# Navigating the Path of Insurance Coverage for Your Family

Please note that every situation is different and the information below are general guidelines

## Five things to know about Insurance

1. For certain diagnoses, insurance companies have dedicated departments and Case Managers. Case Managers are there to help you navigate through your illness and they provide their services at no cost. Ask for one.
2. Know the ins and outs of your insurance plan so that you know what you and your family are entitled to. Your Plan Summary Document will have the details and should be on your company's intranet. If it's not, call your HR department and ask for the full document (sometimes company's post shorter documents, so make sure you get the full document).
3. Insurance companies tend to deny claims that are eligible and if no one questions it, the claim does not get paid. Denied claims can be reprocessed and/or appealed.
4. If something doesn't make sense or sound logical, it probably isn't correct, so keep asking questions to the insurance company (ie: your claim is denied, but you think it should be paid based on your plan summary document). If the person you are speaking with can't help you, either ask for a manager or call back to get another representative.
5. Out-of-network providers are sometimes negotiable. Make sure to negotiate before services if using out of network providers; or at least make sure to ask what the cost will be so that you are not surprised when you get a bill.

## Understanding your insurance plan

Insurance plan rules and benefits vary based on so many factors, which is why it is really important for you to understand your plan:

a) **Is your plan self-funded or fully-insured?**
   - Fully-Insured plans must follow state mandates. State mandates vary based on group size.
   - Self-funded plans do not have to follow state mandates and can customize their plan (sometimes these plans have more coverage than state mandated ones)

b) **Is it a small group plan (under 2-50 employees) or large group plan (over 50)?**
   - Size will also play a part in coverage

c) **Who are your benefits through?**
   - ie: Your employer, Union, Employee leasing company or professional employer organization, individual policy, etc. With each of these insurance sources come different plan designs and benefits.

d) **Where does the plan originate from?**
   - It originates from the state where the company is headquartered
     - If it is based out of Kansas City, NJ mandates will not have to be followed
     - NJ is a heavily mandated state for insurance (which is why in our state the premiums are so high)

e) **Is the plan a state plan or a national plan?**
   - National plans are not subject to NJ mandates, if the plan is sitused out of NJ.

f) **Is your HR department partnering with you?**
   - They should be your advocate to navigating through the system and figuring out what is covered and how to get claims paid. A good relationship here is critical. If they can't help you, ask to speak to the insurance broker who may be able to help.

## What to do if your claim is denied

First, don't panic, many claims get denied. It doesn't mean the service isn't covered. There can be many reasons for this (wrong ID number, wrong date of birth, wrong coding, etc). If everything is not 100% correct when a claim is submitted, the insurance company will deny the claim.

- Call the insurance company and find out why the claim was denied. Sometimes all it takes is for them to reprocess the claim.
    a. Keep a notebook to document all of your calls to the insurance company: who you spoke to (ask for their name), date and time, what they told you, and the reference number (there is a reference number for every time you call and this number(s) will identify your case). Having a record of every call and conversation is very important.
    b. Keep asking questions to find out what needs to happen to get the claim processed (this is where knowing your plan will come in handy)

        **Side note – If you speak with a really helpful and informative representative at the insurance company, let them know how helpful they have been and how thankful you are for their help and then, kindly ask for their direct line or email in case you have questions in the future. Let them know that you will not abuse the contact information, but because this is so overwhelming and insurance can be so confusing, you feel like they can really help you navigate this stuff. If you get their contact information, use it!!!! A contact like this at the insurance company can make your life a lot easier.

- Call your provider's billing office to see why the claim got denied. A good billing department will understand the in's and out's of insurance and should be able to help you. If it's because of a wrong code, they will be able to resubmit the claim on their end.
    a. When you are working with the insurance company to reprocess/appeal the claim, let your provider know. Providers will usually put the bill on hold until it gets worked out, which will keep you out of collections. If they don't volunteer to do this, ask them to.

- If the claim gets denied again (after being reprocessed), you will be able to appeal the decision.

a. Every insurance company has an appeal process, so ensure you understand what needs to be done and the timeframe in which it needs to be done
b. There should be two opportunities to appeal a denied claim (initial appeal and final appeal)

This process will take a lot of time and energy. Find out if your employer has a health advocate company that they contract with. If so, these services are usually free of charge to employees, so reach out to them for help with reprocessing and/or appealing your denied claims. This is what they are there for and they will take on the burden of this process.

Note that it can take months before a claim issue is resolved, but if you know your plan well, ask a lot of questions, document your calls and don't take "no" for an answer when you know your service should be covered, you will get through it.

## Paying bills

You will be responsible to pay certain bills, however, ensure that everything is correct before you make payment:

- Don't pay any provider bills until you see the matching Explanation of Benefits (EOB) from your insurance company
    a. First make sure the bill was processed through insurance and insurance paid their portion (ie: make sure the claim was not denied)
    b. Make sure any bills you receive from providers match the 'Member Responsibility' column on your Explanation of Benefits (EOB).
    c. If the amounts from the provider and the carrier are different, call either the insurance company or the provider and find out why. The bill may need to be reprocessed again.

- The amount of bills might be overwhelming, but most hospitals and other providers have payment plans (free of interest). Call the provider and ask to go on a payment plan. Some will have a timeframe (ie: must be paid in 6 or 12 months), others won't. In order to stay out of collections, you must have agreed to a payment plan. If you make small payments on your own, without a payment plan, it won't count towards keep you out of collections.

- Don't ignore bills that you know or think are wrong. You must contact the provider and let them know you do not think it is right. After a few notices from the provider, the next one is usually a collection notice and whether it is right or wrong, it can be difficult to rectify once it gets to this point. So, address any bills that you are not paying with the provider because they will not go away on their own.

- Be aware of provider bills that are not your responsibility. Providers and labs will send out invoices for services that were either already paid by insurance or that are not your responsibility. Often times the invoice amounts are low and odd numbers (for ex $14.77 due) and many people will pay these bills. Make sure you know whether or not it is your responsibility.

# Healthcare Definitions

**Copay:** A flat amount that you pay for a covered service. For example, $20 copay.

**Deductible:** The amount you pay for covered services before your insurance plan starts to pay. For example, if your plan has a $1,000 deductible, you pay the first $1,000 of covered services before the plan starts paying.

**Coinsurance:** Your share of the costs of a covered service, stated as a percentage of the allowed amount for the service. For example, if your coinsurance is 30%, then you pay 30% and the insurance plan pays 70%.

**Maximum Out-of-pocket Limit:** This is the sum of any in network deductibles, copays and coinsurance for the plan period. Once you hit the Maximum Out-of-pocket, the plan pays 100% of the cost of covered benefits.

**Network:** The providers, facilities and suppliers the health insurance company has contracted with to provide services. These are considered In Network.

**Allowed Amount:** In network providers have a contract with the insurance company. The Allowed Amount is the contracted rate agreed on by both parties and is the maximum that the plan will pay for a covered service. This may also be called the "negotiated rate".

**Balance Bill:** This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is $200 and the allowed amount is $120, the balance bill would $80. An In-Network provider is not allowed to balance bill you. This happens most often when you see an out-of-network provider.

**Explanation of Benefits (EOB):** This is a statement from the insurance company that provides details on payment for medical services you received. It shows the billed amount, the allowed amount and the member responsibility. The member responsibility should match what the provider or facility is billing you.

**Provider:** Term provider can be used to describe a doctor, hospital, lab etc.

**Health Advocate:** A person or company that helps advocate on your behalf. This can sometimes be provided by your employer at no charge.