Brought to you by the State of Oregon

The State of Oregon works 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, contact the Oregon Division of Financial Regulation.

Visit go.usa.gov/xUzRF
Call 888-877-4894 (toll-free)
Email DFR.InsuranceHelp@oregon.gov

Other languages or formats?

Call **1-855-268-3767** (toll-free) from 8 a.m. to 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 (7/19/HIM)

Using your health insurance

A step-by-step guide to understanding health insurance

OREGONHEALTHCARE.GOV

Take the next step

You have taken the first step to better your health by enrolling in a health insurance plan. This is the best time to ask questions and take action so you will know how to use your insurance when you are sick.

This guide explains the basics of understanding your insurance plan and what to do when you have questions.

Understanding your coverage

Once you sign up and **pay your first month's premium** (before 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 explains the key features of your plan, such as what is covered and what is not. Be familiar with your costs (premiums, co-payments, deductibles, and coinsurance).
2. **Insurance card or other document:** This is your proof of insurance with information medical providers need 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 Member Number: XXX-XX-XXX
Effective date	Group Number: XXXXX-XXX
Prescription Group # XXXXX	PCP Copay $15.00 Specialist Copay $25.00 Emergency Room Copay $75.00
Prescription Copay $15.00 Generic $20.00 Name brand	Member Service: 800-XXX-XXXX

Preparing for your health care

While you are thinking about health insurance, get ready for your health care needs by:

Finding a provider:

- Call your insurance company, search its website, or check the member handbook for providers in your network. Networks can change, so double check with your health plan.
- Once you decide which provider you want to see, check to see if you need to ask your insurance company before you make an appointment.

Scheduling an appointment:

- Call to make the appointment. Say you are looking for a new primary care provider and ask for a yearly exam or a wellness visit.

Working with your provider

- When you meet with your provider, share your family health history, current medications you take, and questions or concerns you have about your health.

Deciding if the provider is the right one for you:

- You need a provider 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 or research other providers in your network.

Planning your next steps:

- Follow through with your provider's recommendations. For example, if your provider recommended a specialist, did you make an appointment?

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 insurer.
4. The insurer 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 insurer allows for that procedure and what it 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 bill.

Knowing your rights

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

You can contact your insurer directly. 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 questions about your rights, or need help to understand insurance billing or coverage, call the Oregon Division of Financial Regulation to speak with a consumer advocate, free of charge at 888-877-4894 (toll-free).

You can also email DFR.InsuranceHelp@oregon.gov or look up insurance tips at: go.usa.gov/xUzRJ.

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, such as 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 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 insurer to find out which providers are in network. It might cost you more to see an out-of-network provider.

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, in-network essential health benefits. This limit includes deductibles, co-insurance, co-payments, and any other expenditure required of an individual for a qualified medical expense. The maximum out-of-pocket cost limit for individual Marketplace plans for 2020 can be no more than $8,150 for an individual plan and $16,300 for a family plan.

Premium: The amount you pay for your health insurance. You usually pay it monthly or quarterly. It does not count toward your deductible, your co-payment, or 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 flu shots, vaccines, and screenings.