COMMUNITY CARE PHYSICIANS

www.communitycare.com

7/22

Understanding Health Insurance

A beginner's guide to helpful resources, terms to know, and much more!

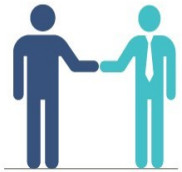
COMMUNITY CARE PHYSICIANS

www.communitycare.com

Let's Start With the Basics:

Health insurance covers medical costs when you get sick or hurt.

Your health plan is an agreement between you and your insurance company.

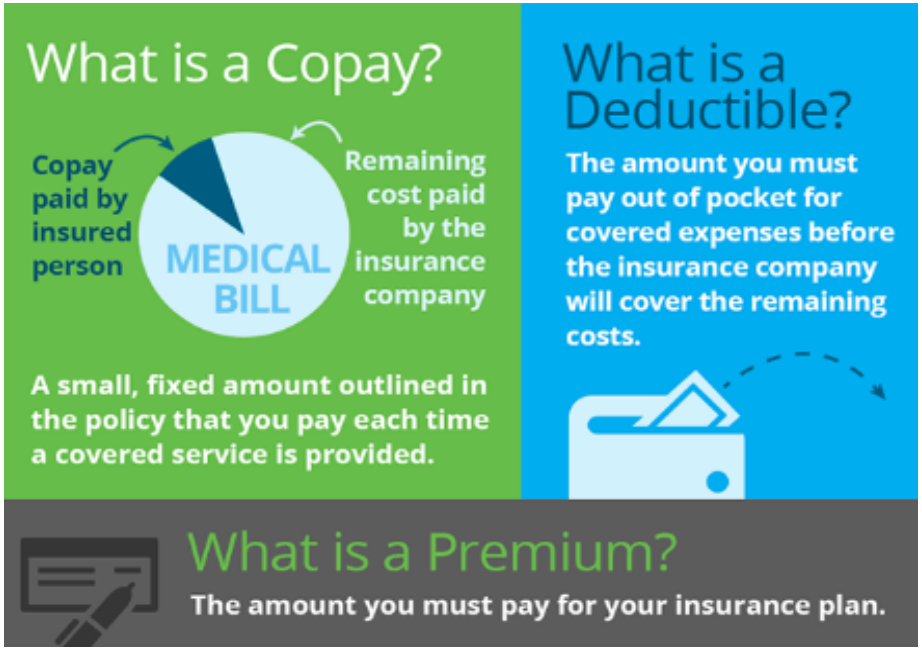


You agree to pay a monthly premium and some of the upfront costs for your care.

If you get sick or hurt, your insurance company helps pay those costs during the year.

Source: Know Your Plan. Retrieved from https://www.wahbexchange.org/current-customers/know-your-plan/

So what is the difference between a premium, deductible, and copay?



Source: Common Health Insurance Terms You Need to Know. (2016, June 23). Retrieved from https://www.healthmarkets.com/resources/health-insurance/common-health-insurance-terms-need-know/

Contacts for Support

Organization	Contact Information	Hours of Operation
MVP Medicaid Managed Care	Customer Care Center 1-800-852-7826	8am-6pm Monday-Friday
NYS Empire Plan	1-877-769-7447	
Tricare East (formerly Tricare North)	1-800-444-5445	7am-7pm Monday-Friday
United Healthcare	Enrollment :	8am-8pm

Need help finding a doctor? Contact our Customer Service Team at 518-782-3700!

Have a billing question? Contact our support team at (518) 782-3700 available Monday through Friday from 8:00am – 4:00pm.

COMMUNITY CARE PHYSICIANS

www.communitycare.com

7/22

Contacts for Support

Organization	Contact Information	Hours of Operation
BlueShield of Northeastern NY	1-800-700-8482	8am-7pm Monday-Friday
BlueShield of Northeastern NY Medicare Advantage	1-877-258-7453	8am-7pm Monday-Friday
CDPHP	All Counties and Regions 1-800-926-7526 HMO 518-641-3700 CDPHP Universal benefits, Inc., POS, PPO, HDPPO, and EPO 518-641-3140 Medicaid and Family Health Plus 518-641-3800 Medicare Choices with HMO Prescription drug coverage 518-641-3950 Medicare Choices with PPO Prescription Drug Coverage 518-641-3950	8am-8pm Monday-Friday
CDPHP Medicare Choice	1-888-519-7898 TTY 711	7:30am-5pm 7 days a week, 24/7
CDPHP Select Plans	CDPHP HMO/CDPHP High Deductible HMO 518-641-3700 CDPHP Universal benefits, Inc. POS, PPO, HDPPO, EPO, HDEPO 518-641-3140 CDPHP Medicare Choices HMO 518-641-3950 Medicare Supplemental 518-641-3980 Child Health Plus Medicaid Select plan 518-641-3800	8am-8pm Monday-Friday

Common Terms to Know:

- **Claim—**a request by a plan member, or a plan member's health care provider, for the insurance company to pay for medical services.
- **Coinsurance**—the amount you pay to share the cost of covered services after your deductible has been paid. The coinsurance rate is usually a percentage. For example, if the insurance company pays 80% of the claim, you pay 20%.
- **Copayment**—one of the ways you share in your medical costs. You pay a flat fee for certain medical expenses (e.g., $10 for every visit to the doctor), while your insurance company pays the rest. This fee doesn't go toward meeting your deductible.
- **Deductible**—the amount of money you must pay each year to cover eligible medical expenses before your insurance policy starts paying. For example: if you have a $2,000 deductible, you'll have to pay $2,000 in medical services until your insurance will start to cover costs.
- **Drug formulary**—a list of prescription medications covered by your plan.

Source: WPS Health Insurance.. Common Health Insurance Terms and Definitions. Retrieved from http://www.wpshealth.com/resources/customer-resources/health-insurance-terminology.shtml

The 4 Main Types of Insurance Plans:

1. Preferred Provider Organization (PPO)

With a PPO organization, you are encouraged to use a network of preferred doctors and hospitals. You will often pay higher fees for using services outside of the preferred network.

2. Health Maintenance Organization (HMO)

Provides health services at a fixed annual fee. You often have a lower out of pocket cost but less flexibility in choice of provider or hospital than other plans.

3. Point-of-Service (POS)

Combination of a PPO and HMO plan. You pay no deductible and a minimal copay when you use a doctor in your preferred network.

4. Exclusive Provider Organization (EPO)

In an EPO organization, you are required to choose providers from a preferred list only except in an emergency. This is the most strict plan. EPO members pay small copayments and may require a deductible.

Source: Different Types of Health Plans: How They Compare. Retrieved from https://www.webmd.com/health-insurance/types-of-health-insurance-plans#2

Contacts for Support

Below are the major insurance carriers for Community Care Physicians. For the full list of all accepted insurance providers, please visit: www.communitycare.com/about/insurance

Organization	Contact Information	Hours of Operation
Empire Blue Cross	518-367-4737	8am-8pm Monday-Friday
Empire Blue Cross Mediblue Plans	1-800-499-9554	8am-8pm Monday-Friday
Fidelis Care New York	Albany Regional Office: 518-427-0481	8am-8pm 7 days a week
Fidelis Medicare	1-888-343-3547 toll free	7 days a week, 24/7
Fidelis Medicaid	1-888-343-3547 toll free	7 days a week, 24/7
Medicaid: Please consult your provider's office	1-800-541-2831	8:00-4:30 Monday– Friday
Medicare/RR Medicare	1-888-687-6277	9:00-5:00
MVP	Customer Care Center (Medicaid and CHPlus members) 1-800-852-7826 Harmonious Healthcare Plan Members 1-844-946-8002	8:30am-5pm Monday-Friday
MVP Medicare Advantage	1-800-665-7924	7 days a week, 24/7

Understanding Medicare Advantage

Original Medicare & Medicare Advantage Plans At-a-Glance

	Original Medicare (Parts A+B)	Original Medicare plus Medigap	HMO (Part C/Medicare Advantage)	PPO (Part C/Medicare Advantage)
What do I pay?	Part B premiums, deductibles and coinsurances	Medigap premiums, Part B premiums, generally no copayment	Medicare premiums and plan premium; your plan sets its own deductibles and copays	Medicare premiums and plan premium; your plan sets its own deductibles and copays
Can I go to any doctor?	Yes, if they accept Medicare	Yes, if they accept Medicare	No, you must go to in-network providers	Yes, though PPOs have provider networks, you may go out of network for a higher copay
Where can I get routine, non-emergency care?	Anywhere in the country	Anywhere in the country	For most plans, in your local geographic area	For most plans, in your local geographic area
Where can I get emergency care?	Anywhere in the country	Anywhere in the country	Anywhere in the country	Anywhere in the country
How do I get prescription drug coverage?	Part D	Part D	You must join a plan that includes drug coverage, also called MA-PD	You must join a plan that includes drug coverage, also called MA-PD
Will I need a referral to see a specialist?	No	No, unless you have a Medicare SELECT plan	Usually	No, but you may pay more out of pocket if you go to a provider who is out of network
Is there a limit to my out-of-pocket spending?	No	No	Yes, all Medicare Advantage plans must have limits on out-of-pocket spending	Yes, all Medicare Advantage plans must have limits on out-of-pocket spending
Will it pay for extras, like vision and hearing aids?	No, Medicare does not cover dental, hearing or vision	No	Maybe; some plans offer these additional benefits	Maybe; some plans offer these additional benefits

Source: National Council on Aging. Medicare Plan At-a-Glance Comparison. Retrieved from https://www.mymedicarematters.org/resource-library/infographics/original-medicare-medicare-advantage-plans-glance/

Which Type of Plan is Best for Me?

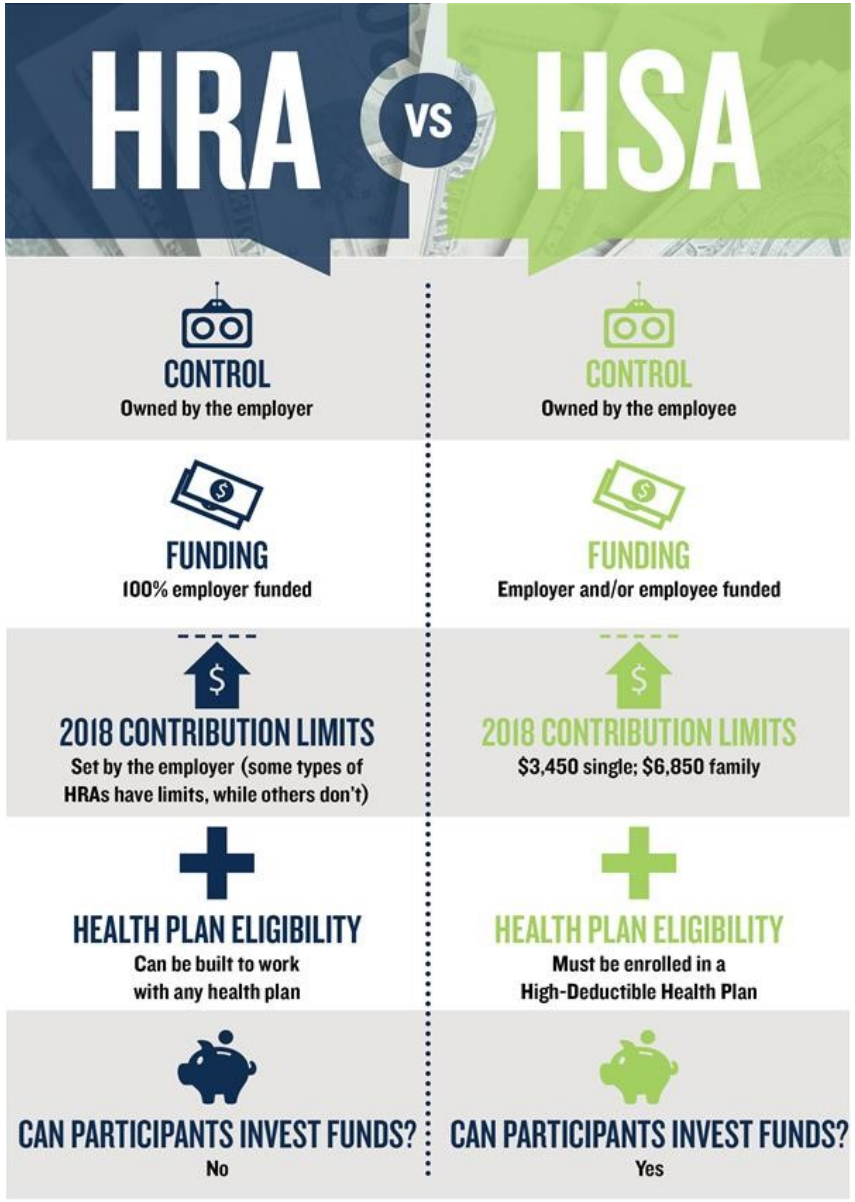
Each plan differs by requirements, benefits and costs. The table below elaborates on the key differences between the types of plans, so you can determine which one is best for you!

	PPO Preferred Provider Organization	EPO Exclusive Provider Organization	POS Point-of-service	HMO Health Maintenance Organization
Primary Care Physician (PCP) required?	No	Sometimes	Yes	Yes
Referral required to see a specialist?	No	No	Sometimes	Yes
"In-network" benefits	Yes	Yes	Yes	Yes
"Out-of-network" benefits	Yes	No	Yes	No
Flexibility	Highest	High	Medium	Low
Cost	$$$$	$$$	$$	$

Source: Cystic Fibrosis Foundation. The Insurance Basics. Retrieved from https://www.cff.org/Assistance-Services/Insurance/Your-Insurance-Plan/The-Insurance-Basics/

What is the difference between a HRA & HSA?:

Check out below the main differences between a Health Reimbursement Arrangement Plan (HRA), and a Health Savings Account (HSA), to determine which plan is best for you!



Source: HRA Vs. HAS: What You Need to Know. Retrieved from https://www.discoverybenefits.com/blog/posts/2018/02/15/hra-vs.-hsa-what-you-need-to-know

What does Medicare Cover?

THE ABCDs OF MEDICARE

PART OF MEDICARE	WHAT'S COVERED
PART A Original Medicare (CMS*)	**Partial Coverage for:** Inpatient Hospital Stay Skilled Nursing Care Hospice Home Care
PART B Original Medicare (CMS*)	**Partial Coverage for:** Doctor Visits Surgery Lab Tests Medical Equipment **Some preventive services**
PART C Private Insurers and Health Plans	Similar to **Parts A & B** with predictable out-of-pocket costs and more coverage. **Often fully covers:** Wellness Services Vision Exams Hearing Exams **Often partially covers:** Eye Glasses Hearing Aids
PART D Private Insurers and Health Plans	Helps with the cost of prescription drugs not covered by Original Medicare. **Covers some:** Prescription Drugs

*Centers for Medicare and Medicaid Services

BlueCross BlueShield. What does Medicare Cover? Retrieved from https://www.bluecrossmn.com/healthy/public/personal/home/shopplans/shop-medicare/what-does-medicare-cover

What is Medicare Part A, B, C, & D?

Medicare is a federal insurance program available to those over 65 years of age, certain younger individuals with disabilities, and those with end-stage renal disease. The four different parts of Medicare cover specific services:

Part A: Inpatient Hospital Insurance

Eligible individuals are automatically enrolled in Part A with no premium. Others may apply to the program when they are eligible or pay a monthly premium if they have worked less than 40 quarters (for 10 years) in their lifetime.

Part B: Outpatient/Physician Insurance

To obtain Part B, an eligible individual must enroll at their Social Security office during a specific period and pay a premium that is determined by their annual income. If an individual does not enroll during that period he/she must pay a penalty when he/she does enroll.

Part C: Medicare Advantage Plans

An alternative method to receive Medicare benefits through private companies approved by and under contract with Medicare. Includes Part A & Part B, and usually includes additional benefits that original Medicare doesn't cover, such as health and wellness programs, chiropractic care, or vision and hearing benefits.

Part D: Prescription Drug Coverage

Voluntary plans that help cover prescription drug costs. Plans are available through private companies that contract with Medicare to provide coverage. Each plan can vary in cost and drugs covered. If an individual does not enroll during a specific period, he/she must pay a penalty when he/she does enroll.

Source: Medicare 101. Retrieved from https://qualchoiceadvantage.com/medicareacademy/First Steps of Medicare/medicare-101

More Common Terms to Know:

- **Explanation of benefits**—the health insurance company's written explanation of how a medical claim was paid. It contains detailed information about what the company paid and what portion of the cost is your responsibility.

- **Health savings account (HSA)—**a personal savings account that allows participants to pay for medical expenses with pre-tax dollars. HSAs are designed to complement a special type of health insurance called an HSA-qualified high-deductible health plan (HDHP). HDHPs typically offer lower monthly premiums than traditional health plans. With an HSA-qualified HDHP, members can take the money they save on premiums and invest it in the HSA to pay for future qualified medical expenses.

- **In-network provider**—a healthcare professional, hospital, or pharmacy that is part of a health plan's network of preferred providers. You will generally pay less for services received from in-network providers because they have negotiated a discount for their services in exchange for the insurance company sending more patients their way.

- **Medicaid**—a health insurance program created in 1965 that provides health benefits to low-income individuals who cannot afford Medicare or other commercial plans. Medicaid is funded by the federal and state governments, and managed by the states.

Source: WPS Health Insurance.. Common Health Insurance Terms and Definitions. Retrieved from http://www.wpshealth.com/resources/customer-resources/health-insurance-terminology.shtml

More Common Terms to Know:

- **Medicare**—the federal health insurance program that provides health benefits to Americans age 65 and older, disabled people under 65 and people with certain medical conditions. Medicare has four parts; Part A covers hospital services, Part B covers doctor services, Part C covers additional benefits such as health/wellness programs, and Part D covers prescription drugs.

- **Out-of-network provider**—a healthcare professional, hospital, or pharmacy that is not part of a health plan's network of preferred providers. You will generally pay more for services received from out-of-network providers.

- **Out-of-pocket maximum**—the most money you will pay during a year for coverage. It includes deductibles, copayments, and coinsurance, but is in addition to your regular premiums. Beyond this amount, the insurance company will pay all expenses for the remainder of the year.

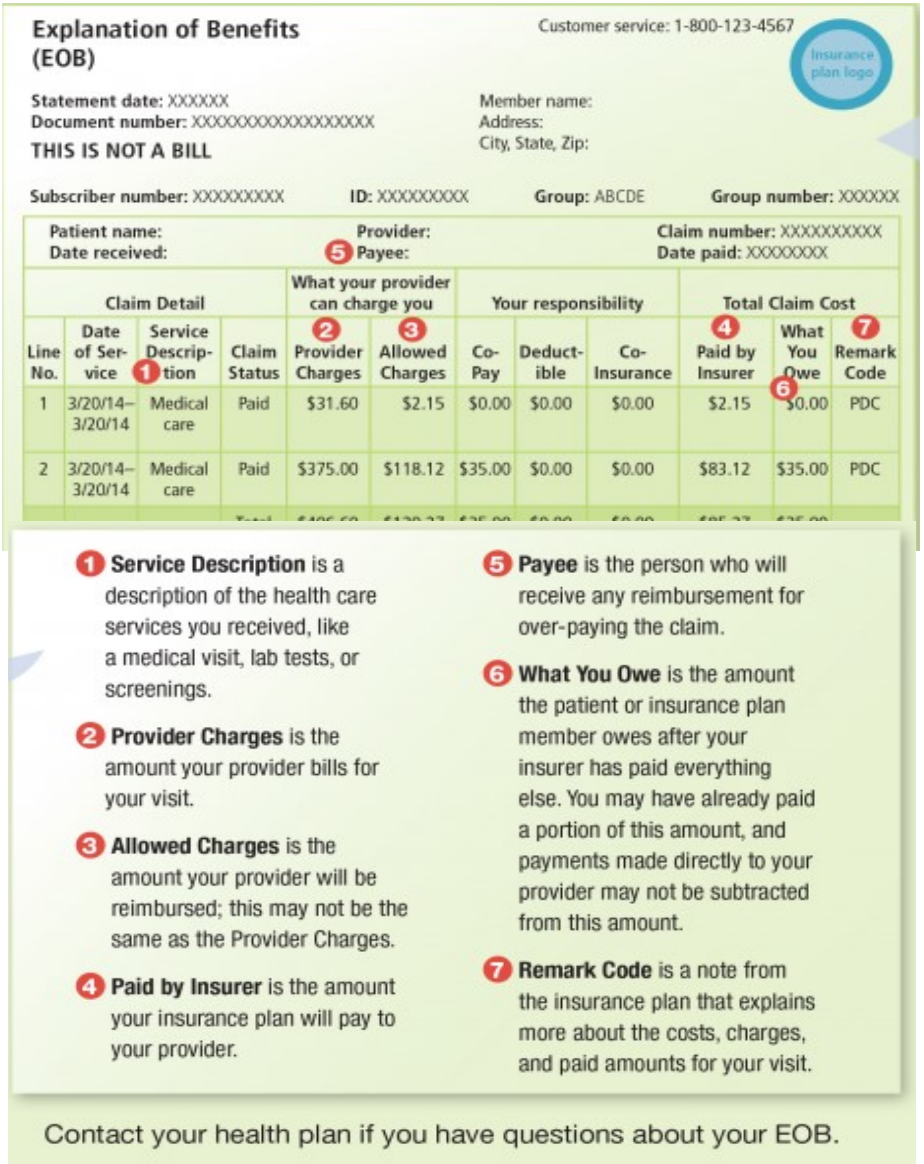
- **Payer**—the health insurance company whose plan pays to help cover the cost of your care; also known as a carrier.

- **Premium**—the amount you or your employer pays each month in exchange for insurance coverage. The average monthly premium in the U.S. per person is $450.

Source: WPS Health Insurance.. Common Health Insurance Terms and Definitions. Retrieved from http://www.wpshealth.com/resources/customer-resources/health-insurance-terminology.shtml

Understanding Your Explanation of Benefits

Understanding your Explanation of Benefits (EOB), can help avoid billing mistakes! You should receive an EOB after every health care visit you have. Take a look at this sample EOB to learn everything you need to know!



Explanation of Benefits (EOB)

Customer service: 1-800-123-4567

Insurance plan logo

Statement date: XXXXXX
Document number: XXXXXXXXXXXXXXXXX
THIS IS NOT A BILL

Member name:
Address:
City, State, Zip:

Subscriber number: XXXXXXXXX ID: XXXXXXXXX Group: ABCDE Group number: XXXXXX

Patient name:
Date received:

Provider:
5 Payee:

Claim number: XXXXXXXXXX
Date paid: XXXXXXXX

Claim Detail				What your provider can charge you		Your responsibility			Total Claim Cost		
Line No.	Date of Service	1 Service Description	Claim Status	2 Provider Charges	3 Allowed Charges	Co-Pay	Deductible	Co-Insurance	4 Paid by Insurer	What You Owe 6	7 Remark Code
1	3/20/14–3/20/14	Medical care	Paid	$31.60	$2.15	$0.00	$0.00	$0.00	$2.15	$0.00	PDC
2	3/20/14–3/20/14	Medical care	Paid	$375.00	$118.12	$35.00	$0.00	$0.00	$83.12	$35.00	PDC

1 **Service Description** is a description of the health care services you received, like a medical visit, lab tests, or screenings.

2 **Provider Charges** is the amount your provider bills for your visit.

3 **Allowed Charges** is the amount your provider will be reimbursed; this may not be the same as the Provider Charges.

4 **Paid by Insurer** is the amount your insurance plan will pay to your provider.

5 **Payee** is the person who will receive any reimbursement for over-paying the claim.

6 **What You Owe** is the amount the patient or insurance plan member owes after your insurer has paid everything else. You may have already paid a portion of this amount, and payments made directly to your provider may not be subtracted from this amount.

7 **Remark Code** is a note from the insurance plan that explains more about the costs, charges, and paid amounts for your visit.

Contact your health plan if you have questions about your EOB.

Source: Avoid Medical Billing Mistakes With An Explanation of Benefits. (2017, July 19). Retrieved from https://www.hendersonbrothers.com/double-check-explanation-benefits-avoid-medical-billing-mistakes/