



Checklist for Diagnosing your Health Care Insurance Coverageⁱ

**Sarah Davis, Center for Patient Partnerships
University of Wisconsin – Madison**

Whether choosing new insurance or using your existing coverage, it is important to know the coverage and appeal rights provided by your health insurance policy.

Why? If you or your family gets sick, it's important to know your coverage and follow the rules to minimize your out-of-pocket costs. Being a proactive health care consumer can ensure you access the best care and stay financially healthy as well.

We all deserve support. Why not ask a friend, relative, or advocate to help you fill out this checklist, so you do it soon.

Contents

- A) Important names and numbers**
- B) Date of open enrollment**
- C) Type of health plan (e.g. HMO, PPO)**
- D) Exclusions and Limitations – what is not covered**
- E) Out-of-pocket costs**
- F) Coverage for “out-of-network” services**
- G) Referrals needed**
- H) Referral process**
- I) Access to specialty care**
- J) Grievances and appeals – what to do when something is not covered and you think it should be**
- K) Notes**

If you would like help reviewing your plan with an advocate, contact the Center for Patient Partnerships' advocacy services, advocacy@patientpartnerships.org, 608.891.0321.

Advocacy services are provided at no cost.

A

Important names and numbers

My **primary-care** physician is: _____ phone: _____

Phone number for **general problems** with insurance coverage: _____

Phone number for **billing questions**: _____

Phone number to **seek care outside of my plan’s service area**: _____

If I seek emergency care, have a hospital admission, or receive care outside of my service area, I must call _____ within _____ hours.

B

Date of open enrollment for my health insurance plan: _____

(When I can pick a new plan if others are offered and I want to change plans)

C

My health plan is a:

Which means...

Health maintenance organization (HMO)

Not allowed to go “out-of network”

Preferred provider organization (PPO)

Can go “out-of-network” with some additional cost

Point-of-service plan (POS)

Out-of-network will cost a lot more

Traditional indemnity plan (also known as fee-for-service)

Watch out for “Usual, Customary or Reasonable (UCR)” rates

Other:

Will depend on your plan – ask an advocate

D

Exclusions and Limitations within my “Evidence of Coverage” section:

My health plan will not pay for:

My health plan limits coverage for:

My plan will cover services at these hospitals:

-
-

E**Out of pocket costs**

\$ _____ annual in-network deductible _____ drug co-pay, formularies
 _____ per visit co-pay _____ drug-copay, generics
 _____ % coinsurance, in-network _____ drug co-pay, brand name
 _____ Annual maximum coverage per person

If I use out-of-network providers, I will pay:

\$ _____ annual out-of-network deductible
 _____ % coinsurance, out-of-network
 _____ Costs above the ““Usual, Customary or Reasonable (UCR)” or
 “Maximum Allowable Charge (MAC)” reimbursement

G**My insurance will not cover “out-of-network” services for:**

- Any service
- Non-emergencies
- Mental health services
- Substance abuse treatment
- Other: _____

F**I need a referral from a primary care physician for:**

- I do not need a referral from my primary care physician
- Lab and x-ray tests
- Gynecologist (for well-woman exam)
- Gynecologist (for other concerns)
- Pediatrician
- Other specialist visits
- Surgery
- Other: _____

H**My insurance requires the following to obtain referrals:**

- I do not need a referral from my primary care physician
- Requires an office visit
- Requires _____ days advance notice
- Other: _____

I**Under my plan, insurance will pay for referrals to specialists who:**

- Are part of my doctor's **group practice**
- Are on the health plan **network** list ("in-network")
- Are **outside of the health plan network** ("out-of-network") only if there are no similar specialists within the network
- Are outside of the health plan network ("out-of-network")
- I do not need a referral from my primary care physician

J**Grievances and Appeals**

If your insurance does not cover health care services, and you believe the denial is an error or wrong, you can appeal. Upon request, your insurance company will provide you information about their Grievance and Appeal procedures.

For additional information or guidance, contact our free advocacy services at 608.890.0321 or your state's Office of the Insurance Commissioner. To find your state's information, go to: www.naic.org and search for "state map".

To receive grievance and appeal information from my insurance company, I can call _____.

If I have a grievance, I must notify my insurance company within _____ days.

Want to learn more about Insurance Coverage? Check out the Insurance and Benefits Section of **Pathways to Empowerment** at <http://www.patientpartnerships.org/pathways/>



ⁱ Adapted from the Kaiser Family Foundation's "A Consumer Guide to Handling Disputes with Your Private or Employer Health Plan," www.kff.org/consumerguide/05-checklist.cfm.