Understanding Your Medical Insurance

Navigating Insurance

When your child has a special health care need, developmental delay, or disability, it is important to understand your insurance coverage. Families are encouraged to consider the following as they navigate their health insurance.

Learn About Your Plan

Learning about your coverage will help you make the best decisions to meet your child's needs. Your insurance plan has a Summary Plan Description, a document that summarizes your coverage and provides some guidance on how to find providers who accept your insurance and/or are in your network. Depending on your employer and the insurance provider, this may be a paper document or information you can read online. To find the information about your plan contact your employer's human relations department or the member service information on your insurance card.

Required Processes

Beyond the basics of learning what your plan covers, it is important to learn about the rules required for coverage:

- Does your plan require a referral from your primary care doctor to see a specialist?
- How do you obtain a referral? Office visit? Notice in advance? Other?
- Does the referral require renewal? Can you get approval for more visits over the phone or do you need to schedule another visit with the primary care doctor?
- What appointments, test and procedures require pre-authorization? Can the doctor obtain the pre-authorization or do you need to contact your health plan directly?
- Are you required to use only providers who have agreed to be covered by the plan (in network providers)?
- If you can also see doctors who are not part of your plan (out of network coverage), what rules does the plan have for seeing these doctors? What will it cost you to use an out of network provider?
- Can you see a doctor who is not in your plan's network in an emergency or when traveling? And what will the cost be to you?

Medically Necessary

Even if you know what benefits your health plan will cover and how the billing works, you may still have problems with getting your child's treatment covered. "Medically necessary" is the term that insurance companies use to determine the medical need for a particular treatment or procedure. This definition is

used as a determining factor of payment for treatment and procedures your child may need. You should always look for your plan's definition of medical necessity; any definition of medical necessity has room for interpretation. If you need to prove medical necessity, a letter can be written by your doctor, you or other medical provider.

Appealing a Denial

If your health plan has not paid for a service or will not agree in advance to a service, then you have the option of appealing the health plan's decision. The information on the appeals process for your health plan is in the Evidence of Coverage. The process for a Health plan appeal will vary from health plan to health plan so you should familiarize yourself with the process at the same time you are reviewing your coverage. Your plan's Explanation of Benefits (EOB) form will tell you if a service is covered or not. Your health plan does not have to cover all services for your child and you should first check the Evidence of Coverage booklet to make sure your plan covers the denied service. In general the following steps can be taken:

- If you believe the service has been denied in error, you can contact your plan by phone to discuss your EOB. This is an informal review process. Make sure you get in writing any outcome from an informal review as you cannot appeal a phone call.
    - Keep a record of every phone call to your plan with the name of the person you talked to and notes of the conversation. If the health plan representative will get back to you with information, make sure you find out when you can reasonably expect a reply and follow up with the health plan if you have not heard back.
- If your customer service representative says your plan will not cover a service, you can still submit a claim for coverage. You will need the written denial if you want to proceed to a formal appeal.
    - If you decide to file a formal appeal, it must be in writing.
        - Your health plan may have an appeal form.
        - If not, the Evidence of Coverage will describe the appeal process.
        - Always keep a copy of your written appeal.
- Expect to provide the following information in an appeal
    - Your name, address, and telephone number
    - Your member identification number or Social Security number
    - Copies of the Explanation of Benefits (EOB) forms and your provider's name and billing form
    - Description of the service or procedure you want covered
    - Information supporting why the service should be covered

You may have to file your appeal within a specified period of time. Appeals filed outside the allowed time period will not be considered by the health plan. In some cases the plan may have a special procedure for urgent cases.

For more information on Insurance regulations in Illinois, call the Illinois Insurance Association Consumer Hotline at 1-800-444-3338 or visit their website at: http://www.illinoisinsurance.org/