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Guide to Understanding Health Insurance

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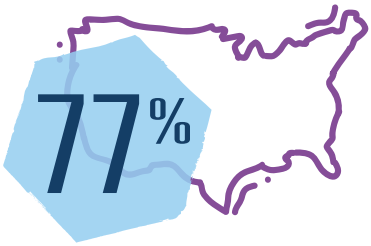
Health insurance is important to have when it comes to the health and wellbeing of an individual and their family.



Approximately 77% of Americans are confused by health insurance terms.[1]

These terms are universal when it comes to healthcare coverage. Understanding them can help prepare you when choosing a plan.

More than half of the U.S. adult population does not understand basic health insurance terms.[2]

It is important to understand health insurance. From defining health insurance terms to walking through how you get coverage, this guide serves as your basic introduction to health insurance.

1. Edward J, Thompson RA, Wiggins A. Health Insurance Literacy Levels of Information Intermediaries: How Prepared Are They to Address the Growing Health Insurance Access Needs of Consumers?. Health Lit Res Pract. 2022;6(1):e30-e36. doi:10.3928/24748307-20220201-01
2. Bailey V. More than Half of Americans Have Low Health Insurance Literacy. HealthPayerIntelligence. Published July 25, 2022. https://healthpayerintelligence.com/news/more-than-half-of-americans-have-low-health-insurance-literacy

What is health insurance?

Health insurance helps you pay for medical care when you have an illness, injury or seek preventive services that are important checkpoints to keeping you healthy. There are several types of plans you can choose and each one has a different amount that you and the insurance company will pay. You can purchase health insurance for yourself or you can get a family plan and cover your spouse, domestic partner and children.

Most plans help you pay for services like:

Preventive visits

Vaccinations

Specialist visits

Hospitalization

Behavioral health/ mental health services

Pregnancy, maternity and newborn care

Prescription drugs

Emergency room visits

Lab work

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Why do you need health insurance?

Health insurance is important no matter what stage of life you or your family are in. Health insurance companies work with doctors, hospitals, clinics and pharmacies to get you care at an affordable cost. Health insurance is used for basic wellness in addition to managing chronic conditions, men's/women's health, pediatric care and other high-risk health issues. It allows you to join with a larger group of people (your company or groups of individuals) and pool your money together to spread out the risk of large healthcare costs.

Even as a completely healthy individual it is important to get routine check-ups to help prevent future health issues from arising and to prevent future medical bills that could get expensive.

Planning for the unexpected and having health insurance can give you security when an emergency arises.

How and where do you get health insurance?

Employee Sponsored:

- Most people buy health insurance through an employer or a “group” plan. This can be your own employer or your partner/spouse’s employer.

Individual Plans:

- Individual plans are available to everyone through the government marketplace (healthcare.gov) established by the Affordable Care Act.
- You can also purchase individual plans through privately owned health insurance companies.

Government Programs:

- Medicare is a federal program designed for people who are 65 and older and young people with disabilities.
- 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 by states and the federal government.

Parents or guardians can keep children (dependents) under the age of 26 on their health plan.

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When do you get insurance?

The time you select/register for a plan is called **Open Enrollment Period (OEP)**. For Medicare, it's called the **Annual Election Period (AEP)**.

Although Open Enrollment can occur at any time of the year, it typically occurs at the end of the calendar year. You will choose your plan to start January 1 the following year. For Medicare and the Annual Election Period, you choose your plan between October 15 through December 7.

You can enroll outside of Open Enrollment Period(OEP) during a **special enrollment period** with the following situations (also called a **qualifying life event**:

- **Changing marital status**
- **Starting work with a new employer**
- **Losing other health coverage**
- **Moving to a new state**
- **Having a child or adding a dependent**
- **Qualifying for Medicaid or CHIP (Children's Health Insurance Program)**

What is a network?

Your network consists of a group of doctors, hospitals and other healthcare professionals who have agreed to provide medical services to members of a healthcare plan for a certain price. Arkansas Blue Cross and Blue Shield, Health Advantage and Octave Blue Cross and Blue Shield create a comprehensive statewide network to ensure strong coverage for you, while making sure every medical provider and facility agrees to certain discounts that make care more affordable for you.

In-network

Doctors, hospitals and other healthcare providers **that have agreed** to provide medical services at set prices with your health plan. This will be the discount shown when you get an explanation of benefits for a visit.

Out-of-network

Doctors, hospitals and other providers **who have not agreed** to set prices with your health plan.

What does this mean?

To save money, you will typically choose an in-network provider because Arkansas Blue Cross, Health Advantage and Octave Blue Cross have negotiated what their services will cost. Out-of-network providers usually charge more. If you receive care from a doctor or hospital that is out-of-network you won't get the negotiated price (meaning you will pay more out-of-pocket).

How does health insurance work and how much does it cost?

Health insurance works by splitting the cost of healthcare between an individual and the insurer to pay the provider. If you hit your maximum out-of-pocket amount for a specific year, your insurer will pick up 100% of the cost.

Prior to receiving healthcare, you will show proof of insurance to your provider. This will tell them what kind of coverage you have and how to bill or charge you for your visit. The amount you are billed depends on many things such as:

Plan type

Deductible amount

In-network or out-of-network care

Each month you pay a **premium** to have health insurance coverage. Most of the time, plans with a higher deductible have a lower monthly premium. Plans with a lower deductible have a higher monthly premium. What do all these words mean? The following pages will define the terms and explain how they work together.

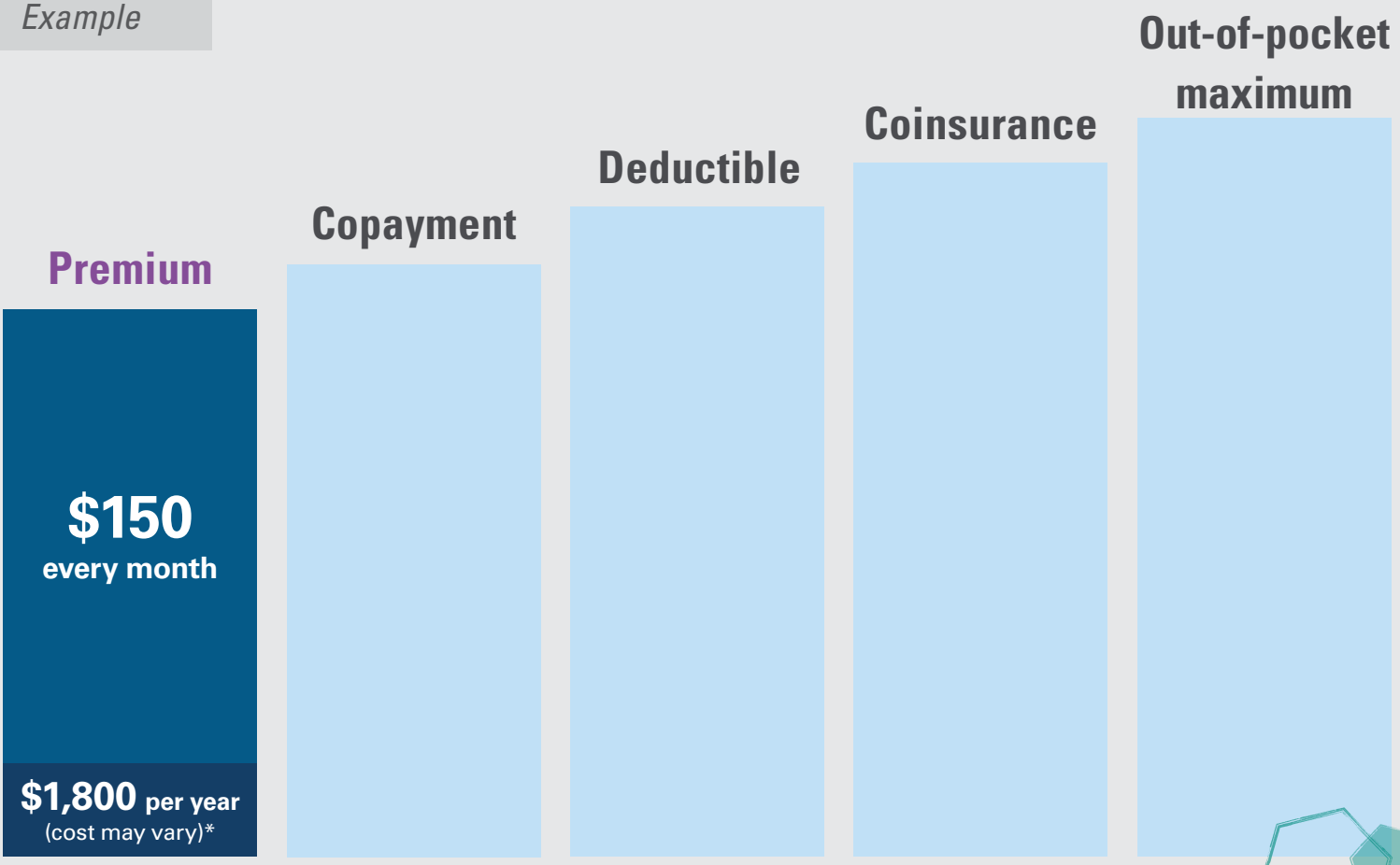
Premium

Premium is the amount you pay each month for your health insurance coverage even if you don't use it. It's your monthly bill for your health insurance, similar to a monthly payment for car insurance. If you're on an employer health plan, it automatically comes out of your paycheck and your employer pays a portion of it.

Your premium amount is determined by several factors:

- Age
- Location
- Tobacco use
- Dependents
- Plan category

Example



*Prices are to be used as an example and can vary. Figures are based on individual plans with no dependents.

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Copayment

This is the fixed amount you pay, usually at the time of a medical service. Some plans do not have a copayment for visits. Usually, copayments are separate from and do not count toward your deductible amount. They do count toward your out-of-pocket maximum, which can help if you have high medical expenses during a calendar year. Your copayment can vary, depending on the type of service you receive (for example, a copayment for seeing a specialist may be more than a copayment for a PCP visit. You also may have a copay with prescriptions.

A primary care provider (PCP) could be a doctor, physician assistant or a nurse practitioner.

Example

Premium

$150
every month

$1,800 per year
(cost may vary)*

Copayment

In-network PCP visit

You Pay: $40

Copayment amounts vary. *Some plans do not have a copay.

Deductible

Coinsurance

Out-of-pocket maximum

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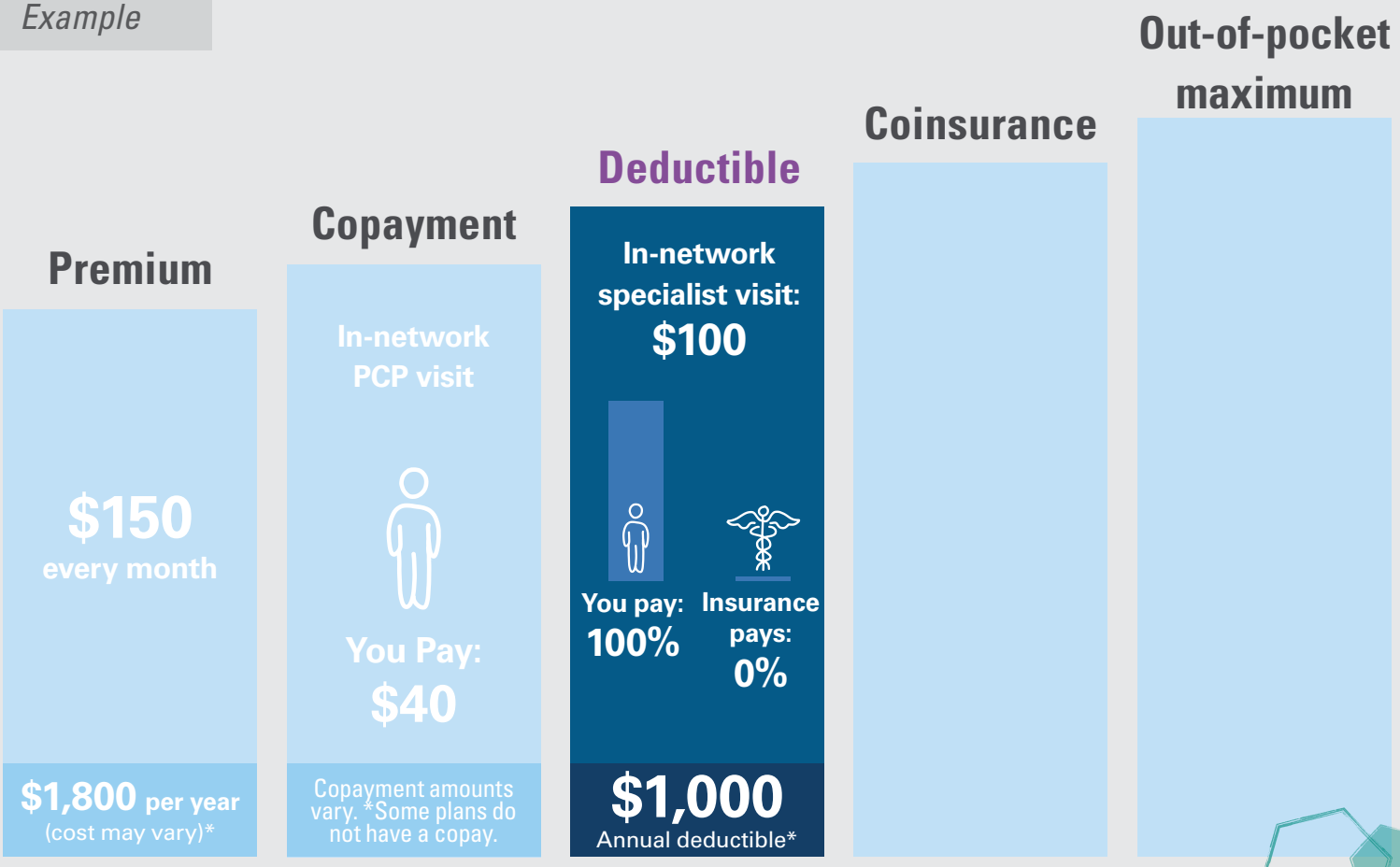
Deductible

Deductible is the amount you pay for medical costs before your health insurance begins to make payments to providers for services. Your insurance provider will have certain things that are considered allowable charges to go towards your deductible. They also have different deductible amounts for in-network and out-of-network services.

Example:
If your deductible is $1,000, your plan begins to help you pay once you have met your $1,000 deductible.

Example



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Coinsurance

This is the percentage of the cost you are responsible to pay. Once you meet your deductible, your insurance begins to pay a majority of your in-network visits and you may pay 20% and they pay 80% (exact percentages depend on your provider and plan). Sometimes the health plan pays 100% of coinsurance once the deductible is met.

Example

Premium

$150 every month

$1,800 per year (cost may vary)*

Copayment

In-network PCP visit

You pay: **$40**

Copayment amounts vary. *Some plans do not have a copay.

Deductible

In-network specialist visit: **$100**

You pay: **100%**

Insurance pays: **0%**

$1,000 Annual deductible*

Coinsurance

In-network hospital visit: **$500**

You pay: **20%** **($100)**

Insurance pays: **80%** **($400)**

Amount varies by plan*

Out-of-pocket maximum

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Out-of-pocket maximum

Most plans have an **out-of-pocket maximum**, meaning once you pay the set amount, your insurance will cover 100% of any further eligible healthcare expenses.

If you or a family member have larger-than-normal health expenses, and you reach your out-of-pocket maximum for the calendar year, your insurance will cover you at 100% for the rest of that year. The out-of-pocket limit includes your deductible, coinsurance and copay amounts. **The out-of-pocket limit does not include premium payments or charges for services that are not covered.**

For example, if your out-of-pocket maximum is $3,000, when you reach this amount, your insurance will cover everything else at 100%. Please note that there are in-network and out-of-network out-of-pocket maximums. This means you may meet your out-of-pocket maximum for in-network services, but if you receive out-of-network services and have not met that deductible, you still may receive a bill.

Example

Premium

$150
every month

$1,800 per year
(cost may vary)*

Copayment

In-network PCP visit

You pay:
$40

Copayment amounts vary.*Some plans do not have a copay.

Deductible

In-network specialist visit:
$100

You pay:
100%

Insurance pays:
0%

$1,000
Annual deductible*

Coinsurance

In-network hospital visit:
$500

You pay:
20%
($100)

Insurance pays:
80%
($400)

Amount varies by plan*

Out-of-pocket maximum

(per person)

In-network specialist visit:
$200

You pay:
$0

Insurance pays:
$200

$3,000 per year*

*Prices are to be used as an example and can vary. Figures are based on individual plans with no dependents.

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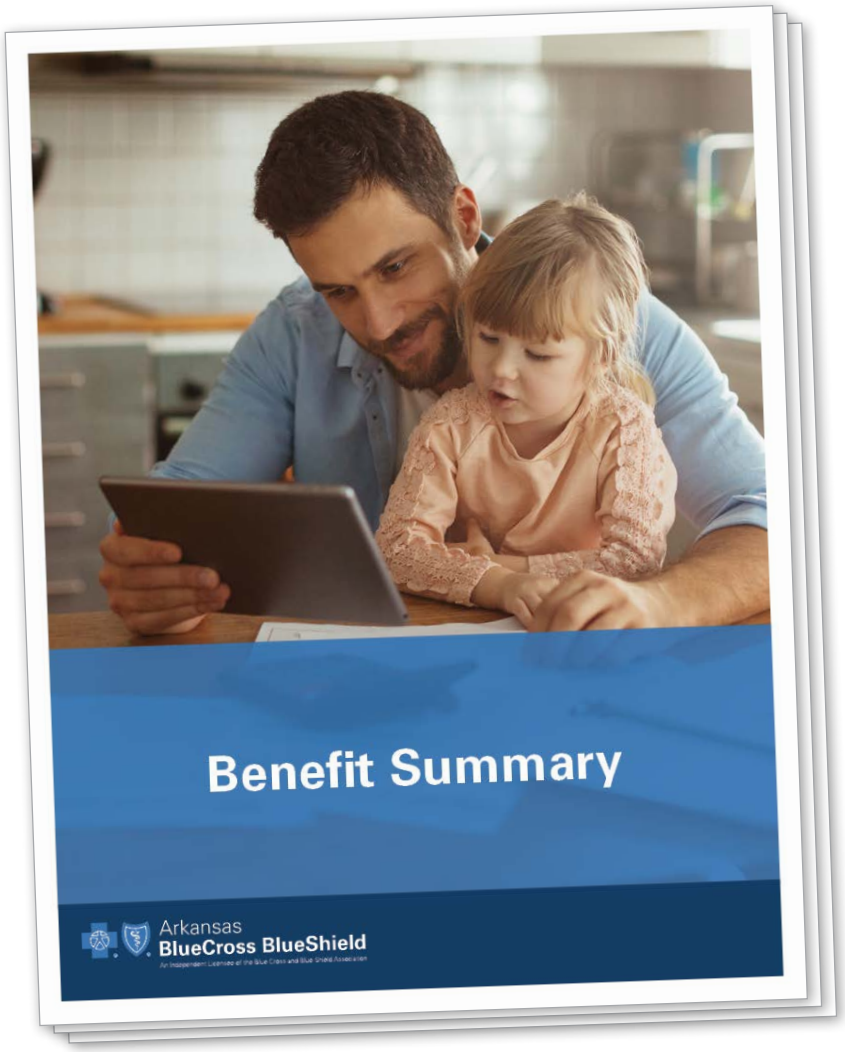
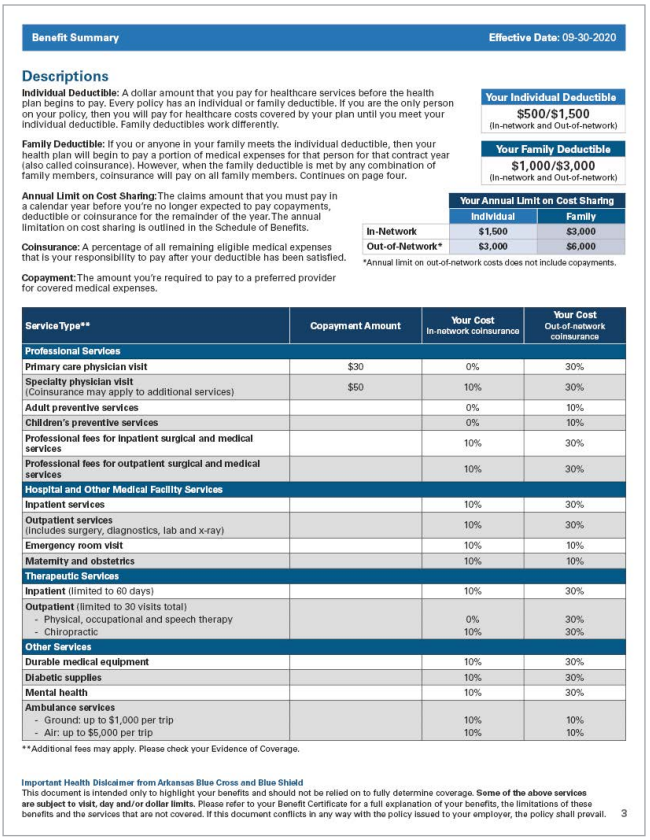
Summary of Benefits and Coverage (SBC)

When looking for health plans, you will have access to a Summary of Benefits and Coverage (SBC) outlining exactly what a plan will pay for different medical services. Sometimes called a “schedule of benefits,” this will provide you with a summary to use for comparison on cost and coverage. This is beneficial when choosing what plan will work best for you. You can access your plan’s SBC in Blueprint Portal.





Benefit Summary — **Effective Date:** 09-30-2020

Descriptions

Individual Deductible: A dollar amount that you pay for healthcare services before the health plan begins to pay. Every policy has an individual or family deductible. If you are the only person on your policy, then you will pay for healthcare costs covered by your plan until you meet your individual deductible. Family deductibles work differently.

Your Individual Deductible
$500/$1,500
(In-network and Out-of-network)

Family Deductible: If you or anyone in your family meets the individual deductible, then your health plan will begin to pay a portion of medical expenses for that person for that contract year (also called coinsurance). However, when the family deductible is met by any combination of family members, coinsurance will pay on all family members. Continues on page four.

Your Family Deductible
$1,000/$3,000
(In-network and Out-of-network)

Annual Limit on Cost Sharing: The claims amount that you must pay in a calendar year before you’re no longer expected to pay copayments, deductible or coinsurance for the remainder of the year. The annual limitation on cost sharing is outlined in the Schedule of Benefits.

Coinsurance: A percentage of all remaining eligible medical expenses that is your responsibility to pay after your deductible has been satisfied.

Copayment: The amount you’re required to pay to a preferred provider for covered medical expenses.

	Your Annual Limit on Cost Sharing	
	Individual	Family
In-Network	$1,500	$3,000
Out-of-Network*	$3,000	$6,000

*Annual limit on out-of-network costs does not include copayments.

Service Type**	Copayment Amount	Your Cost In-network coinsurance	Your Cost Out-of-network coinsurance
Professional Services			
Primary care physician visit	$30	0%	30%
Specialty physician visit (Coinsurance may apply to additional services)	$50	10%	30%
Adult preventive services		0%	10%
Children’s preventive services		0%	10%
Professional fees for inpatient surgical and medical services		10%	30%
Professional fees for outpatient surgical and medical services		10%	30%
Hospital and Other Medical Facility Services			
Inpatient services		10%	30%
Outpatient services (Includes surgery, diagnostics, lab and x-ray)		10%	30%
Emergency room visit		10%	10%
Maternity and obstetrics		10%	10%
Therapeutic Services			
Inpatient (limited to 60 days)		10%	30%
Outpatient (limited to 30 visits total) - Physical, occupational and speech therapy - Chiropractic		 0% 10%	 30% 30%
Other Services			
Durable medical equipment		10%	30%
Diabetic supplies		10%	30%
Mental health		10%	30%
Ambulance services - Ground: up to $1,000 per trip - Air: up to $5,000 per trip		 10% 10%	 10% 10%

**Additional fees may apply. Please check your Evidence of Coverage.

Important Health Disclaimer from Arkansas Blue Cross and Blue Shield
This document is intended only to highlight your benefits and should not be relied on to fully determine coverage. **Some of the above services are subject to visit, day and/or dollar limits.** Please refer to your Benefit Certificate for a full explanation of your benefits, the limitations of these benefits and the services that are not covered. If this document conflicts in any way with the policy issued to your employer, the policy shall prevail. 3

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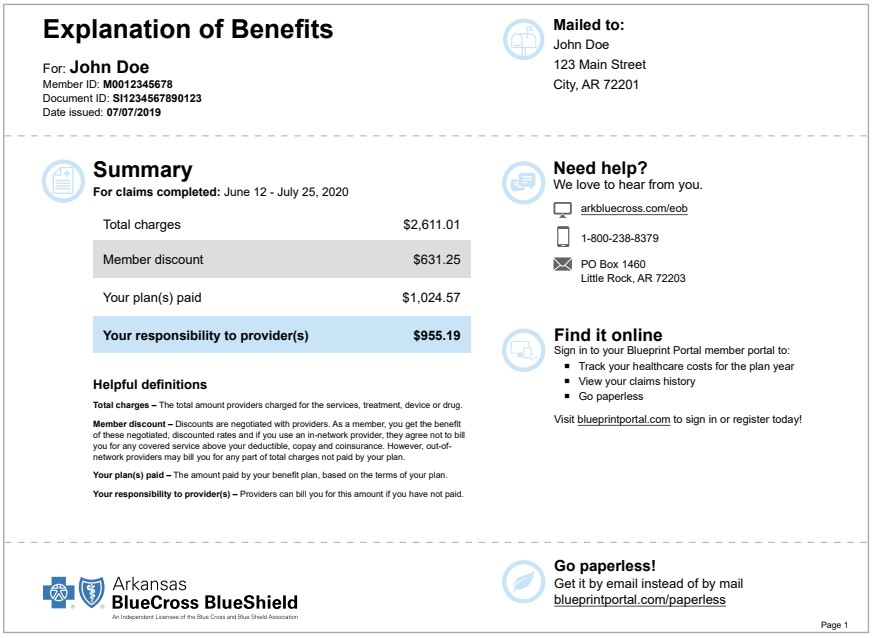
Explanation of benefits (EOB)

You will receive an explanation of benefits when you use your health insurance. This shows you the total cost of the care you received, how your insurance was applied and the discounts you received, how much was paid by your health plan and provider and what remaining costs (if any) are owed. **This is not a bill**. It is a simple way for you to see all of your claims in a given period and how your insurance is being used.



Explanation of Benefits

For: **John Doe**
Member ID: **M0012345678**
Document ID: **SI1234567890123**
Date issued: **07/07/2019**

Mailed to:
John Doe
123 Main Street
City, AR 72201

Summary

For claims completed: June 12 - July 25, 2020

Total charges	$2,611.01
Member discount	$631.25
Your plan(s) paid	$1,024.57
Your responsibility to provider(s)	**$955.19**

Helpful definitions

Total charges – The total amount providers charged for the services, treatment, device or drug.

Member discount – Discounts are negotiated with providers. As a member, you get the benefit of these negotiated, discounted rates and if you use an in-network provider, they agree not to bill you for any covered service above your deductible, copay and coinsurance. However, out-of-network providers may bill you for any part of total charges not paid by your plan.

Your plan(s) paid – The amount paid by your benefit plan, based on the terms of your plan.

Your responsibility to provider(s) – Providers can bill you for this amount if you have not paid.

Need help?
We love to hear from you.
arkbluecross.com/eob
1-800-238-8379
PO Box 1460
Little Rock, AR 72203

Find it online
Sign in to your Blueprint Portal member portal to:
- Track your healthcare costs for the plan year
- View your claims history
- Go paperless

Visit blueprintportal.com to sign in or register today!

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Get it by email instead of by mail
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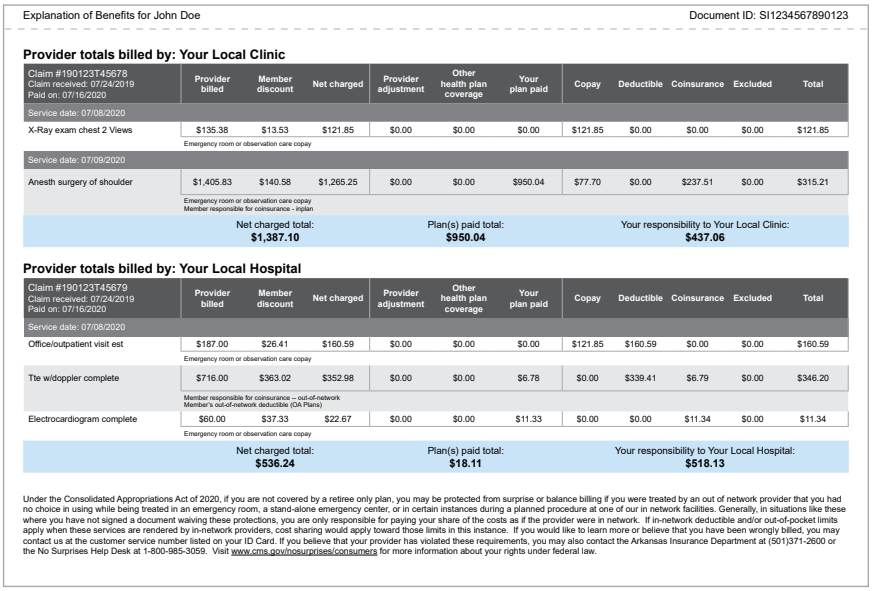

Explanation of Benefits for John Doe — Document ID: SI1234567890123

Provider totals billed by: Your Local Clinic

Claim #190123T45678 Claim received: 07/24/2019 Paid on: 07/16/2020	Provider billed	Member discount	Net charged	Provider adjustment	Other health plan coverage	Your plan paid	Copay	Deductible	Coinsurance	Excluded	Total
Service date: 07/08/2020											
X-Ray exam chest 2 Views	$135.38	$13.53	$121.85	$0.00	$0.00	$0.00	$121.85	$0.00	$0.00	$0.00	$121.85
Emergency room or observation care copay											
Service date: 07/09/2020											
Anesth surgery of shoulder	$1,405.83	$140.58	$1,265.25	$0.00	$0.00	$950.04	$77.70	$0.00	$237.51	$0.00	$315.21
Emergency room or observation care copay Member responsible for coinsurance - inplan											

Net charged total: **$1,387.10** — Plan(s) paid total: **$950.04** — Your responsibility to Your Local Clinic: **$437.06**

Provider totals billed by: Your Local Hospital

Claim #190123T45679 Claim received: 07/24/2019 Paid on: 07/16/2020	Provider billed	Member discount	Net charged	Provider adjustment	Other health plan coverage	Your plan paid	Copay	Deductible	Coinsurance	Excluded	Total
Service date: 07/08/2020											
Office/outpatient visit est	$187.00	$26.41	$160.59	$0.00	$0.00	$0.00	$121.85	$160.59	$0.00	$0.00	$160.59
Emergency room or observation care copay											
Tte w/doppler complete	$716.00	$363.02	$352.98	$0.00	$0.00	$6.78	$0.00	$339.41	$6.79	$0.00	$346.20
Member responsible for coinsurance – out-of-network Member's out-of-network deductible (OA Plans)											
Electrocardiogram complete	$60.00	$37.33	$22.67	$0.00	$0.00	$11.33	$0.00	$0.00	$11.34	$0.00	$11.34
Emergency room or observation care copay											

Net charged total: **$536.24** — Plan(s) paid total: **$18.11** — Your responsibility to Your Local Hospital: **$518.13**

Under the Consolidated Appropriations Act of 2020, if you are not covered by a retiree only plan, you may be protected from surprise or balance billing if you were treated by an out of network provider that you had no choice in using while being treated in an emergency room, a stand-alone emergency center, or in certain instances during a planned procedure at one of our in network facilities. Generally, in situations like these where you have not signed a document waiving these protections, you are only responsible for paying your share of the costs as if the provider were in network. If in-network deductible and/or out-of-pocket limits apply when these services are rendered by in-network providers, cost sharing would apply toward those limits in this instance. If you would like to learn more or believe that you have been wrongly billed, you may contact us at the customer service number listed on your ID Card. If you believe that your provider has violated these requirements, you may also contact the Arkansas Insurance Department at (501)371-2600 or the No Surprises Help Desk at 1-800-985-3059. Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

Health spending accounts

There are special accounts you can use toward medical expenses and prescription: health savings accounts (HSA), flexible spending accounts (FSA) and health reimbursement arrangements (HRA). These accounts let you save and use tax-advantaged money to cover qualified medical expenses. HSA accounts rollover year to year while FSA and HRA accounts must be used before the end of the year.

HSA vs FSA vs HRA

Account comparison	HSA	HRA	FSA
You own the account.	✓	✗	✗
Your employer owns the account.	✗	✓	✓
You must have a high-deductible health plan.	✓	✗	✗
Only your employer can put money in.	✗	✓	✗
You and your employer can put money in.	✓	✗	✓
You can invest the money in the account.	✓	✗	✗
Must report account when you do your taxes.	✓	✗	✗

What are the types of health plans?

There are different options for the type of health plan you choose. Depending on how you get your coverage (employer sponsored, individual, etc.) you may or may not have all of these options.

- **Health Maintenance Organization (HMO)**
- **Preferred Provider Organization (PPO)**
- **Point of Service (POS)**
- **High Deductible Health Plan (HDHP)**

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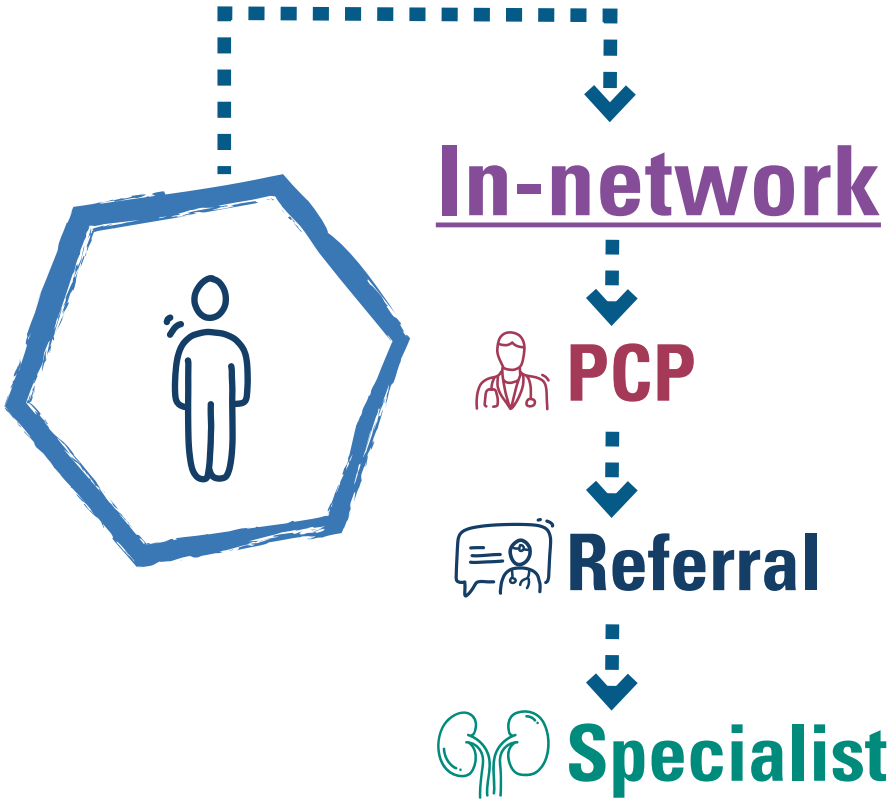
Health Maintenance Organization (HMO)

With this plan, you choose a PCP who coordinates your care using doctors and hospitals that are in your plan's network. If you need a specialist, such as a cardiologist, a referral from your PCP is required. Generally, an HMO won't cover services from an out-of-network provider.

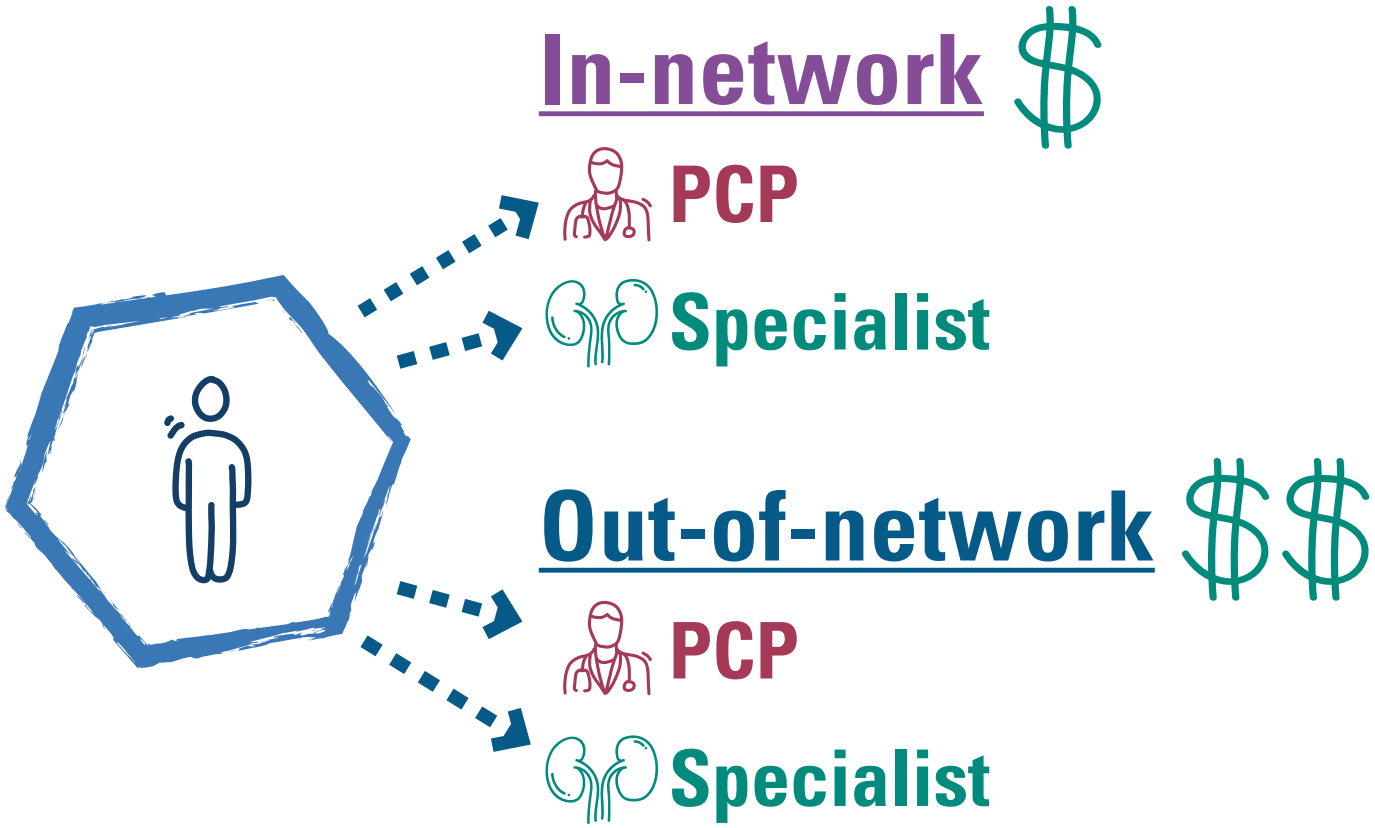
An HMO plan will usually have a lower monthly premium and deductible, but include coinsurance and copays.



Preferred Provider Organization (PPO)

This plan allows you to manage your own care, with or without referrals from a PCP. You have a choice in which provider to see, although you'll save money if you remain in network.

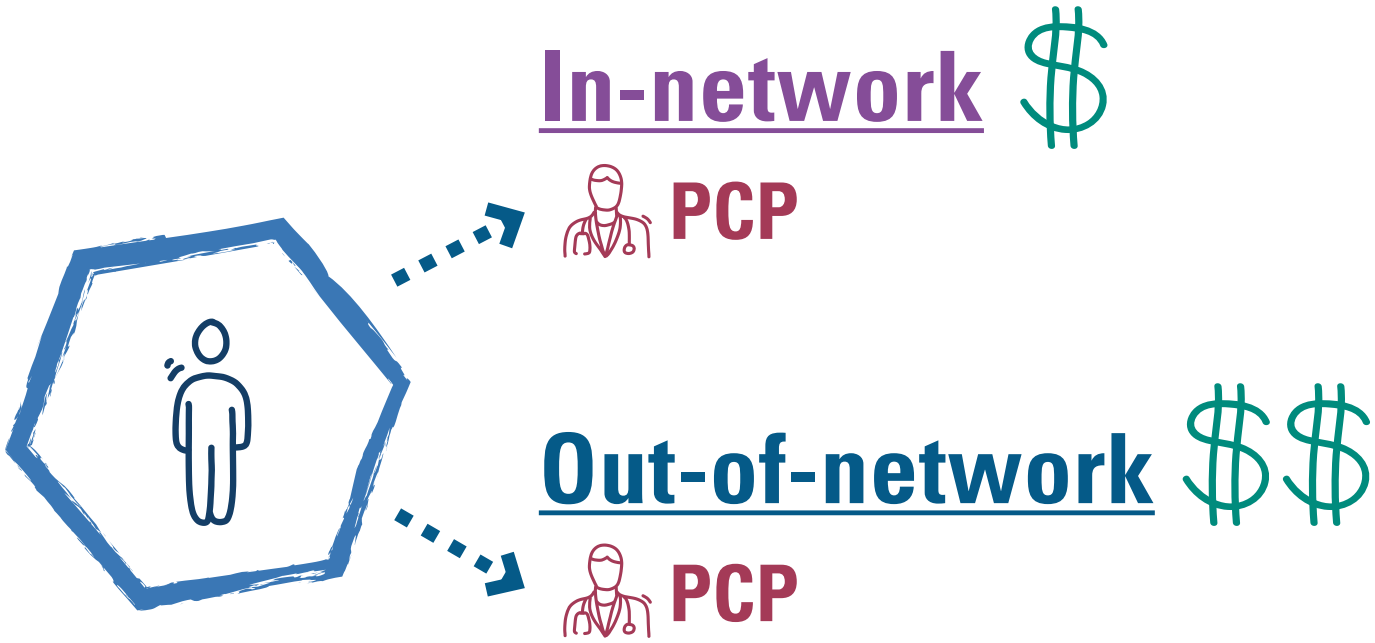
A PPO will likely have higher premiums than other types of plans, but lower copays and coinsurance.



Point of Service (POS)

A POS is a combination of HMO and PPO. Like an HMO, you choose a PCP. But like a PPO, you can get medical care from both in- or out-of-network providers. You'll pay less when you use a doctor or hospital in-network and more if you choose out-of-network.

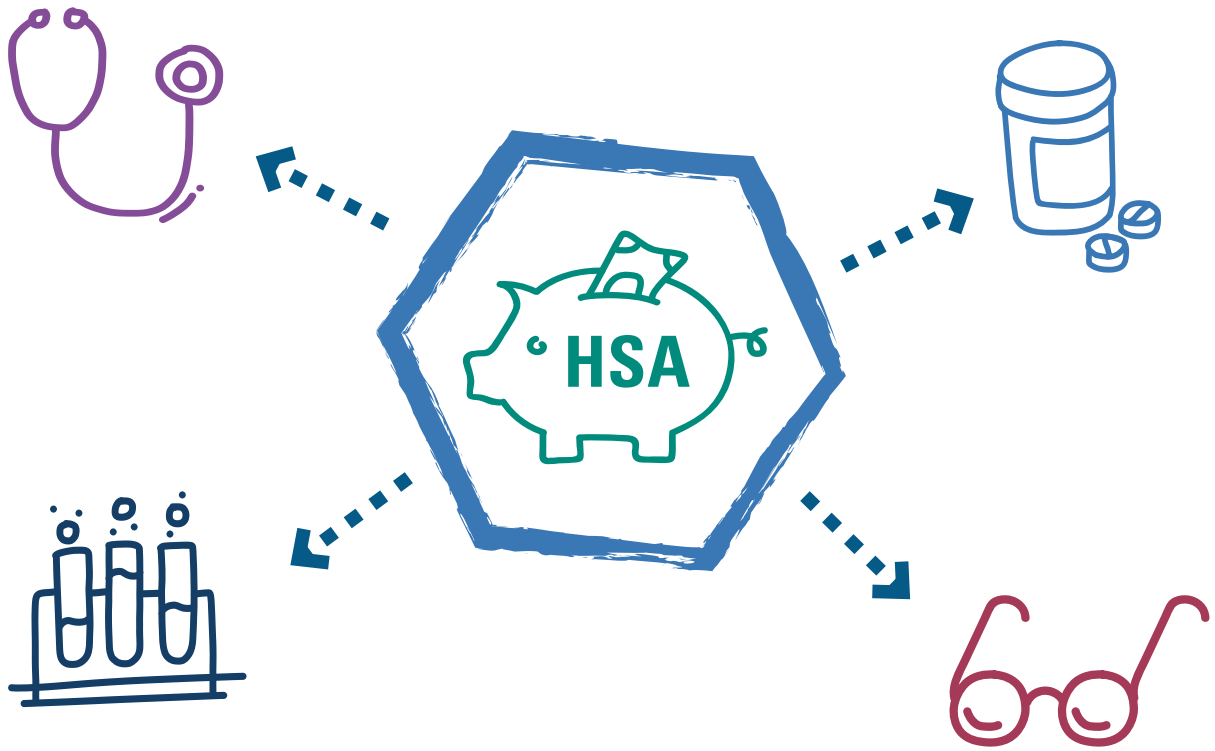
A POS plan may require you to pay a higher premium and have copays, but most have no deductible for in-network services referred by your PCP.



High Deductible Health Plan (HDHP)

This plan gives you the most control on how your healthcare dollars are spent. A HDHP has a higher deductible, but a lower monthly premium and a special HSA account to help you save money for healthcare expenses.

HDHPs typically have lower premiums, but you will pay more out-of-pocket for healthcare. Most HDHPs pay for several preventive care visits, but you will pay out-of-pocket for other types of care and prescriptions at the contracted amount set by your insurance and provider.

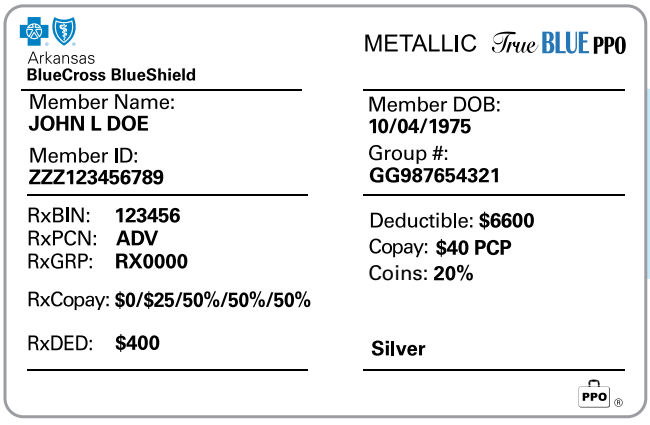


How do you use your ID card?

Arkansas Blue Cross, Health Advantage and Octave Blue Cross will send you a member ID card once you've enrolled in your plan and your coverage has started. This includes the essential information you need to know about your coverage, payment amounts and customer service phone numbers. Each provider you visit will need to make a copy of your ID card to make sure they bill correctly. Always carry your ID card with you in your wallet.

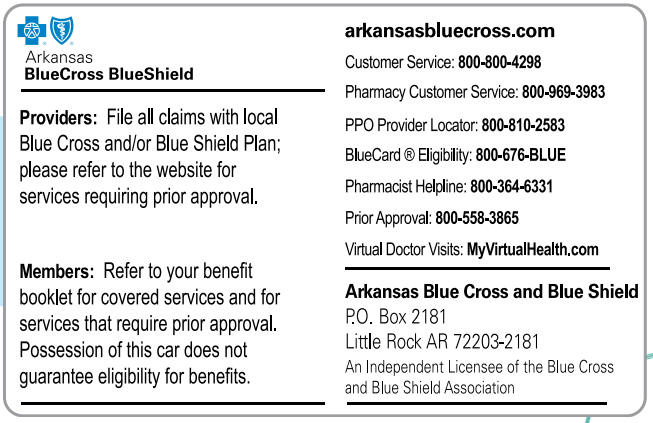
You also have access to a digital ID card on **Blueprint Portal**. Download the app to have your ID card anywhere you have your phone.

Your card may look slightly different than this example, depending on the health plan you have.



Healthcare providers use the elements on the front of your card to apply your health plan's benefits and file your claims with us.

This is your go-to reference when you have questions or need help.



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How does pharmacy work?

Different plans have their own set of prescription drugs they cover. The list of drugs your plan covers is called a prescription drug list (PDL) or "formulary."

When researching what medicine is covered by your plan, you may see there are tiers. Drug tiers represent different levels of cost and can save you money on your medications. You pay the least for medications in tier 1, which usually are generic drugs.

Plans differ on the amount of tiers they have. An example of how a four-tier formulary might be structured:

Tier 1:

Generic, non-specialty drugs

Lowest plan member copayment.

Tier 2:

Preferred, brand-name products

Intermediate plan member copayment.

Tier 3:

All non-specialty, non-preferred, brand-name products

Higher plan member copayment.

Tier 4:

Specialty medications

Highest plan member copayment.

5 easy ways to save money on medications

1. **Check the drug list before going to the pharmacy.**
   Ask your prescriber to consider your health plan's drug list before writing you a prescription. This allows him or her to see your lowest cost options before writing your prescription.
2. **Use generic medications whenever possible.**
   Generics have been reviewed by the U.S. Food and Drug Administration (FDA) as safe and effective and have been approved to be used in place of their brand-name counterparts. There are usually (but not always) many generics for a single brand-name medication.
3. **Try a combo of medications.**
   Some combination brand-name medications contain ingredients that are available separately as generics. It might cost less to take two different generic pills instead of one brand-name pill.
4. **Consider ordering extended-day supplies through mail order.**
   If filling your prescriptions through mail order is covered by your health plan and approved by your doctor, you may be able to save money by ordering more medication at once. For example, if your cost for 30 days of medication is $15 and your cost for a 90-day supply is only $30, you can save money by asking your prescriber to write a 90-day supply prescription. To find out if your plan covers prescriptions by mail, check your Blueprint Portal account.
5. **Check costs online.**
   By signing in to your Blueprint Portal account, you can access the Pharmacy Center and check for potential cost savings opportunities that may be available for your medications based on your specific plan.

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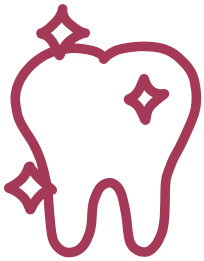
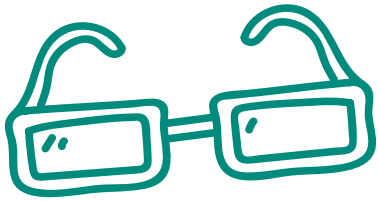
What about ancillary coverage?

What about the other stuff? Dental, vision, life and disability are all additional insurance products you can get with your health insurance. If you are getting your health plan through your employer, they will usually have options for you. There are individual options too through privately owned companies as well as government resources.





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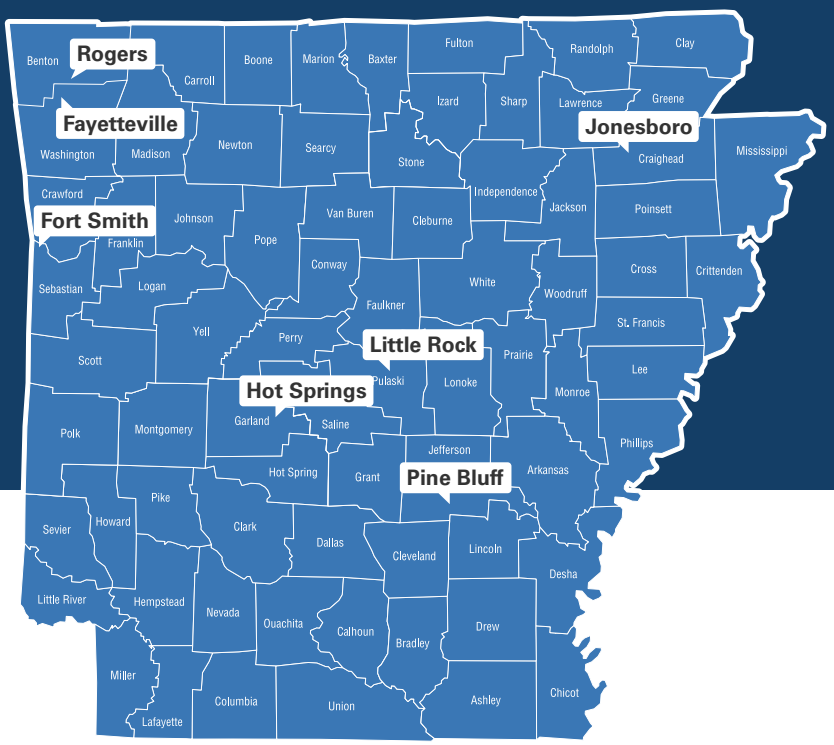
ArkansasBlue Welcome Centers

If you are ready to enroll in an individual plan (not through your employer), stop by or schedule an appointment at your nearest ArkansasBlue Welcome Center at **arkbluecross.com/locations**.



Fayetteville
3013 N. College Ave.
479-379-5180
Monday - Saturday 9:00 a.m. - 6:00 p.m.
Fayetteville@arkbluecross.com

Fort Smith
3501 Old Greenwood Road, Suite 3
479-648-1635
Monday - Friday 9:00 a.m. - 6:00 p.m.
Customerservicewc@arkbluecross.com

Hot Springs
1635 Higdon Ferry Road, Suite J
501-620-2620
Monday - Friday 9:00 a.m. - 6:00 p.m.
HotSpringsCS@arkbluecross.com

Jonesboro
2110 Fair Park Blvd
870-935-4871
Monday - Friday 9:00 a.m. - 6:00 p.m.
NERegionCS@arkbluecross.com

Little Rock - Midtown
416 S. University Ave., Suite 110
501-396-8675
Monday - Saturday 9:00 a.m. - 6:00 p.m.
Midtown@arkbluecross.com

Pine Bluff
509 Mallard Loop
870-536-1223
Monday - Friday 9:00 a.m. - 6:00 p.m.
PBCS@arkbluecross.com

Rogers
4602 W. Walnut St.
479-973-6675
Monday - Saturday 9:00 a.m. - 6:00 p.m.
Rogers@arkbluecross.com

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Health insurance is not just for people with chronic health conditions or expensive situations. Having health insurance gives you access to healthcare at a lower cost than if you were uninsured. Even if you do not have health issues you are aware of, taking advantage of preventive care can allow you to get ahead of unplanned circumstances and make sure you are maintaining your health. Now that you know a little more about the basics of health insurance, take that important first step by finding a PCP in Blueprint Portal and scheduling your annual wellness exam.

Have more questions?

Visit us online at **arkansasbluecross.com** or call the customer service number on the back of your ID card.

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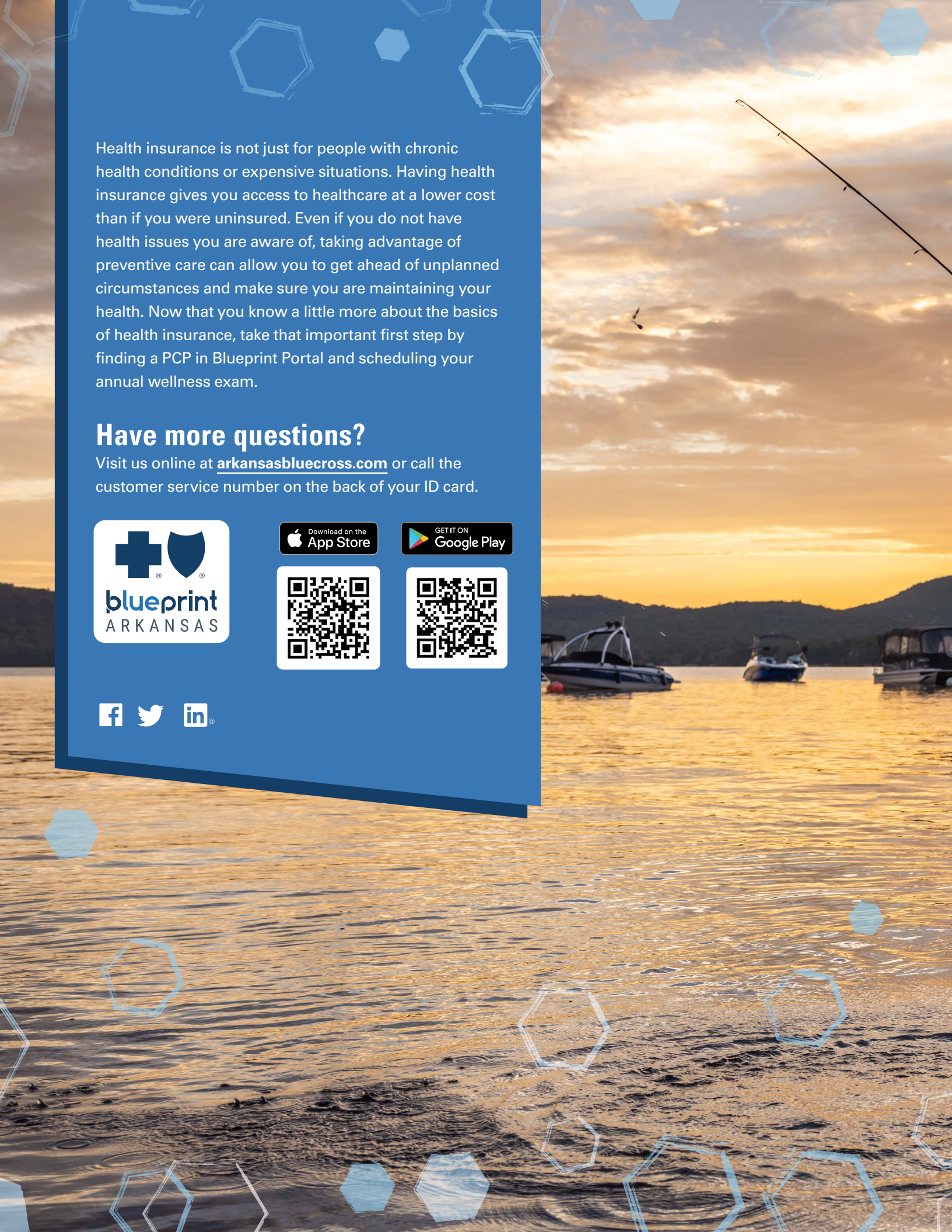

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