Tangohealth | Solutions for Employer-Sponsored Healthcare

HEALTHCARE LITERACY:

6 Things You Need to Know About Using Your Medical Plan

Enrolling in a medical plan is one thing. Understanding your plan is another.

During a typical day, you're ready to celebrate if you got off work at 5 p.m., shuttled the kids off to their extracurricular activities, and squeezed in a moment to pay the bills. Who has time for reading a complex insurance policy? Understanding your health plan is important so that you can feel confident you are getting the most out of your plan. And we're here to help. We know you are busy, so we created a guide that covers 6 common (real-life) scenarios you might encounter—explaining what to know and what to consider.

Real-Life Scenario #1:

Reading Your Explanation of Benefits

You recently went to a surgical center for outpatient surgery. You know there's a lot of paperwork involved, but you're a bit surprised when you receive a letter titled "Explanation of Benefits" that looks like a billing statement. Before you write that check, you should know that an Explanation of Benefits (EOB) is actually not a bill. Instead, it's a document that helps you understand how your benefits impacted your latest medical expense.

Think of an EOB as a way to quickly see:

- The actual cost of your medical bill is based on the retail or list price.
- How much your insurance provider will cover based on negotiated prices.
- What part you're responsible for based on the negotiated prices.

To better understand your EOB, here are some essential terms to know:

TERMS TO KNOW

- **Allowable Amounts:** Next to the actual cost of your bill, you should notice something called "allowable amount." This is the negotiated amount you or your insurance will allow for a medical services. If the cost of the service is higher than the allowable amount, the difference is written off as a contractual agreement, if the provider is in-network.
- **Cost-Sharing:** In a nutshell, cost-sharing is how you're responsible for helping an insurance company shoulder your medical bill. You'll likely share costs in three ways, which we've defined below (these are included in your EOB).

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  - **Deductible:** A deductible is the amount you'll have to pay before your policy will help cover your bill. For instance, if the allowable amount for your minor surgery is $1,400, but you haven't met any of your $1,500 deductible, you would pay the full $1,400. If you have met your deductible, then your coinsurance would kick in.
  - **Coinsurance:** Once you've paid your deductible, you'll need to think about coinsurance. Coinsurance is a percentage of your bill that you'll need to pay (for instance, 10% or 20%).
  - **Copayment (Copay):** Unlike deductibles and coinsurance, a copayment is a fixed amount that you must pay for a healthcare service determined by your insurance plan. For example, a health insurance company may set a $30 copay for a regular doctor visit.
- **Out-of-Pocket:** Generally speaking, out-of-pocket expenses are what you—not the insurance company—pay. You'll find how much you've paid out of pocket since you've had your insurance policy on your EOB. However, you do have a safety net called an out-of-pocket maximum. Once you've hit this amount, there's no need to pay a deductible or coinsurance amount for the services covered by your policy for that benefit year. However, be aware that your out-of-pocket maximum usually doesn't apply to copayments. The good news is, copayments for standard health needs won't break the bank—as copays usually fall under $100.

WHAT TO CONSIDER

Just because EOBs aren't bills doesn't mean they don't belong in your filing cabinet. In fact, we recommend filing away your EOBs to prove your medical expenses if you have an HSA account (more on that in a bit).

Real-Life Scenario #2:

Planning a Medical Procedure

Maybe your child needs his or her tonsils removed. Or perhaps you're realizing that it's time to take the plunge...and undergo a much-needed knee surgery. Whatever situation you're facing, understanding your benefits is the key to smoothly planning a medical procedure. Your benefits impact *which* doctor, hospital, or organization you choose. They even affect *how* you'll request a medical procedure. To see why, let's go over some important terms to understand.

TERMS TO KNOW

- **Network:** To save on medical bills, insurance companies create a network of healthcare providers that they partner with. As the Texas Department of Insurance explains, healthcare providers give "a lower cost in exchange for more patients." Membership in a network is one way healthcare providers get more patients.
- **In-Network:** When you go to a doctor's office or hospital that your insurance company has partnered with, you've chosen an in-network provider. This means you can expect to pay less because of negotiated rates.
- **Out-of-Network:** If you choose a healthcare provider that hasn't made a deal with your insurance company, you've chosen to go out of network. As you might expect, for some medical plans, going out of the network can come with a steep price tag.
- **Primary Care Physician (PCP):** This is simply a fancy term for your family doctor. Having well-rounded medical knowledge, a PCP keeps tabs on your general health, directing you to a specialist if needed. Some plans require you to visit your PCP first before you can see a specialist.
- **Specialist:** A specialist is a doctor who has chosen to focus on a single area of care. For instance, a pulmonary specialist has devoted his or her career to treating lung issues.

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- **Health Maintenance Organization (HMO) Plan:** An HMO is a group of healthcare providers who've made an agreement with your insurance company...sometimes to work exclusively with members like you.

  When it comes to HMO medical plans, finding someone in-network is very important. Going outside the HMO network can mean you're completely responsible for your medical bill. With an HMO, you'll need to select a primary care physician. And, if you experience a medical issue that requires an expert, you'll need that doctor to refer you to an in-network specialist.
- **Preferred Provider Organization (PPO) Plan:** With a PPO plan, you'll still have a network of healthcare providers. However, you're also able to choose a doctor, hospital, or practice that's outside of the network (for a higher price tag). Unlike an HMO plan, you don't need to choose a primary care physician from your network, and you can make an appointment directly with a specialist without a referral.
- **Point of Service (POS) Plan:** POS medical plans are known as hybrids of HMOs and PPOs. With a POS, you will need to select a family doctor. However, you'll still get coverage for doctors, hospitals, or practices outside of your network.
- **High-Deductible Health Plan (HDHP):** An HDHP has a high deductible but also helps you significantly lower your monthly insurance premium. Many HDHPs are eligible for a health savings account (HSA) to help consumers save tax-free money for healthcare expenses. Healthcare.gov explains the latest individual and family deductibles that qualify for an HDHP.
- **Consumer-Directed Health Plan (CDHP):** A CDHP is another way to describe plans that give you more control over your healthcare expenses. They are generally high-deductible health plans that have a low cost and can be paired with a health savings account.

WHAT TO CONSIDER

Before you plan a medical procedure, look at your health insurance policy and determine whether you have an HMO, PPO, POS, HDHP, or another type of health plan. If you're unsure, don't hesitate to call your insurance company for clarification.

Find a list of the healthcare providers who are in your network. You can usually find this on your insurance company's website. As you look for highly rated doctors or hospitals for your procedure, you'll want to start with this list before searching outside of your network.

If you have an HMO and you need a specialist, we'd recommend you do research before visiting your primary care doctor. See which specialists have the best credentials for your procedure, and create a prioritized list of your options. When you meet with your primary care doctor, explain that you've found a specialist whom you're comfortable with, and ask for a referral.

Real-Life Scenario #3:

Visiting Your Primary Care Doctor

When it comes to visiting your primary care doctor, many times, you're going for an annual wellness visit, vaccine, or routine screening. The good news? Under the Affordable Care Act (ACA), you can enjoy a number of services free of charge. It all comes down to the difference between diagnostic costs and preventive costs.

TERMS TO KNOW

- **Diagnostic Costs:** In the insurance world, diagnostic costs are what you pay for services that determine if you have a medical condition.
- **Preventative Costs:** Preventive costs are what you pay for medical services that screen for or protect you against potential illnesses—for instance, vaccines, blood pressure checks, or diabetes screening. This also includes your annual wellness exam with your primary care doctor. Under the Affordable Care Act (ACA) many of these preventive services are covered at 100%.

WHAT TO CONSIDER

Just because you go for a preventive wellness visit doesn't mean you won't pay diagnostic costs. As Medical Mutual explains, a routine screening can lead to diagnostic care if your doctor sees something that causes concern.

Before going to your doctor, make sure you have enough set aside to pay any unexpected deductible, copay, or coinsurance that's needed.

Real-Life Scenario #4:

Paying for Medical Expenses... the Savvy Way

Life isn't always predictable. Even if you have excellent health, there's a good chance you'll eventually face an unexpected medical issue you'll need to address. If you have a Consumer-Directed Health Plan (CDHP) that gives you more control over your healthcare expenses (this is also known as a High-Deductible Health Plan [HDHP]), you're responsible for paying a significant deductible before insurance kicks in. Curious how to pay a higher deductible without breaking the bank? Here are some terms you need to know.

TERMS TO KNOW

- **Health Savings Account (HSA):** An HSA allows you to put aside pre-tax income for everything from deductibles to contact lenses. The big advantage of HSAs? All contributions roll over year to year, and your funds will always stay with you...even if you change jobs. Think of this account as a regular bank account that can only be used for eligible medical expenses. Only the money that has been contributed is available to be spent.

  Another added bonus is that once you turn 65 years of age, an HSA follows the same rules as a 401K plan. This allows you to either continue to use the funds on medical expenses (tax free) or use them for anything you want and just pay applicable taxes. Most HSA providers give you interest on the account balance and allow you to invest your funds.

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- **Flexible Spending Account (FSA):** Like an HSA, an FSA also saves pre-tax income for medical expenses. The biggest advantage of an FSA is that you can use all your planned funds at the beginning of the year (before you have actually made the contributions). However; you cannot roll over leftover FSA funds to the next year like you can with an HSA. With employer permission, you could receive an exception and roll over up to $500 of your FSA funds. In other words, if you don't spend contributions to your FSA, you'll lose them. In addition, you can't take your FSA with you if you change jobs (unless you pay into COBRA).
- **Limited Purpose Flexible Savings Account (LPFSA):** You can't have both an HSA and a regular FSA at the same time, but you can have an HSA and an LPFSA. The main difference between an FSA and an LPFSA is that you can only use the LPFSA for a narrow list of expenses like dental and vision costs.

  The reason for this is that both FSAs and HSAs are governed by the IRS and are tax deferred. The IRS considers having both as "double dipping" on tax breaks so you can only have one or the other to pay for medical expenses. An LPFSA does not interfere with this rule because it cannot be used for medical expenses. In the IRS world, medical and prescription expenses are separate and different from vision and dental expenses.
- **Health Reimbursement Account (HRA):** HRAs also allow you to save pre-tax income for medical expenses. Unlike HSAs and FSAs, where you and your employer can contribute to the savings account, only your employer can contribute to an HRA. And—if you leave your job—you cannot take your HRA with you. HRAs do have a big upside. Under some circumstances, you can use your HRA funds to pay for insurance premiums. Generally, the IRS does not allow an HRA alongside an FSA or HSA as they are all considered tax advantaged.

WHAT TO CONSIDER

As you can see, you have several options when it comes to paying for medical expenses. However, if you're going with an FSA, realize that you face a "use it or lose it" policy. If you don't spend your funds within a specified amount of time (usually a calendar year and a grace period), they'll go to your employer. In addition, while some HRA funds roll over into the next year, many of them have time limitations, too.

When deciding how much to put into your savings account, make sure you estimate your healthcare costs for the next year first. If you have an FSA, it's recommended that you contribute enough to cover your expected costs. But with an HSA, the more you contribute, the more tax savings you have. And those funds will roll over, so there's no risk.

Another thing to understand is the term "eligible expenses." The reality is, your savings account can pay for expenses your medical, dental, vision, or pharmacy policy won't cover. For instance, Lasik eye surgery is an HSA-eligible expense...even if your insurance company won't foot the bill.

Real-Life Scenario #5:

Going to the Pharmacy

Getting a prescription can be tricky and if you don't ask the right questions could end up costing you significantly more than necessary.

If you're daunted by the alphabet soup in your local drugstore, take a deep breath. In this section, we're covering some important definitions (and considerations) for your medicine cabinet.

TERMS TO KNOW

- **Brand-Name Prescription:** Brand-name prescriptions are typically identified by a nonclinical name. When a drug first enters the market, it's often released as a brand-name drug. For instance, Prilosec is a brand name for a drug called omeprazole that treats acid reflux.
- **Generic Prescription:** A generic prescription is a medication that has the same active ingredients as a brand-name drug...without the snazzy name. A generic prescription must pass the same quality standards as its brand-name equivalent. While a generic prescription has the same active ingredients as a brand-name drug—it's important to note that it can contain different inactive ingredients. You'll find that generic drugs are named by their active ingredients. For example, the generic version of Prilosec is Omeprazole, which is the active ingredient in Prilosec.

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- **Preferred Drug (Formulary):** A preferred prescription is simply a drug that your insurance company will cover—including both generic and brand-name medicines.
- **Non-Preferred Drug:** This specific drug is treated differently by your insurance policy. Many times these are expensive or new brand name drugs. Not surprisingly, these drugs are more expensive than drugs on your carrier's preferred list. TIP: Many doctors don't check your preferred drug list before prescribing. You should be proactive in asking your doctor to check your formulary and stick to it whenever possible.
- **Preventive Prescription:** As its name might imply, a preventive prescription keeps a condition from occurring or getting worse. Even better, this type of drug is often covered by insurance before you hit your deductible if you have a High-Deductible Health Plan (HDHP).
- **Specialty Drug:** Drugs in this category are more complex than most prescription medications and are used to treat serious and chronic conditions like cancer and rheumatoid arthritis. Specialty drugs are expensive, often difficult to administer (like injection or infusion), may need special handling like temperature control, and may require additional education or oversight from a healthcare provider. These drugs are not available at most retail pharmacies.
- **Step Therapy:** This approach is designed to control prescription drug costs. You must start with a less expensive drug, usually on the preferred drug list. If the less expensive medication does not yield the expected results, then you can step up to try a more expensive medication.

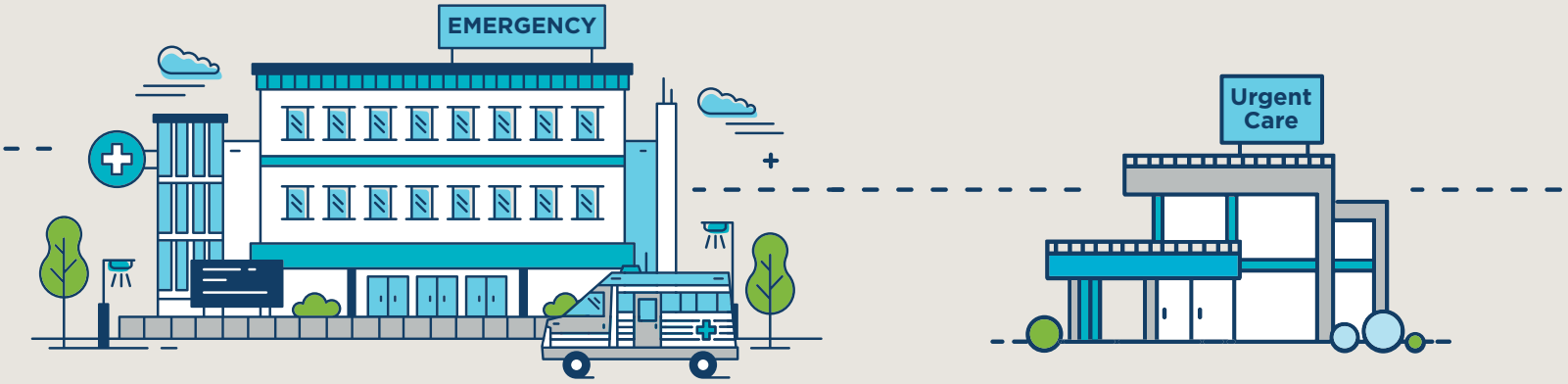
WHAT TO CONSIDER

As you look to save at the pharmacy, here are some things you need to consider...

1. **Know your preferred drug list.**
   Making savvy decisions at the pharmacy starts with getting your insurance company's list of preferred prescriptions as well as their list of preventive drugs. Have these in hand (or on your phone) when you visit the doctor. Let your doctor know you would like to stay on the preferred drug list if possible. Your doctor gets this request all the time and will do their best to help you find the least expensive drug that is effective.
2. **Ask for a generic drug when possible.**
   When your doctor prescribes a drug, ask him or her to indicate to the pharmacy to fill with a generic version if available. Give that same instruction to your pharmacy.
3. **Request a prescription.**
   Even if you only need an over-the-counter (OTC) drug, it's a good idea to get a doctor's prescription. That's because—under federal rules—you can't use your HSA, HRA, or FSA to buy OTC drugs (except for insulin). You'll also want to request a 90-day prescription to save on costs.
4. **Do your research.**
   Once you have a doctor's prescription, shop around for the best deal. It's a well-known fact that some pharmacies charge more than others, so do a little investigation, and take advantage of any drug manufacturer coupons online. You may even find the most cost-effective option is a mail-order prescription.

Real-Life Scenario #6:

Choosing Between the ER and Urgent Care



From dull kitchen knives to wobbly ladders, most of us will find ourselves in a mishap that creates a medical emergency requiring instant help. When the unexpected happens, it's important to know whether to choose the ER or an urgent care center. If you're wondering what the differences are between the two, you're not alone. After all, emergency rooms and urgent care centers have some similarities.

Both will allow you to walk in without an appointment. Both can address health problems within hours...or even minutes. However, going to the ER versus going to urgent care can make a big difference when it comes to getting the most out of your insurance plan. To understand why, let's start off with some basic definitions.

TERMS TO KNOW

- **Emergency Room:** Usually an attached department of a hospital, the emergency room is designed to treat walk-in visitors with life-threatening conditions, trauma, severe injuries, and sudden illnesses.
- **Urgent Care:** An urgent care center also takes walk-in visitors and can treat many of the same illnesses, injuries, and health problems as an ER. However, it has a limited ability to treat certain conditions and is better for minor health issues—not life-threatening situations or conditions that may require operation or more complex diagnostic tests (e.g., MRI or CAT scan).
- **Walk-In Clinics:** Often found within or near local retailers and pharmacies, these clinics are best suited for handling conditions such as colds, flu, minor cuts, immunizations, or health screenings.
- **Public Hospital:** As the National Procedures Institute (NPI) explains, public hospitals receive government funding and tend to be large with staff that's stretched thin and potentially long wait times. They are usually less expensive than private hospitals and cannot turn away anyone needing service.

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- **Private Hospital:** In contrast, NPI explains that private hospitals are smaller and tend to have lower patient-to-doctor ratios and shorter wait times. As NPI points out, some downsides are that private hospitals usually cost more than public hospitals and have the right to refuse service, provided they've stabilized a patient facing an emergency.

WHAT TO CONSIDER

Knowing the difference between each of these terms can have a real impact on your wallet and your experience. The emergency room is—by far—your most expensive option. As PhysicianOne Urgent Care explains, going to the ER (on average) costs $750 or more. Getting the same service from an urgent care center? According to PhysicianOne Urgent Care, that lowers your cost to $200.

Be Aware of Standalone ERs...That Look like Urgent Care Centers

Many cities are seeing an increase in stand-alone emergency rooms. It's easy to confuse these facilities for an urgent care center, but they will bill you the same amount as an ER connected to a hospital. To avoid a surprise on your bill, before you check in, confirm with the front desk if a facility is an emergency room or an urgent care center.

Understand Your Best Option

Save ER visits for critical health needs, such as heart attacks, strokes, difficulty breathing, severe pain or fever, and other dangerous illnesses. While urgent care centers have some medical equipment, they simply aren't equipped like an emergency room for severe medical needs. In contrast, emergency rooms are prepared to respond to almost any emergency and have the needed equipment—for instance, radiology labs, CAT scanners, ultrasounds, MRIs, and operating rooms.

If you need minor health services, opt for urgent care. Not only will you reduce your bill, but there's a good chance you'll enjoy a better experience. Urgent care facilities are ideal for the following services:

- Noncritical stitches
- Noncritical x-rays
- Allergy, cold, and flu treatment
- Preventive care

For immunizations or health screenings, you might give your local walk-in clinic a try.

Be Prepared during Travel

The first step toward saving is preparing. Research the best in-network urgent care centers and ERs for your local area. If you're travelling, find a list of medical centers along your route that accept your insurance. For urgent care centers, pay attention to the stated hours. While some urgent care facilities are open 24/7, others close at night.