Mended Hearts® | little mended hearts®

NAVIGATING INSURANCE

One of the most overwhelming things about my hospital visit was trying to figure out what my insurance covered and what it didn't.

Most patients and caregivers find navigating health coverage and medical bills one of the most complex and confusing things they face. It can almost feel like it was designed to be that way. There are so many different health coverage plans and each state has its own unique system and coverage regulations. This complexity can often seem overwhelming, especially when you are already trying to manage your care or your child's care and needs. Here is some useful information that may help you navigate the system:

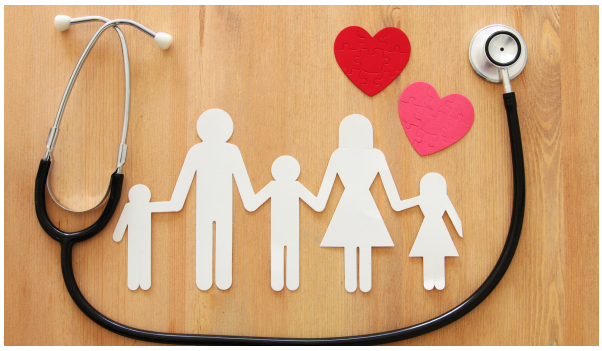
INSURANCE CARDS

Have your insurance card with you for appointments and hospital admissions. This card, provided by your insurance company, has important details such as your policy number and the insurance

company's contact information. You may need to present it at the clinic or hospital to provide proof of coverage. Your insurance card will also contain information on what kind of plan you have and the co-pay cost for each type of healthcare provider.

UNDERSTANDING YOUR COVERAGE

Your insurance company should have sent you a booklet or other information explaining your coverage and benefits. It is your responsibility to know what your policy covers — and what it doesn't — because you may be accountable for the cost of services not covered by your policy. Your insurance card will have a phone number you can use to contact your insurance company if you have additional questions about your policy or coverage. If you don't understand your coverage, talk with someone who can explain it to you. Ask whether you or your child is eligible for complex case management services to help you with the insurance system and any pre- authorizations that may be needed.



> *If you need to use an out-of-network provider, be sure to find out how your out-of-pocket caps may be affected.*

IN-NETWORK AND OUT-OF-NETWORK PROVIDERS

Some insurance policies specify which hospitals, clinics, and healthcare providers they consider to be "in-network" and "out-of- network." You may receive less coverage (or no coverage at all) if you choose to go to an out-of-network provider. View your plan online or ask your insurance company for a list of in-network providers and find out about your coverage for out-of-network providers. Some insurers require referrals from your primary care physician for specialty services or out-of-network providers. It's your responsibility to understand these requirements. If you choose to go out-of-network, you may need to work with the hospital or healthcare provider to find out whether they will accept what the insurance company is willing to pay. If not, you could get stuck paying the difference between what the insurance company will pay and what the hospital or physician charges. Keep asking until you get a clear idea of how much you might owe.

PRIOR AUTHORIZATION REQUIREMENTS

Some policies require prior authorization for most specialist appointments, medical testing, medical procedures, and hospital admissions. Most hospitals have staff members who will contact the insurance company on your behalf to get this authorization. Ask your health care providers if they will be making those calls or if you are expected to. Even if they make the call for you, it never hurts to double-check your coverage.

MEDICATION COVERAGE

Many insurance companies have a separate process for medication coverage. You may have a different card that you will need to show at the pharmacy. Pharmacists can assist you in figuring out which medications are covered, at what cost and whether any prior authorization is required. They may also be knowledgeable about drug assistance programs if your medication is not covered. There may be a cap on your prescription plan coverage. Be sure to know what that is so you don't get stuck with costs over that cap.

DENIAL APPEALS

If you find yourself with a bill that you did not expect or receive a notice of a denied insurance claim, contact your insurance company. Before calling, review your written policy information so that you understand your plan's coverage. Ask the insurance company to clarify the reason for denial. Your healthcare provider may need to re-submit the claim or you may need to file an appeal. Check your policy or call your insurance provider to find out what the appeals process is for your plan. You may need a letter of support from your healthcare provider.

A resource for appeals, "Your Guide to the Appeals Process," is available at PatientAdvocate.org.

COVERAGE AFTER 18

If you are worried about having insurance coverage for a child once they turn 18, you should begin to explore options early. If you have a private insurance policy, call the number on the card and ask how long children can remain on their parents' policy. Current rules allow children to stay on parental policies until they are 26 under certain conditions. This may change, however, and does not happen automatically. Most policies allow kids to stay on their parents' insurance while they are in school. Call your insurance company to find out what your plan allows.

DISABILITY COVERAGE

If you or your child has a condition that might qualify for disability coverage, visit the office of Social Security's website at www.ssa.gov. There, you can find out whether the diagnosis meets the qualifications for coverage and what information you need to apply. If disability coverage is a good option for you or your child, start the application process as soon as possible. If you are applying for a child transitioning to adult care, be sure to get the application completed and turned in at least six months before his or her 18th birthday. Adult disability is called SSDI. Child disability is called SSI.

Also, mothers may qualify for coverage for infant formula for your baby through the Women, Infants and Children (WIC) program. Learn more about WIC at www.fns.usda.gov.

BENEFITS AND EMPLOYMENT

When getting a new job, changing jobs or leaving a job, you will want to consider insurance benefits. If you are in the final decision phase for new employment, get details about health benefits the organization offers, if any, and when you are eligible for them. You may find that taking a lower-paying job with better medical benefits makes more financial sense in the long run. A job with good health coverage benefits can make a big difference for people who have health issues.

If you are leaving employment, be sure to research individual coverage or other coverage that may be available to you in your state. It is very important to check whether your healthcare providers

are included in any plan you may select.

If you will be working remotely, you will need to make sure you are able to get coverage that will be accepted in your state.

COST ESTIMATES

Many hospitals now have a mechanism to provide cost estimates for procedures or appointments for people without insurance. Sometimes they are billed at a lesser rate and they may be eligible for charity care funding. If you are without insurance coverage, contact your hospital or clinic in advance to discuss costs and payment options to help you plan.

FINANCIAL ASSISTANCE IN HOSPITALS

Most hospitals have a community care program that offers financial assistance to patients with no or poor insurance. You may be asked to fill out a financial form and to explain your circumstances. The hospital might be willing to reduce your bill or work out a reasonable payment plan with you. It is important to do this in a timely manner, however, as unpaid bills will eventually be sent to collections, at which point they can affect your credit rating and may no longer be negotiable.

Patient Advocation Foundation has more helpful information for patients at patientadvocate.org.