MISSISSIPPI
HEALTH ADVOCACY
PROGRAM

A Member of
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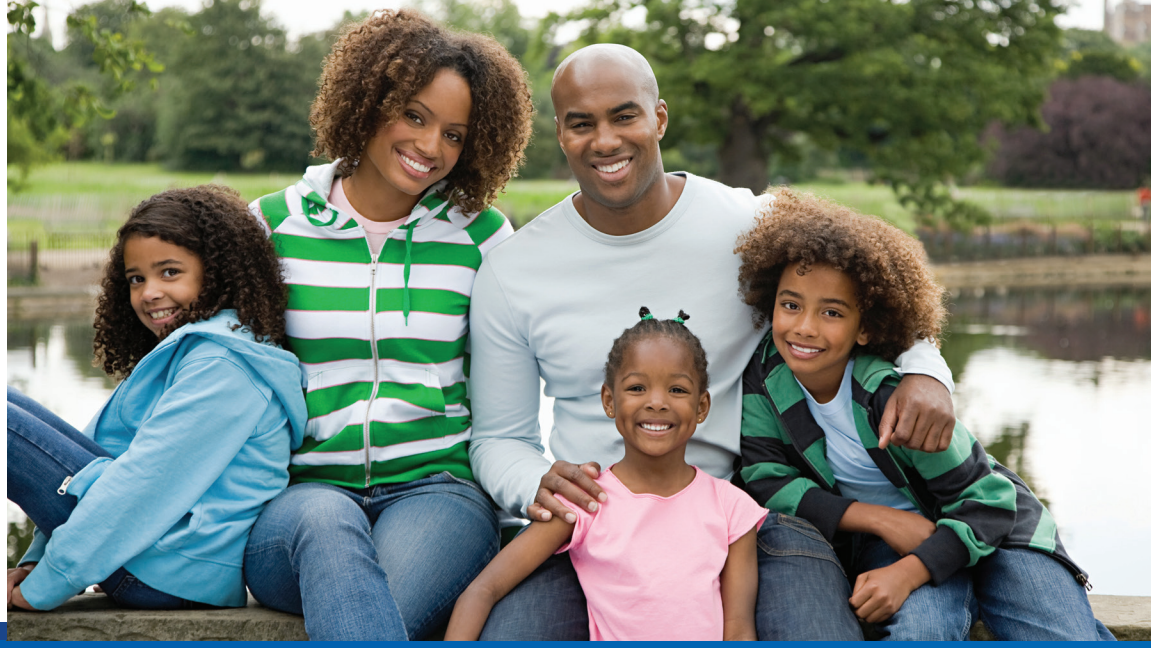

Health Insurance Marketplace Consumer Guide

What you need to know about health insurance, your coverage options, prescription medication, and how to appeal insurance decisions

HEALTH HELP
mississippi

Call our Counselors if you have any questions:

1-877-314-3843

Monday – Friday from 9 a.m. to 5 p.m.

Health Help Mississippi
800 N. President Street
Jackson, MS 39202

www.healthhelpms.org

Important Account Information For You To Keep Up With

Healthcare.gov

Username: _____

Password: _____

Monthly Tax Credit: _____

Your Marketplace Health Plan

Provider: _____

Account Number: _____

Monthly Premium (What YOU have to pay): _____

Local Agent: _____

Your Plan Start Date: _____

Notes: _____

_____

Basic Insurance Terms

Accumulation Period (Collection Period): The time it takes for you to gather funds toward your deductible. The period is usually one year, and then the amount resets.

Claim: A bill for medical services submitted to the insurance company.

Cost-sharing (Share of Costs): The cost of non-covered services that you pay out of your own pocket, including deductibles, coinsurance, and copayments, but not premiums.

Co-payment: A fixed amount that you pay for a covered health care service at the time of service. Prices may vary depending on the type of health coverage you have. (for example, $25)

Deductible: A deductible is the amount you pay for your health care services before your insurance plan will pay. For example, if your deductible is $1,200, your plan may not pay until you have paid this amount.

Group: A plan offered by an employer or employee organization that provides health coverage to employees and their families.

Network: The facilities, providers, and suppliers that your health insurer has contracted to provide health care services, such as hospitals and doctors.

Premium: The amount that must be paid for your health insurance plan. You and/or your employer usually pay it monthly, quarterly, or yearly.

Open Enrollment Period: The yearly period when people can enroll in a health insurance plan. You can only enroll outside of this open enrollment period if you qualify for Special Enrollment Periods that allow people to enroll if they have certain life events, like getting married, having a baby, or losing other coverage. You can apply for Medicaid or CHIP at any time of the year.

Using Your Coverage

Getting Started

Now that you have enrolled in a health plan the next thing you should do is pay your premium. You can talk with your insurance company about the best way to make your payments. After enrolling and paying your premium your insurance company should mail to your home a welcome packet that includes your insurance card. It's very important to take your insurance card with you to any doctor visits.

What's a Premium?

Premium is what you pay monthly, quarterly or yearly for your insurance.

Finding a Provider

To make sure you get the most out of your insurance, it is important that you find a doctor that is within your insurance company's network.

There are a few ways for you to find out if a doctor or hospital takes your insurance.

1. If you know a doctor you want to see, call the doctor's office ask if they accept your insurance. You should also call your insurance company to make sure that this doctor is in your network.
2. Call your insurance company and ask for a list of in-network providers in your area. You can also check the insurance companies website and search their provider directory. By choosing a provider from this list, you can be sure that a doctor is in your insurance company's network.

On Your Insurance Card You Will Find:

- Insurance plan number
- Group number, and
- Contact information for the company.

It is very important to verify that your doctor is in a plan before you select it.

Primary Care Provider

Whether it's a doctor, physician assistant or nurse practitioner, a primary care provider is who you should see for your common medical problems. They can also conduct health screenings and physical exams, and provide primary, wellness, and preventive health care.

Seeing a primary care provider is a good way to take advantage of all of your health insurance benefits including the feature allowing for free preventive services. Preventive services is care designed to keep you healthy and to catch or avoid serious issues before they worsen. In short, preventive care will keep you healthy and help you save money.

Free Preventive Care

With your new insurance you should visit a primary care provider and take advantage of free preventive items.

Most preventive care is fully covered by your health insurance plan. That means that you do not have to pay anything for it.

Here Are Some Examples Of Preventive Care:

- Annual physical
- Well woman visits (your annual visit to the gynecologist)
- Birth control
- Flu shots & other select vaccines
- Hepatitis A
- Hepatitis B
- Herpes
- Human papillomavirus (HPV)
- Meningitis
- Pneumonia
- Tetanus, diphtheria, pertussis (TDaP)
- Chicken pox (Vericella)
- Blood pressure tests
- Mammograms
- Colonoscopies
- Help quitting smoking
- Nutritional counseling and help losing weight
- Breastfeeding support
- STI (Sexually Transmitted Infection) testing
- HIV Screening

Your Co-Pay

A co-payment is the fixed amount you pay for a covered health service at the time of your visit. The amount of your co-payment depends on your plan and what type of provider you are seeing. (For example, $25)

Deductible

A deductible is the amount you pay for your health care services before your insurance plan will pay. For example, if your deductible is $500, your plan may not pay until you have met this amount.

Cost-sharing

The portion of your medical bill you pay, for certain services after you have paid your deductible and co-pay.

Out-of-Pocket Maximum

The highest amount you will spend out of pocket for healthcare. If you reach this amount, your insurance company may be responsible for all of your costs above that amount.

What To Expect At The Doctor

If this is your first time using your new insurance or you are seeing a new doctor, there are a few things to remember:

- Have your insurance card with you.
- Bring a photo ID (Driver's license, government or school ID, passport, etc.)
- Show up early to fill out and complete forms.

You should also expect to make a co-payment to your doctor or provider on your visit.

In addition to your premium and co-pays, there are other things that may affect how much you spend on your healthcare.

Can I Go To My Regular Pharmacy To Get My Medication?

Just like different health plans cover different medications, different health plans allow you to get your medications from different pharmacies (called "in-network pharmacies"). Call your insurance company or visit their website to find out whether your regular pharmacy is in-network under your new plan and, if not, what pharmacies in your area are in-netwrok. You can also learn if you can get your prescription delivered in the mail.

How Do I Know If My Prescription Is Completely Or Partially Covered?

To find out which prescriptions are covered through your new Marketplace plan:

1. Visit your insurer's website to review a list of prescriptions your plan covers:

   Humana Website (www.humana.com)

   Magnolia Website (www.magnoliahealthplan.com)

   United Healthcare (www.uhc.com)

2. See your Summary of Benefits and Coverage

3. Call your insurer directly to find out what is covered. Have your plan information ready. The number is on your insurance card, the insurer's website, or the detailed plan description in your Marketplace account.

   Humana's Call Center: 1 (800) 448-6262

   Magnolia's Call Center: 1 (877) 687-1187

   United Healthcare Call Center: 1 (866) 633-2446

4. Review any coverage materials that your plan mailed to you.

Your Co-Pay

A co-payment is the fixed amount you pay for a covered health service at the time of your visit.

The amount of your co-payment depends on your plan and what type of provider you are seeing. (For example, $25)

Get Emergency Care

In an emergency, you should get care from the closest hospital that can help you. That hospital will treat you regardless of whether you have insurance.

So What Counts As A Real Emergency, That Your Insurer Will Pay?

Health plans are required to pay for an ER visit where a reasonable person believes his or her health or life is threatened. That means that if you are having strong chest pains that would scare most people into thinking they may be having a heart attack that person may qualify as a real emergency.

Some Examples Of An Emergency

- Bleeding that won't stop
- Trouble breathing
- Coughing up or spitting up blood
- Neck or back injury (**DO NOT MOVE SOMEONE WHO MIGHT HAVE BROKEN THEIR BACK**)
- Fainting or someone does not respond to you when you talk or touch them
- Poisoning or drug overdose
- Unusual and severe headache that comes on suddenly
- Any sudden and unexplained changes in behavior, walking, speaking, or confusion

What Does It Mean That Insurance Companies Cannot Charge Me More?

In most cases insurance plans can't make you pay more in copayments or coinsurance if you get emergency care from an out-of-network hospital. There are some "grandfathered plans" that do not have to comply with this rule. You should also keep in mind, that there might be doctors within the ER unit that may bill you for charges not covered by your insurer. This happens when your doctor has not contracted with your insurance company.

This practice is called "balance billing." Balance billing happens when hospitals make arrangements with doctors for medical services within the hospital. These doctors are not technically hospital employees and make their own decision on whether to participate with the insurance company. So these doctors may send you a bill directly for any costs (the balance) the insurance company does not pay.

Will I Have To Pay For My Emergency Hospital Visit?

This depends on the plan that you chose and if the hospital has particular rules in place.

What Can You Do If Your Insurer Won't Pay For A Procedure Or Claim?

Internal Appeal

You can file an internal appeal if your health plan won't provide or pay some or all of the cost for health care services you believe should be covered.

Three Steps in the internal appeals process:

1. You file a claim: A claim is a request for coverage. You or a health care provider will usually file a claim to be reimbursed for the costs of treatment or services.

2. Your health plan denies the claim: Your insurer must notify you in writing and explain why:

    - Within 15 days if you're seeking prior authorization for a treatment
    - Within 30 days for medical services already received
    - Within 72 hours for urgent care cases

3. You file an internal appeal: To file an internal appeal, you need to:

    - Complete all forms required by your health insurer. Or you can write to your insurer with your name, claim number, and health insurance ID number.
    - Submit any additional information that you want the insurer to consider, such as a letter from the doctor.
    - If you still have questions, call 877-314-3843. Health Help Mississippi can assist you with filing an external appeal.

What happens if your insurance company denies your internal appeal?

Filing an external appeal

If your health insurance company doesn't pay for a specific healthcare provider or service, you have the right to appeal the decision and have it reviewed by an independent third party.

Your insurance company must first notify you in writing within a set amount of time (based on the type of claim you filed) to explain why they denied coverage. They also must let you know how you can appeal their decisions.

If the timeline for the standard appeals process would seriously put your life at risk, or risk your ability to fully function, you also can file an appeal that would get you a quicker decision. If you meet the standards for a quicker review, the final decision about your appeal must come as quickly as your medical condition requires, and no later 72 hours after your request for external review is received.

If you have questions contact Health Help Mississippi at:
601-354-3470 or 1-877-314-3843.

HEALTH HELP
mississippi

High quality and affordable health care is available to those eligible in Mississippi through the Medicaid program or children via the CHIP program. On March 23, 2010, the Patient Protection and Affordable Care Act was signed into law which created greater access to health for all Mississippians. Health Help serves as a resource to help Mississippians navigate the new benefits under health care reform.

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