



Brought to you by the State of Oregon

The State of Oregon is working with **HealthCare.gov** to help Oregonians get health care coverage.

Have a problem with your insurance?

If you have problems after you sign up for insurance, please contact the Oregon Insurance Division.

Visit insurance.oregon.gov and click on "Get Help"

Call 1-888-877-4894

Email cp.ins@oregon.gov

Other languages or formats?

Call **1-855-268-3767** (toll-free) between 8 a.m. and 5 p.m. Monday through Friday to request this information in Español, Русский, Tiếng Việt, 汉语, 漢語, large print, or another format.

440-5079 (2/16/COM)

Using your health insurance

A step-by-step guide to understanding and using your health insurance



Get answers and learn more

OregonHealthCare.gov



Take the next step

You've taken the first step to better your health by enrolling in a health insurance plan. Now is the best time to ask questions and take action so you'll know how to use your insurance when you're sick and when you're well.

This is a guide to the basics of understanding your insurance plan and what to do when you have questions about specific coverage, billing, and everything in between.

STEP 1: UNDERSTANDING YOUR COVERAGE

Once you sign up and **pay your first month's premium** (prior to the effective date of coverage), your insurance company should send you a membership package that includes:

- 1. Summary of Benefits and Coverage:** A document that tells you the key features of your plan, such as what is covered and what is not. Be familiar with your costs (premiums, co-payments, deductibles, co-insurance).
- 2. Insurance Card or other document:** This is your proof of insurance with information any medical provider will need in order to provide services. Your card or document may look different from this one, but will have the same type of information.

INSURANCE COMPANY NAME

Plan type	Member Name: Jane Doe
Effective date	Member Number: XXX-XX-XXX
	Group Number: XXXX-XXX
Prescription Group # XXXXX	PCP Copay \$15.00
	Specialist Copay \$25.00
Prescription Copay \$15.00 Generic	Emergency Room Copay \$75.00
\$20.00 Name brand	Member Service: 800-XXX-XXXX

STEP 2: PREPARING FOR YOUR HEALTHCARE

While you're thinking about health insurance, get ready for your healthcare needs by:

Finding a provider

- Call your insurance company, search their website, or check the member handbook for providers in your network. Sometimes networks change, so it's a good idea to double-check with your health plan.
- Once you decide which provider you'd like to see, check with your insurance company if you need to ask them before you make an appointment.

Scheduling an appointment

- Call to make the appointment. Let them know you are looking for a new primary care provider and ask for a "yearly exam" or a "wellness visit".
- When you meet with your provider, share your family health history, any current medications you take, and questions or concerns you have about your health.

Learn More



STEP 2: HEALTHCARE, CONTINUED

Deciding if the provider is the right one for you

- You should have a provider that you can trust and feel comfortable talking to. After your first visit, if you have concerns about your provider, decide whether you want share your concerns with the provider and give them another try, or research other providers in your network.

Planning your next steps

- It's important to follow through with your provider's recommendations. For example, if they recommended a specialist, did you make an appointment?

STEP 3: UNDERSTANDING INSURANCE BILLING

You and your insurance company share the costs of care covered by your plan. Call the member services for your health plan to find out details or read the summary of benefits.

How health insurance typically works:

1. You give your provider your insurance card at the time you seek medical care.
2. You pay the provider any co-payment required by the plan.
3. Usually, the provider bills the insurance company.
4. The insurance company sends you an **Explanation of Benefits** (or **EOB**). This is an overview of the total charges for your visit. It lists what the provider charged, the maximum amount the insurance company allows for that procedure, what the insurance company paid as its share, and your share of costs. **An EOB is NOT A BILL.**
5. You will most likely get a bill separately from the provider. You pay your share of the bills.

STEP 4: KNOWING YOUR RIGHTS

After reviewing your EOB, you may have questions regarding the details or are unhappy that certain services weren't covered by your plan. You may be able to file a complaint and get the services covered.

You can contact your insurance plan directly. Insurers have call centers to assist plan members. This number is listed on your insurance card or in the plan handbook.

If you would like third-party assistance, have additional questions about your rights, or if you need help to understand something related to insurance billing or coverage, you can contact the Oregon Insurance Division to speak with a consumer advocate, free of charge.

Insurance advocates are available at the toll free hotline: **888-877-4894**.

You can also email cp.ins@state.or.us or look up insurance tips at insurance.oregon.gov.



GLOSSARY OF INSURANCE TERMS: Key terms you may come across in the summary of benefits or when seeking medical services.

Co-insurance: Your share of the costs of a covered health care service, calculated as a percent of the allowed amount for the service. You pay co-insurance plus any deductibles you owe.

Co-payment (or **co-pay**): An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit. A copayment is usually a set amount, rather than a percentage.

Deductible: The amount you pay for health care services before your health insurance or plan begins to pay within a benefit year. Not all out-of-pocket payments you make count toward reaching the deductible. Plans vary – read your Summary of Benefits and Coverage.

Network: The facilities, providers, and suppliers your health insurer has contracted with to provide health care services. Contact your insurance company to find out which providers are "**in-network**." If a provider is "**out-of-network**" it might cost you more to see them.

Out-of-pocket maximum: The most you pay during a policy period (usually one year) before your plan starts to pay 100% for covered essential health benefits. This limit includes deductibles, co-insurance, copayments, or similar charges and any other expenditure required of an individual for a qualified medical expense. The maximum out-of-pocket cost limit for any individual Marketplace plan for 2016 can be no more than \$6,850 for an individual plan and \$13,700 for a family plan.

Premium: The amount you pay for your health insurance or plan. You usually pay it monthly or quarterly. It does not count toward your deductible, your copayment, or your co-insurance. If you don't pay your premium, you could lose your coverage.

Preventive Services: Routine health care including screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems or to detect illness at an early stage when treatment is likely to work best. This can include services like flu shots, vaccines, and screenings, depending on what is recommended for you.