STEP 2: HEALTH CARE, 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 if you want share your concerns with the provider and give him or her another try or research other providers in your network.

Planning your next steps

- It is important to follow through with your provider's recommendations. For example, if your provider recommends 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 the plan requires.
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 separate bill from the provider. You pay your share of this bill.

STEP 4: KNOWING YOUR RIGHTS

After reviewing your EOB, you may have questions about the details or may be unhappy that certain services were not covered by your plan. You may be able to file a complaint and get the services covered.

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

If you want third-party help, have more questions about your rights, or if you need help to understand something about insurance billing or coverage, call the Division of Financial Regulation's consumer advocates, free of charge.

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

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

STEP 5: SUBMITTING A REIMBURSEMENT REQUEST

The program will reimburse you for allowed in-network out-of-pocket costs up to $1,000 (individual enrollment) or $2,000 (family enrollment).

To get reimbursed for your out-of-pocket costs, you need to submit:

1. **COFA Program Reimbursement Claim Form**
2. Copy of original receipt from your doctor, pharmacy, or other provider
3. A copy of your insurance company's Explanation of Benefits

Type or clearly print your information into the form, then print and mail or fax (along with a copy of your Explanation of Benefits and your official receipt) to the program:

COFA Premium Assistance Program
Oregon Health Insurance Marketplace
P.O. Box 14480
Salem, OR 97309
Fax: 503-947-7092

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 co-payment 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 him or her and the COFA program will not be able to reimburse you for these costs.

Out-of-pocket maximum: The most you pay during a policy period (usually one year) before your plan starts to pay 100 percent for covered essential health benefits. This limit includes deductibles, co-insurance, co-payments, or similar charges and any other expenditure required of an individual for a qualified medical expense. The maximum out-of-pocket cost limit for a COFA program-approved plan for 2020 can be no more than $1,000 for an individual plan and $2,000 for a family plan.

Premium: The amount after advanced premium tax credits that the COFA program pays for your health insurance or plan. It does not count toward your deductible, your co-payment, or your co-insurance.

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 such as flu shots, vaccines, and screenings, depending on what is recommended for you.