



Understanding Your Health Insurance Policy Documents

When you purchase a health insurance policy, your insurance company agrees to financially protect you if you get sick or hurt by helping to pay for healthcare services you need. They also agree to provide preventative services and screening tests, which must be provided at no cost to you.

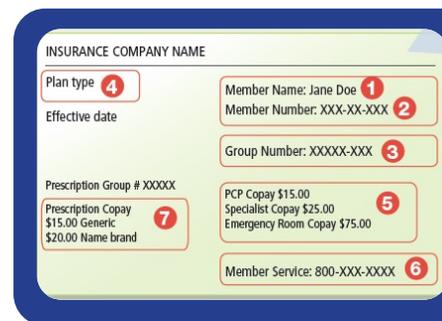
Past that, the additional benefits and coverage provided by your policy are different across each insurance company and policy. But it's still vital to know what is inside your plan. You might not need these services right now, but you or a family member may need them in the future and it's better for everyone if you are prepared with knowledge about your health insurance policy.

WHAT DOCUMENTS SHOULD I PAY ATTENTION TO?

Member/Subscriber ID Card

After you purchase your health insurance policy, the insurance company will provide you with an insurance card. This is also called a member ID card or a subscriber ID card. During your first visit to your doctor or pharmacy be sure you

provide this card to them. They will probably make a copy of your insurance card to have on file, but it's a good idea to have your card handy on subsequent visits just in case. You should always carry the card in your wallet in case you must visit a hospital or emergency room immediately.



- 1 Member name. This is usually printed on your card.
- 2 Member number may also be called a subscriber number. Each person covered by a health insurance policy has a unique ID number. This number is used to identify you, so your provider knows how to bill your health plan. If your spouse or children are also on your coverage, your member numbers may look very similar.
- 3 Group number. This number is used to track the specific benefits of your plan. It's also used to identify you, so your provider knows how to bill your insurance.
- 4 Plan type. Your card might have a label like HMO, PPO, HSA, Open or another word to describe the type of plan you have. These labels tell you what type of network your plan has and which providers you can see who participate "in-network."
- 5 Co-payment. These are the amounts that you will owe when you receive medical care.
- 6 Phone numbers. You can call your health plan if you have questions about finding a provider or what your coverage includes. Phone numbers are typically listed on the back of your card.
- 7 Prescription co-payment. This is the amount you will owe for each prescription you have filled.





Summary of Benefits and Coverage Document

The information provided on a Summary of Benefits and Coverage document is important not only after you purchase a policy but also while you are shopping for coverage. You have the option to look at the document before you purchase so you can review the benefits offered as well as the prices. The policy must offer two different health scenarios to help people compare benefits and prices. The two scenarios are pregnancy/childbirth and diabetes care.

You must be given copies of the Summary of Benefits and Coverage at important points in the enrollment process, including at enrollment or renewal. However, you can ask for a copy of the Summary of Benefits and Coverage at any point.

First Page | Asks basic questions like, what is the overall deductible for the plan? Do you need a referral to see a specialist? What is the most you will pay in a year for healthcare services under this plan? It also answers these questions in easy-to-understand language. In addition, if you view the document online, it is easy to click on a health insurance term you might not recognize and get a quick definition.

Second Page | Goes over common medical events like doctor's office visits, tests like x-rays and bloodwork, medications, surgeries and emergency room care. It shows what you will pay if you use providers that are inside your plan's network of contracted health providers versus if you go outside the plan's network. It also lists any limitations, exceptions or other important information you may need to know about a particular health service.

Third Page | Lists any services that are excluded. A commonly excluded service is something like cosmetic surgery. Your health insurance is most likely not going to pay for services like plastic surgery or other procedures that are done solely for cosmetic reasons.

This page also lists other services that this policy covers with limitations or only in certain circumstances.

Last Page | Provides examples and estimates of how the plan covers medical care you may need. The document outlines what the policy would pay versus what the policy holder would be responsible to pay.

Summary Plan Description

This document is similar to the Summary of Benefits and Coverage because it is intended to provide easy-to-understand information about their policies. This Summary Plan Description is going to apply only for those people who receive their health insurance from the employer. This is a requirement of the Department of Labor.

Policy Language

Your plan's policy language can also be referred to as a plan booklet, plan document or policy document and is the most comprehensive of any plan document. It provides information like:

- Eligibility (who is covered - self, spouse, dependents, etc.)
- Detailed information on covered benefits
- Information about exclusions/ non-covered benefits
- How to file a claim
- How to file an appeal if coverage is denied
- Benefits outside of medical if included in your policy (dental or vision)

It is easiest to get this information on your health policy's member portal or website.

