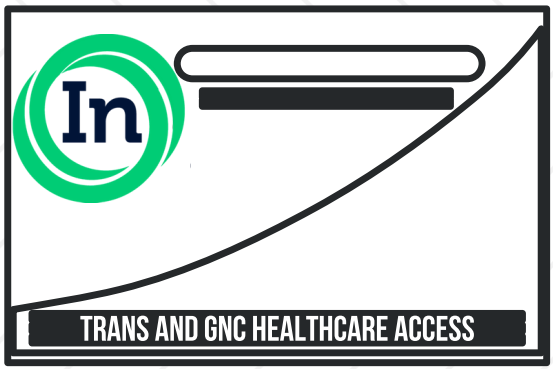
insurance explainer guide



INGERSOLL GENDER CENTER

www.ingersollgendercenter.org

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HEALTH INSURANCE BASICS

Healthcare insurance is a means of financial loss protection developed to cover some part of your medical expenses when you are injured or sick. Health insurance also covers preventative care – i.e. physicals, labs, etc that gauge your health and help you maintain wellness before you get sick.

Healthcare insurance plans do not always cover your medical expenses at 100%. Many insurance plans are created to share costs with you up to a certain point. This is called the **out of pocket limit**. Once the out of pocket limit is reached, your insurance pays medical claims at 100%.

Example: Eli's out of pocket limit is $2000. Once Eli has paid $2000 for their medical care (including copays) then their medical expenses will be covered by their insurance plan at 100% which means that Eli will have no other financial obligation to pay medical bills (other than the actual cost of maintaining their plan – also known as a ***premium****) during that calendar year until they renew their plan.*

There are a few ways that health insurance companies might share costs with you. Here are some key terms and key parts of your insurance plans to be aware of.

» **Deductible** The amount you pay for covered health care services before your insurance plan starts to pay. *For example: With a $2,000 deductible you pay the first $2,000 of covered services yourself.* After you pay your deductible, you usually pay only a copayment or coinsurance for covered services. Your insurance company pays the rest.

» **Premium** The amount you or your employer pays for your health insurance every month.

» **Copayment (Copay)** A fixed amount ($20, for example) you pay for a covered health care service after you've paid your deductible. Let's say your health insurance plan's allowable amount for a doctor's visit is $100. Your copayment for a doctor visit is $20.

> **If you've paid your deductble:** You pay your copay amount at the time of the visit.
> **If you haven't met your deductble:** You pay $100, the full allowable amount for the visit.

Copayments can vary for different services within the same plan, like drugs, lab tests, and visits to specialists. Generally plans with lower monthly premiums have higher copays. Plan with higher monthly premiums usually have lower copays.

» **Allowed Amount** The maximum amount a plan will pay for a covered health care service. This may also be called an *Eligble Expense, Payment Allowance,* or *Negotiated Rate*. If your provider charges more than the plan's allowed amount, you may have to pay the difference.

» **Out of Pocket Limit** Sometimes called the *Out of Pocket Maximum*, these are your expenses for medical care that aren't reimbursed by insurance. Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services plus all costs for services that aren't covered.

For other key and important insurance terms, please visit http://bit.ly/iGlossary

TYPES OF HEALTHCARE INSURANCE

There are two types of health insurance: public health insurance (like Medicaid, Medicare, and CHIP) and private health insurance (whether you purchase on-exchange or elsewhere). Most people have some form of private health insurance purchased through a marketplace or from an employer. State exchanges and the federal exchange can offer community members both public health insurance and private health insurance.

In Washington State, both types of insurance can be obtained via *www.wahealthplanfinder.org* – the state's "one stop shop" for insurance plans where you can see if you are eligble for public/state funded insurance plans, or purchase a plan via the market place. **Note:** if you lose coverage before open enrollment in November, you can also see if you qualify for a special enrollment period if you've experienced any of these life events including: losing health coverage, moving, getting married, having a baby, or adopting a child.

» **Medicare** is a federal health insurance program for Americans above the age of 65 and disabled folks. Anyone above the age of 65 can buy health insurance, regardless of their income level. There are four parts to Medicare that cover different healthcare services. Two parts – Parts A and B – are paid for by taxes, while the other two parts – Parts C and D – are paid for by the community member.

» **Medicaid** is a federal and state health insurance program for low-income families and individuals. Medicaid has eligibility requirements that are set on a state-by-state basis, but it is primarily designed for those with low incomes and low liquid assets. It is also designed to help families and caretakers of small children in need. In Washington, this program is called Apple Health.

» **Self Funded Insurance** also known as Administrative Services Only (ASO), is an arrangement whereby an employer

provides health or disability benefits to employees that is paid from the company's own funds. With self funded plans, employers can pick and choose the services they would like to cover and ditch the ones they don't. **Often times, trans-specific healthcare is listed as an exclusion (a service that is not covered)**. In Washington State, insurance plans (public and private plans) are required to cover trans health. However, employers often get around this by purchasing self funded plans out of other states that do not have to follow state non-discrimination laws and protections.

» **Private Insurance:** All private health insurance plans, whether they're on-exchange or off-exchange, work by partnering with networks of healthcare providers (In-Network Providers). But the way that these plans work with networks can vary significantly. To find out which one of these plans you might have, please check out the illustration and caption on page 5.

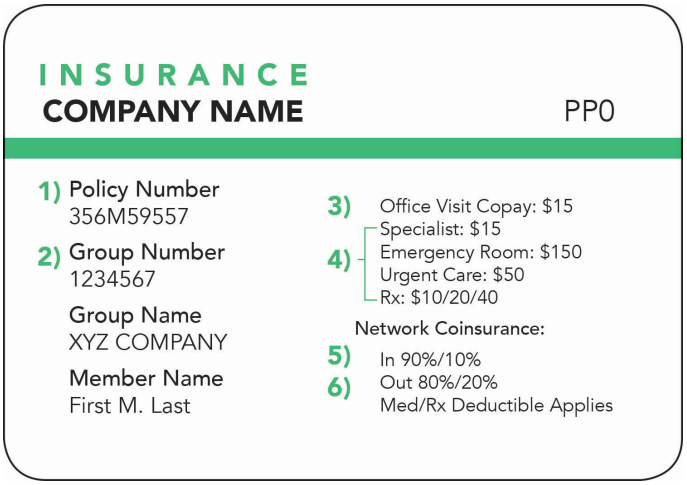
» **Health Maintenance Organization (HMO)** plans are the most restrictive type of plan when it comes to accessing your in-network providers. If you have an HMO plan, you'll be asked to choose a primary care physician (PCP) that is in-network. All of your care will be coordinated by your PCP, and you'll need a referral from your PCP to see a specialist (endocrinologist, physical therapist, etc). HMOs do not cover any out-of-network healthcare costs. HMO plans typically have cheaper premiums than other types of private health insurance plans.

» **Preferred Provider Organization (PPO)** plans are the least restrictive type of plan when it comes to accessing your network of providers and getting care from outside the plan's network. Typically, you have the option between choosing between an in-network doctor, who you can see at a lower cost, or an out-of-network doctor at a higher cost. You do not need a referral to see a specialist, but you may still choose a primary care physician (some states, like California, may require that you have a primary care physician). PPO plans typically have more expensive premiums than other types of private health insurance plans.

» **Exclusive Provider Organization (EPO)** plans are a mix between HMO plans and PPO plans. EPO plans give you the option of seeing a specialist without a referral. However, EPO plans do not cover out-of-network physicians. EPO plans typically have more expensive premiums than HMOs, but less expensive premiums than PPOs.

» **Point of Service (POS)** plans are another hybrid of HMO and PPO plans. You'll have a primary care provider on an HMO-style network that can coordinate your care. You'll also have access to a PPO-style network with out-of-network options (albeit at a higher cost). The HMO network will be more affordable, and you will need to get a referral to see HMO specialists. POS plans typically have more expensive premiums than pure HMOs, but less expensive premiums than PPOs. Medicaid Washington utilizes a POS plan (Provider One) for specific services like dental, and trans-specific surgeries. The cost of this plan is paid for by the state.

» **Catastrophic Plans:** There's a fifth category of health insurance plans that you may see on the marketplace, called "catastrophic" plans. Catastrophic plans have very high deductibles. Often, the deductible is the same as the out-of-pocket max – which means they're really only useful for preventing an accident or serious illness from causing you to go into severe debt. Catastrophic plans are only available for people under 30 or people with a hardship exemption. You cannot use a subsidy on catastophic plan premiums, but catastrophic plans do count as qualifying health care when it comes to the health insurance mandate.



» **1. Your policy number** is a unique identifier that is assigned to you think of it as the insurance version of a social security number or a licence number.

» **2. Your Group Number** is the number assigned to your employer by the health insurance plan purchased for your workplace.

» **3. Office visit copay** is the amount you pay out of pocket for seeing your dr after your deductible is met.

» **4. These are the copays you pay out of pocket** for utilizing these services after your deductible is met. In some instances copays can also go towards meeting your deductible (the best way to know if this is the case with your insurance is to call your insurance provider to inquire)

» **5. Network Coinsurance In Network**- The first percentage (90%) is the amount your insurance is responsible for when you go to see a provider who is in your insurance company's network of contracted providers (in network), the second percentage (10%) is the amount you are responsible for.

» **6. Network Coinsurance Out of Network**- The first percentage (80%) is the amount your insurance is responsible for when you go to see a provider who is outside of your insurance company's network of contracted providers (out of network), the second percentage (20%) is the amount you are responsible for when you see a provider out of network.

WHAT ARE THE METAL TIERS?

Remember earlier when we talked about how all health insurance plans split some of the costs between the insurer and the consumer? Metal teirs are a quick way to categorize plans based on what that split is. Some people get confused because they think metal tiers describe the quality of the plan or the quality of the service they'll receive, which isn't true. Here's how health insurance plans roughly split the costs, organized by metal teir:

Bronze	40% Consumer / 60% Insurer
Silver	30% Consumer / 70% Insurer
Gold	20% Consumer / 80% Insurer
Platinum	10% Consumer / 90% Insurer

These are high level numbers across the entirety of the plan, taking into account the deductible, coinsurance, and copayments, as dictated by the specific structure of the plan, based on the expected average use of the plan. These percentages do not take premiums into account. They also do not represent the exact amount that you'll actually pay for medical services.

In general, Bronze plans have the lowest monthly premiums and Platinum have the highest. As you can see from the cost-sharing split above, Bronze plan premiums are cheaper because the consumer pays more out of pocket for healthcare services. If you frequently utilize healthcare services, you'll probably end up paying more out-of-pocket if you choose a Bronze plan, even though it has a lower premium.

If you qualify, you can use a health insurance premium subsidy (tax credit via the market place) to help you afford a plan in a higher tier, ultimately saving you money.

HOW TO FIND OUT WHAT IS COVERED

Many people have trouble figuring out just what is covered by their insurance, from switching medications seeing and new provider or trying a new treatment. Figuring out what types of gender affirming care are covered can be especially tricky for our community. It's important to know precisely what is covered (or at least where to find this information) so that you can avoid the stress and headache of having to dispute charges that you didn't know that you'd have.

So, what does "covered" even mean?

The word covered in healthcare means that that your insurance will pay for some or all of the costs associated with you seeking medical care. This could mean in or out of network coverage. How much your insurance pays depends on network as well as the type of care you use and where you get it from.

For example:

- Some covered services are completely free to you, like going to the doctor for your yearly physical/exam. Your plan pays everything.
- For others – like seeing the doctor for a lingering UTI or filling a prescription for antibiotics or anxiety – you'll pay a fee. The amount you pay will be different depending on the type of plan you have and whether or not you've taken care of the deductible.

It's important to remember that often plans are different for each other (even plans under the same insurance company) that means that they might cover different medications, providers, medical clinics and other services. This is because often there are different plans for members to choose from. Knowing the specifics of what your insurance covers helps you avoid learning that your insurance doesn't cover things you expected. We advocate making sure the care you are wanting/needing is covered and how much you will have to pay at every step before you make your first appointment.

There are a few ways to figure out what is covered with your plan.

One of these ways is the Summary of Coverage and Benefits.[1] This document lists covered services and cost associated with accessing those services as well as any exclusions or advisements. If your insurance provider has an online portal or app access for its members you may be able to access this information online/app. When you first sign up for benefits (insurance) you will typically get a member package that includes various important documents including the SBC (Summary of Coverage and Benefits.)

You can also get information about what is covered is by calling customer care, or customer service, also called member services and either asking (which may or may not be fruitful depending on their level of training) or simply asking that they send you a hard copy of your SBC.

Another way that can be helpful is discussing what is and isn't covered with your doctors office,depending on the service or treatment you are looking for they may have navigators that will look into your insurance coverage and let you know what is and isn't covered. This is a better practice for a specific service as opposed to being able to get a list of everything that is or is not covered.

1: http://bit.ly/summarybenefits

MEDICAID/MEDICARE

Medicaid provides health coverage to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults and people with disabilities. Medicaid is administered by states, according to federal requirements. The program is funded jointly by states and the federal government.[2]

Many folks in the trans and gender diverse community access services through Medicaid and/or Medicare.

In Washington State these federally funded programs are required to cover gender affirming care such as HRT and specific gender affirming surgeries including the following but not limited to[3]:

- Breast reconstruction.
- Genital surgery.
- Genital electrolysis as required as part of the genital surgery.
- Hysterectomy.
- Mammoplasty with or without chest reconstruction.
- Metoidioplasty.
- Orchiectomy.
- Phalloplasty.
- Placement of testicular prosthesis.

These programs are also required to cover 10 essential services:[4]

- **Hospitalization** — A stay in the hospital, including inpatient surgery and recovery.
- **Emergency services** — Visits to the emergency room, including ambulance services or treatment at an urgent care center.
- **Ambulatory services** — Doctor visits when you're sick or injured, or outpatient clinic visits.

2: https://www.medicaid.gov/medicaid/index.html
3: http://bit.ly/applehealth-hie
4: https://www.hca.wa.gov/assets/free-or-low-cost/19-040.pdf

» **Prescription drugs** — Medicine your doctor orders'.

» **Laboratory services** — X-rays, MRIs, blood tests, etc.

» **Maternity and newborn care** — For women who need prenatal care or help with pregnancy, complications and delivery.

» **Pediatric services, including oral and vision care** — Dental check-ups, routine eye doctor visits, eyeglasses, immunizations, and more.

» **Preventive and wellness services, including chronic disease management** — Screening tests for things like osteoporosis and mammograms, and help living with long-term illnesses like diabetes.

» **Mental health and substance use disorder services, including behavioral health.**

» **Rehabilitative services and devices** — Physical therapy, speech therapy, artificial limbs and other medical equipment.

» **Habilitative* services and devices** — Helping people with disabilities learn life skills.

To access healthcare through Washington State Medicaid (Apple Health) you will have to meet specific eligibility requirements for adults which include[5]:

» Age 19 through 64.

» Have an annual household income at or below the Medicaid standard (see income chart below).*

» Are a U.S. citizen or meet Medicaid immigration requirements.

» Are not entitled to Medicare.

Program	Single Person	2-Person Household	3-Person Household	4-Person Household	5-Person Household	6-Person Household	7-Person Household
Apple Health for Adults (19-64)	$1,436 monthly	$1,945 monthly	$2,453 monthly	$2,961 monthly	$3,470 monthly	$3,978 monthly	$4,486 monthly

5: http://bit.ly/apincome-hie

Medicare is the federal health insurance program for:

- People who are 65 or older
- Certain younger people with disabilities
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD)

The different parts of Medicare help cover specific services:

Medicare Part A (Hospital Insurance)

Part A covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

Medicare Part B (Medical Insurance)

Part B covers certain doctors' services, outpatient care, medical supplies, and preventive services.

Medicare Part D (prescription drug coverage)

Part D adds prescription drug coverage to:

- Original Medicare
- Some Medicare Cost Plans
- Some Medicare Private-Fee-for-Service Plans
- Medicare Medical Savings Account Plans

These plans are offered by insurance companies and other private companies approved by Medicare. Medicare Advantage Plans may also offer prescription drug coverage that follows the same rules as Medicare Prescription Drug Plans. https://www.medicare.gov/what-medicare-covers/your-medicare-coverage-choices/whats-medicare

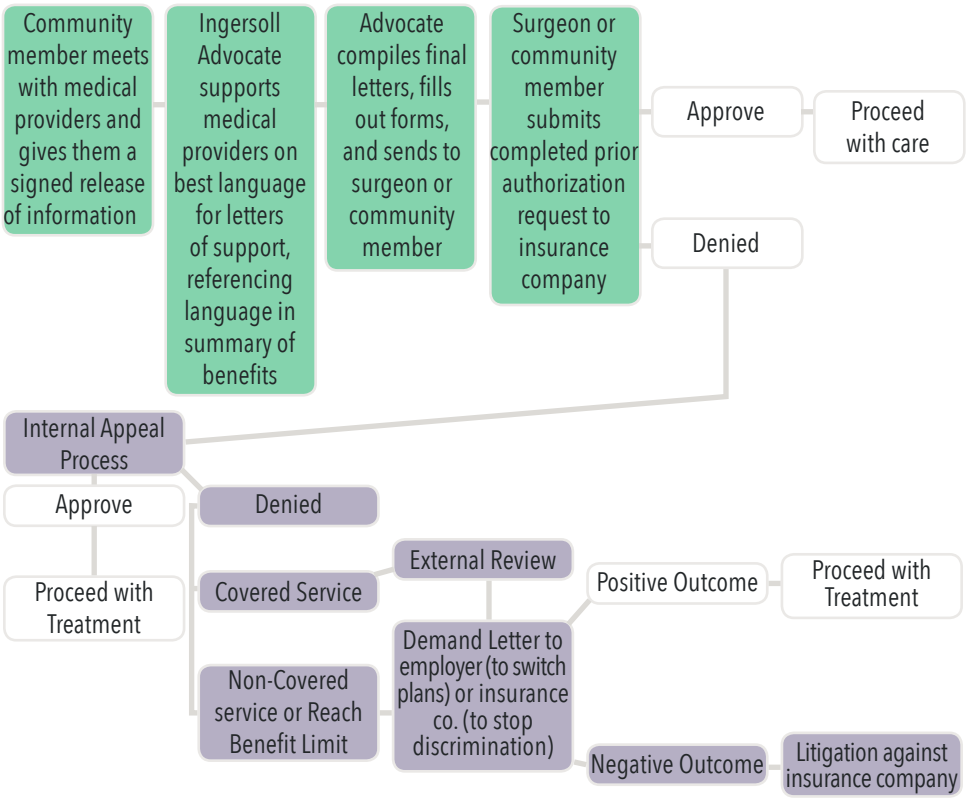
For information on how to apply to these programs please visit Ingersoll Gender Center visit healthplanfinder.org

EXCEPTION TO THE RULE

The exception to the rule process is a process that theoretically makes trans specific surgical procedures listed on the non covered services list available to community members on a case by case basis assuming they are medically necessary. However we know that gender affirming care is life saving care, and as such having access to these surgeries and procedures are in fact medically necessary to prevent suicide, but also mental, emotional, physical safety & wellness.

We don't necessarily agree with the existence of non covered services lists but we are able to assist our community in navigating the process of getting their healthcare covered through this rule.

Navigating Private Insurance Denials

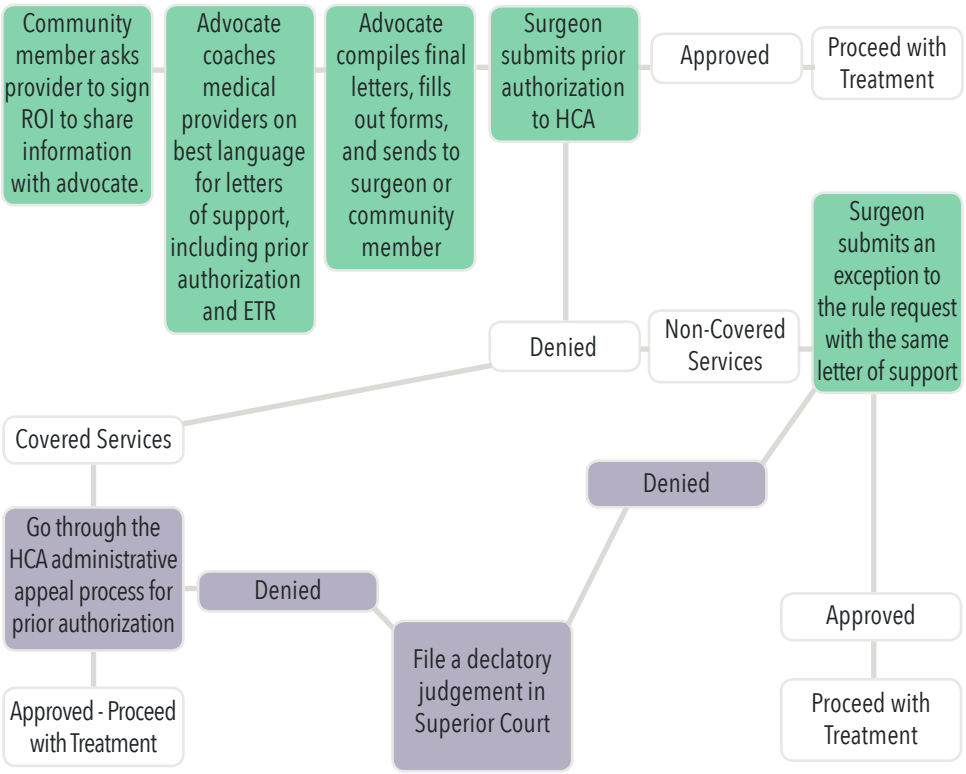


APPEAL & DENIALS

Navigating an insurance denial and putting together documents for your appeal can be timestaking if you do not know the proper steps to take or dont have support. Here at Ingersoll Gender Center we can help you through the process step by step and support you in collecting medical records, letters, as well as evidence to support your appeal.

We've created a flowchart of the Denial and Appeals Process with help from our friends at Lavender Rights Project in order to help you understand what happened when you receive a denial and file an appeal. The green parts of the charts below are parts of the process that Ingersoll staff can support community members with. As communitiy members move into the purple parts of the process, they should secure direct legal representation.

Navigating Medicaid Insurance Denials



ABOUT THIS GUIDE

Navigtating insurance can sometimes be an absolute headache. Ingersoll Gender Center's Healthcare Access Program can help you demistify your insurance policies so that you are better able to look at your insurance plans and find the information that you need; in order to make better informed healthcare decisions for yourself and to know your rights within the context of your insurance plans in Washington State.

ABOUT INGERSOLL GENDER CENTER

Ingersoll Gender Center is an organization by, and for transgender and gender diverse people that provides mutual support through peer-led support groups, advocacy in navigating resources, community organizing, and education — all in the pursuit of our collective self-determination.

INGERSOLL GENDER CENTER OFFERS FINANCIAL ASSISTANCE FOR:

$ Financial Assistance

For transgender and gender nonconforming community members experiencing crisis.

Amending Identification Documents

Financial assistance for community members who need support changing their name or amending their identity documents to reflect their name and gender identity.

Gender Affirming Clothes

Financial support for community members to buy gender affirming clothing items while looking for new work or transitioning on the job in Seattle.

Ingersoll gender center

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