pursuant to Massachusetts or federal law.

### **Primary care physician**

Under a health plan, the primary care physician is usually a patient's first contact for health care. This is often a family physician, internist, or pediatrician. A primary care physician monitors health, treats most routine health problems, and refers patients, if necessary, to specialists for more complicated treatments.

### **Prior authorization**

Prior authorization is an additional step that insurance

- How does this plan deal with disputes over benefits?

### **Financial**

- What can I and my family afford?
- What are the benefits and drawbacks in choosing between a plan with high out-of-pocket expenses and lower premiums or low out-of-pocket expenses and possibly higher premiums?
- What health plan related discounts may be available from my employer or other sources?

### ***What are the plan's costs?***

- Your monthly premium,
- Deductible (the amount paid upfront before the policy begins to pay medical expenses),
- Co-insurance (percentage of the allowed charge for a specific service, prescription or supply), and
- Co-payment (a specific charge for a specific service or prescription, i.e., \$20 co-pay for visits or \$10 fee co-pay for prescriptions).

### ***If I am considering a plan with a deductible:***

- After the deductible is met, what are the percentages of fees paid by the plan for network providers?
- After the deductible is met, what are the percentages of fees paid by the plan for out-of-network providers?

### ***What are the plan's dollar amount limits?***

- Is there a maximum amount for a particular type of service?
- What is the plan's annual out-of-pocket expense limit?
- What costs are included in the out-of-pocket expense limit? Excluded?
- How does the plan handle visits to the ER or ED? Are there different out-of-pocket costs for emergency care if I

- What is the procedure for care if I or family members are away from home?
- What are the processes to follow if frequent visits to a doctor are required?
- Is there a referral process if a specialist is needed? How does it work?

### **Plans**

- What plans are available through my employer?
- Are there any exclusions, such as pre-existing medical/health conditions or circumstances, that can make me ineligible for healthcare coverage?
- Am I or any family member eligible for Medicare, MassHealth, Commonwealth Care or other non-employer sponsored health plans?
- Are stand-alone dental or vision plans available?

### **Benefits**

- Does the health plan include regular check-ups?
- Is preventive healthcare included within the health plan?
- Are hospitalizations and major medical expenses covered?
- Does this health plan cover extra services, such as therapy, dental, vision, mental health services, alternative therapies or equipment?
- What services are excluded from this plan?
- Are any of my prescriptions not covered under the plan?
- Is there a waiting period before coverage commences?
- Does the plan have a wellness component i.e., fitness or lifestyle management resources?

companies require before they will pay for a service, prescription or supply where the healthcare provider must show cause why the patient needs the medication or treatment.

### **Provider network**

A group of doctors, hospitals, and other healthcare providers who work together with a health plan to provide healthcare services.

### **Referral**

A note from one health provider for a patient to receive care from another provider. Some plans require that referrals have “prior authorization” by the health plan in order to be reimbursed. Each plan has its own rules about authorizations for referrals and may restrict referrals to its own networks of specialists.

### **Self-funded employer sponsored plan**

A health plan provided by an employer to eligible employees and their dependents where the employer does not purchase an insured health plan but rather pays for covered benefits from its own resources. Self-funded employer sponsored plans are not subject to state insurance laws and are not required to include mandated benefits.

### **Utilization Management**

A process where healthcare professionals review planned hospital admissions, surgery, and other procedures to make sure they are medically necessary and appropriate.

## TYPES OF PLANS:

### Health Maintenance Organization (HMO)

HMOs cover hospital, medical and preventive care. Except in a case of emergency, patients are only covered if they receive care from their HMO's network of providers.

### Preferred Provider Plans (PPP)

PPPs cover hospital, medical and preventive care. These plans have a network of preferred providers in addition to out-of-network providers. PPPs will pay more of the cost if you use in-network providers, i.e., the plan will pay 100% of services for in-network providers and 80% for out-of-network providers.

### Major Medical Plans/ Indemnity Plans

Major medical plans cover hospital and medical expenses for an accident or illness. Some may also cover preventive care and office visits. These plans cover a percent of covered costs, i.e., the plan pays 80% of a hospital stay and the patient pays the other 20%.

### Health Savings Account (HSA)

HSAs are accounts that allow individuals covered by high-deductible health plans to receive tax-preferred treatment of money saved for medical expenses. All money in a HSA must be used within that fiscal year or the balance is forfeited.

### High-Deductible Health Plan (HDHP)

HDHPs are plans with higher annual deductibles than typical health plans and an out-of-pocket maximum. Plans differ and offer a range of different services, prescriptions or supplies, so it is always a good idea to first evaluate

your own and/or your family's needs before choosing a plan. It is also important to recognize that most plans offer different payment options or various payment structures. Be sure to compare each plan and determine whether a plan meets your health and financial needs.



## QUESTIONS TO ASK BEFORE PURCHASING A HEALTHCARE PLAN:

### Coverage

- Are there any special healthcare needs to consider?
- Are certain specialists or specific treatments required?
- Will I need chronic care or costly medications?
- Are any types of mental health benefits provided?
- Do I want access to specific doctors?
- Do I want direct access to specific specialists?
- Do I want access to a clinic that is open in the evenings?
- Do I want prescription drug coverage?
- Do I want ancillary services such as vision, dental or medical equipment?
- Is home health care covered?
- Is inpatient rehabilitation or skilled nursing care covered?

### Provider Choice

- Does the plan allow the choice of specific doctors or hospitals?
- Does this plan have provider networks? If so, is my current doctor or hospital part of the network?