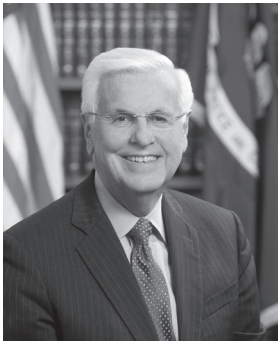
Louisiana Department of Insurance

Consumer's Guide to Health Insurance

James J. Donelon, Commissioner of Insurance

Message from Commissioner of Insurance

Jim Donelon



Health care costs are continuing to rise throughout the country. Consequently, the cost of health insurance has been a major issue for consumers in Louisiana and throughout the nation. Many of us have health insurance through our employers, but many others have to purchase individual health insurance to help with the cost of general health care needs and to protect themselves and their families against major illness, injury or accidents.

Choosing the best individual health insurance plan for you and your family can be a difficult and stressful task. We hope this guide will be helpful to you by providing a general understanding of individual health insurance, explaining the different types of health insurance plans available and offering tips to consider when purchasing health insurance coverage. We also offer steps you should take if you have a problem with your health insurer, while outlining your appeal rights in the event of a dispute with your insurer. Additionally, this guide contains information regarding the Affordable Care Act, including details on the Health Insurance Marketplace and open enrollment periods.

Should you have any further questions regarding individual health insurance, or have problems with a company's services or a claim dispute, the Louisiana Department of Insurance is here to help. Please contact our Office of Health Consumer Affairs staff at 225-219-4770, or toll free, statewide, at 1-800-259-5300.

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Table of Contents

What you need to know about health insurance.....2

Types of health insurance.....2

Why do you need health insurance?.....4

Understanding the Affordable Care Act.....4

Consumer protections under the ACA.....5

Where to get health insurance.....6

Open enrollment period.....7

Shopping for an individual insurance policy.....7

Managed Care: A way to control costs.....8

Supplemental Health Plans.....9

Do I have appeal rights under my health care plan?.....11

LDI Mailbag: You've got questions, we've got answers.....13

Understanding health insurance terms.....15

What you need to know about health insurance

There are many different types of health insurance. Each has pros and cons and there is no one "best" plan. The plan that's right for a single person may not be best for a family with small children. And a plan that works for one family may not be right for another.

Cost isn't the only thing to consider when buying health insurance. You also need to consider what benefits are covered. You should compare plans carefully for both cost and coverage.

Quick Tip:

Definitions of health insurance terms are included in the section called "Understanding Health Insurance Terms."

What are the different types of health insurance?

Health Maintenance Organizations (HMOs) and Exclusive Provider Organizations (EPOs)

These types of health insurance may limit coverage to providers within a designated network. A network is a list of doctors, hospitals, and other health care providers that offer medical care to members of a specific health plan. If you visit a doctor or facility that isn't in the plan's network, you may have to cover more of the costs for services provided.

HMO members usually have a primary care doctor and must get referrals to see specialists. This is generally not true for EPOs.

Preferred Provider Organizations (PPOs) and Point-of Service (POS) plans

These insurance plans give you a choice of getting care within or outside of a provider network. With PPO or POS plans, you may use out-of-network providers and facilities, but you'll have to pay more than if you use in-network ones.

If you have a PPO plan, you can visit any doctor without a referral. If you have a POS plan, you can visit any in-network provider without a referral, but you'll need one to visit a provider out-of-network.

Catastrophic Health Insurance Plan

A catastrophic health insurance plan covers essential health benefits as defined by the ACA, but has a very high deductible. Catastrophic plans work as a safety net in case you have an accident or serious illness and usually do not cover services such as prescription drugs or shots. Premiums for catastrophic plans may be lower than traditional health plans, but deductibles are usually much higher.

Why do you need health insurance?

With health insurance, you can protect yourself and your family against unaffordable or unexpected medical care. You may also need health insurance to avoid paying a penalty fee under the Affordable Care Act (ACA). Individuals who choose not to purchase a health insurance policy are required to pay a penalty fee as well as be responsible for all of their health care costs.

About the fee...

The ACA penalty fee, sometimes called the "individual mandate" or "individual responsibility payment," will increase every year. The penalty fee for children is half the amount adults will pay.

- The fee in 2014 is 1 percent of your yearly income or $95 per adult, whichever is higher.
- The fee in 2015 is 2 percent of your yearly income or $325 per adult, whichever is higher.
- The fee in 2016 and later years is 2.5 percent of your yearly income or $695 per adult, whichever is higher.

**Note: The penalty fee in subsequent years will be adjusted for inflation.*

Under certain circumstances, some individuals may be exempt from the penalty fee. Eligibility requirements for the exemption can be viewed on the Health Insurance Marketplace website www.healthcare.gov.

Understanding the Affordable Care Act

Signed into law by President Barack Obama on March 23, 2010, the ACA has dramatically changed the market for and the requirements of health insurance. While many of the legislation's provisions have already been implemented, including the creation of a Health Insurance Marketplace (or Exchange), others are scheduled to be phased in over the next few years.

What are the consumer protections under the Affordable Care Act?

- No lifetime or annual limits on essential benefits. The ACA ensures that all health plans offer a comprehensive package of items and services known as essential health benefits. They are:
  - Ambulatory patient services, such as doctor visits and outpatient services; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

- Rescissions, which are retroactive cancellations of insurance, may occur only for fraud or intentional misrepresentation of material fact. As of September 23, 2010, Acts 2010, No. 484 included this provision in state law.

- Coverage of preventive health services, such as a wide range of immunizations for children as well as adults, specific preventive services for women, children and depression.

- Extension of adult dependent coverage to age 26. As of September 23, 2010, Louisiana has included this provision in state law.

- Health insurers seeking to increase their rates by 10 percent or more must submit their requests to state or federal reviewers to determine whether they are reasonable or not.

- Plans are no longer allowed to exclude coverage for pre-existing conditions or to adjust your premiums based upon your health status or health status factors, except for tobacco usage.

- Plans are required to offer coverage to all persons seeking coverage during the open annual enrollment period, and are generally required to renew that coverage at the option of the insured.

- Plans are subject to limits on out-of-pocket expenses, which means there is a maximum amount of money that you will be required to pay during each plan year. Once that out-of-pocket limit is met, your plan must cover the remainder of your covered services during the plan year. An out-of-pocket expense includes deductibles, coinsurance, co-payments, and other charges. The out-of-pocket expense limit for the 2014 plan year is $6,350 for an individual and $12,700 for a family plan. In later years, the maximum limit may be adjusted for inflation.

Where do people get health insurance coverage?

You can purchase health insurance through an agent, insurance company or the Marketplace.

One of the key components of the ACA is the creation of the Health Insurance Marketplace. These online Marketplaces (or Exchanges) serve as a way for individuals to purchase health insurance – however, they are not the only way for you to acquire health insurance. You can find out more about the Health Insurance Marketplace by visiting the U.S. Department of Health and Human Services (HHS) website www.healthcare.gov or calling 1-800-318-2596, (TTY: 1-855-889-4325)

Quick Tip:

Individuals who choose to purchase health insurance through the Marketplace may qualify for a subsidy and/or tax credit to help lower their monthly premiums and out-of-pocket costs if their annual income falls between 100 and 400 percent of the federal poverty level.

There are four metal levels of coverage provided under the Marketplace. They are Bronze, Silver, Gold and Platinum. Each of these types of coverage provide different levels of insurance coverage, with platinum plans offering the highest levels of coverage and a bronze plan the lowest. (See chart below)

Level	Percent of Insurance Coverage	Percent of Co-Insurance
BRONZE	60%	40%
SILVER	70%	30%
GOLD	80%	20%
PLATINUM	90%	10%

Bronze and Silver plans require patients to pay more of the costs, while Gold and Platinum plans have higher premiums but lower out-of-pocket costs.

Premiums for different plans at the same level vary from one insurance company to another, based on the overall use of services by enrollees, the price of health care services negotiated by each insurance company, and the extent of covered services, among other reasons.

Open Enrollment Period

The open enrollment period is the timeframe during which individuals can purchase a health insurance policy through an agent, insurance company or the Marketplace.

After the open enrollment period ends, individuals will not be able to purchase health insurance through the Marketplace until the next annual enrollment period.

Quick Tip:

To purchase health insurance outside of the open enrollment period, you must have a qualifying life event. A qualifying life event is a change in your life that can make you eligible for a special enrollment period. Examples of qualifying life events are moving to a new state, certain changes to your income, and changes in your family size such as marriage, divorce or having a baby.

Shopping for an individual insurance policy

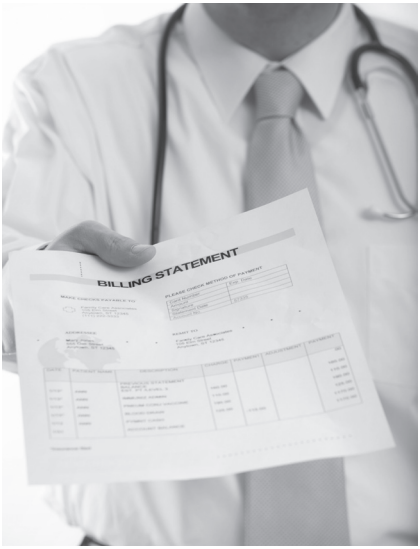
- Shop carefully. Policies can differ in coverage and cost. Contact different insurance companies or ask your agent to show you policies from several insurers in order to compare the policies.
- Make sure there is a “free look” clause. Companies may give you at least 10 days to look over your policy after you receive it. If you decide it is not for you, return it and the company will refund your premium.
- Beware of single disease insurance policies. Some policies offer protection for only one disease, such as cancer. If you already have health insurance, your regular plan probably already provides all the coverage you need. Check to see what protection you have under your regular plan before buying specialty insurance.

Managed Care: A way to control costs

Managed care influences how much health care you use. Almost all plans have some sort of managed care program to help control costs. For example, if you need to go to the hospital, one form of managed care requires that you receive approval from your insurance company before you are admitted to make sure that the hospitalization is needed. If you go to the hospital without this approval, you may not be covered for the hospital bill.

Facts to consider...

- Remember to thoroughly review the "Exclusions and Limitations" portion of the health policy. Even if a treatment is considered medically necessary, you will not be covered if a benefit or service is limited or excluded.
- If you currently see a doctor, be sure to check your potential health plan's list of preferred providers to see if he/she will be in your insurer's provider network.
- Individual policies generally pay benefits for your spouse and on your dependent children up until age 26. However, your insurance company cannot terminate coverage for dependent children who lack other means of support due to mental or physical handicaps.
- Use caution when making the decision to utilize an out-of-network provider for medical care and treatment. Some individual health plans contain both in-network and out-of-network benefits at different percentages (for example, in-network paying 90 percent vs. out-of-network paying 60 percent). You may find yourself paying more than expected.



What are Supplemental Health Plans?

Supplemental health plans provide limited coverage and benefits for specified losses. These policies should be used as supplements rather than substitutes for basic or comprehensive health insurance.

Accident Only policies cover death, disability, hospital and medical care resulting from an accident. A variation of this type of policy, called accidental death and dismemberment, can pay additional benefits for death due to motor vehicle or at-home accidents.

Cancer policies provide limited benefits when the insured person is diagnosed with cancer (as defined in the policy contract). Most policies contain a schedule of benefits describing the amount of payments for "covered" cancer treatments. Not all forms of cancer are covered under these policies.

Quick Tip:

Many specified disease policies only provide coverage for the actual treatment of the specified disease and will not cover charges that do not directly treat the specified condition. For example, a person being treated for cancer requires chemotherapy, which may cause extreme nausea. If anti-nausea medication is prescribed for the patient, the insurer may not cover the drug since it is treating the nausea, not the cancer.

Critical Illness policies pay a lump sum if you are diagnosed with a specified critical illness. Examples of "critical illness" are stroke, heart attack, life threatening cancer, paralysis, deafness, organ transplant, blindness, kidney failure, etc.

Dental insurance provides benefits for care and treatment of teeth and gums. Benefits can vary as some policies may cover 100 percent of preventive care while others may only cover a portion of the costs. Typically, dental insurance plans provide limited benefits for preventive, basic, major and orthodontic services.

Quick Tip:

Dental insurance policies may be available in the Marketplace either as part of a comprehensive health insurance plan or as "stand-alone" plans.

Disability Income policies periodically pay income for a specific period if you suffer a disability and cannot continue to work. The payment is usually a set dollar amount not to exceed a certain percentage of your income. Most disability policies reduce benefits based on other income to which you may be entitled, such as sick leave, Social Security benefits, workers' compensation or sabbatical pay.

Home Health Care policies cover services prescribed by a physician and provided by a Medicare-certified or state-licensed home health care service. The care must help with activities of daily living or the supervision or protection of a patient with cognitive impairment such as Alzheimer's disease or senility.

Hospital Indemnity policies typically provide benefits for each day of hospital confinement. The benefits are usually specified dollar amounts and are not based on actual expenses.

Long-Term Care policies help cover the day-to-day costs of care for a person living with an acute or long-term disability. These policies can pay for some or all of long-term care services such as home health care, nursing home care, respite care, adult day care and care in an assisted living facility.

Medicare Supplement policies are designed to pay most medical expenses for Medicare beneficiaries. Medicare does not cover all expenses. As a result, you may consider purchasing a Medicare Supplement policy that helps pay for certain expenses not covered by Medicare.

Nursing Home Care policies offer an alternative to home health care policies and cover either one or several levels of care such as skilled, intermediate and custodial. Cognitive impairment or the inability to perform two or more of the activities of daily living will activate the benefits of this care.

Vision insurance provides benefits for eye care such as exams, glasses and contact lenses. Some plans may also include surgical benefits for injury or illness associated with the eye.

Do I have appeal rights under my health plan?

Yes. When your health plan refuses to pay a claim or terminate your coverage, you have the right to ask your health plan to reconsider its decision. Your health plan is required to inform you why they've denied your claim or terminated your coverage. Also, your health plan must notify you of your appeal rights and provide steps on how to file an appeal.

Quick Tip:

There are two ways to appeal a claim denial, an internal claims appeal and an external review.

The **internal claims appeal** process is also known as a grievance procedure. In this process you may ask your health plan to conduct a full and fair review of its decision. An internal appeal must be filed within 180 days (six months) of receiving notice that your claim for a treatment or service has been denied.

Your health plan must provide you with a written decision regarding your internal appeal. If you have an urgent care situation, an **expedited internal appeal** can be requested. An expedited internal appeal requires your health plan to notify you of its final decision as quickly as possible.

An **external review** can be requested if your claim is still denied after an internal appeal. A written request for an external review must be filed within 120 days (four months) of a claim denial. You can submit additional information to support your appeal. Any information you submit will be reviewed along with information you submitted on your application. Your health plan will determine if the request is eligible or ineligible for an external review and will notify you of its decision within five business days of receiving the request.

Quick Tip:

Starting in 2015, if your health plan determines that your request for an external review is ineligible, you may appeal to the Commissioner of Insurance. The Commissioner will decide if the request for external review is eligible or ineligible within five business days, and will decide immediately for an expedited review. The health plan must comply with the Commissioner's decision.

An **expedited external review** can be requested if the timeline for the standard external review would seriously jeopardize your life or your ability to regain maximum function. In this case, your health plan must immediately determine if your request is eligible or ineligible.

External reviews are conducted by state-licensed entities known as an independent review organization (IRO). The IRO assigned to your appeal will either uphold or reverse the claim denial and will notify you, your health plan and the Insurance Commissioner of its decision. If the IRO decides in your favor, your health plan must immediately approve the claim.

IRO Timeline: An IRO will make its final decision within…

- 45 days for a standard external review
- 72 hours for an expedited external review
- 20 days for an experimental or investigational review
- 48 hours for an expedited experimental or investigational review

Why do companies raise premiums?

- Medical cost inflation is a major factor in premium hikes. Insurers often raise premiums when the cost of paying medical claims increases.
- Medical utilization or an increase in the number of medical procedures performed each year also causes premium increases.
- Cost shifting occurs when one group of patients pays less than the true cost of their medical care. When this happens, insurers may overcharge others to make up the difference.

Can my insurer cancel my health insurance policy?

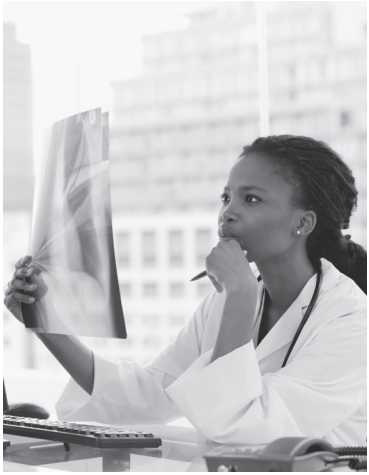
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was passed to protect individuals from having their health insurance policy cancelled. But individual health insurers can cancel coverage under specific circumstances.

Generally, a policy may be cancelled if the insurance company withdraws a particular policy, provided a 90-day written notice is given and the insurer offers policyholders a replacement policy. If the insurer withdraws all policies from the state, a 180-day notice of cancellation must be given. Additionally, the insurer is prohibited from issuing such policies in the state for five years.

Other reasons that an insurer could cancel your policy are nonpayment of premium, fraud or failure to comply with plan provisions. If it is unclear after reading the notice of cancellation if these conditions have been met, you may file a complaint with the Louisiana Department of Insurance.

Why is my share of the medical bill higher than expected?

You may have used an out-of-network doctor or hospital that does not contract with your insurer to give you a discounted price. Out-of-network providers can bill the difference of the full charge and the amount covered by your insurer to you. In addition, you may pay a higher coinsurance for out-of-network services. For example, you might be obligated to pay only 20 percent of the negotiated charges for services provided by an in-network provider, but 40 percent for an out-of-network provider.



I chose a health insurance policy but I am not happy with it. Can I get a different policy?

This depends on the type of insurance you purchased. Most insurance products allow a 10-day free look period during which you can cancel coverage and have your money refunded. Medicare supplement and long-term care policies have a 30-day free look period. The free look provision should be on the front page of your policy.

If I purchase an individual plan with an effective date of March 1 and I get sick or injured on March 3, would I be covered for treatment of the sickness or injury?

Yes. The individual plan should provide coverage from day one for all conditions that are covered under the policy.

I need family coverage, not just individual coverage. How do I get coverage for my family?

It is called individual coverage because you are buying it on your own rather than through an employer group plan. If the members of your family qualify as dependents, they can also be covered under your individual plan.

Understanding Health Insurance Terms

Adverse Determination - A health insurer may decide that it's not going to pay a claim, or it's not going to pay the dollar amount that the insured requested. The denial can be for many reasons such as the health plan simply doesn't cover the procedure or the health plan defines the service as "experimental or investigational" or "not medically necessary." When insureds receive adverse benefit determinations from their health plans, insureds can file an appeal.

Authorized Representative - A person who has express written consent to act on behalf of the covered person, like a family member or other trusted person. Some authorized representatives may have legal authority to act on the covered person's behalf.

Agent - An agent or broker is a person or business who can help you apply for help paying for coverage and enroll you in a Qualified Health Plan (QHP) through the Marketplace. They can make specific recommendations about which plan you should enroll in. They're also licensed and regulated by states and typically get payments, or commissions, from health insurers for enrolling a consumer into an issuer's plans. Some agents and brokers may only be able to sell plans from specific health insurers.

Annual Limit - A cap on the benefits your insurance company will pay in a year while you're enrolled in a particular health insurance plan. Many health insurance plans place limits on how much money they will pay you or your doctor over the course of a plan year. The Affordable Care Act bans annual limits for essential benefits for plan years starting after Sept. 23, 2010.

Appeal - A request for your health insurer or plan to review a decision or a grievance again.

Balance Billing - When an out-of-network provider bills you for the difference between the provider's charge and the amount allowed by the plan. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you for covered services.

Catastrophic Health Plan - Health plans that meet all of the requirements applicable to other Qualified Health Plans (QHPs) but that don't cover any benefits other than three primary care visits per year before the plan's deductible is met. The premium amount you pay each month for health care is generally lower than for other QHPs, but the out-of-pocket costs for deductibles, copayments, and coinsurance are generally higher. To qualify for a catastrophic plan, you must be under 30 years old OR get a "hardship exemption" because the Marketplace determined that you're unable to afford health coverage.

Claim - A request for payment that you or your health care provider submits to your health insurer when you get items or services you think are covered by your policy.

Co-op - A non-profit organization in which the same people who own the company are insured by the company. Cooperatives can be formed at a national, state, or local level and can include doctors, hospitals, and businesses as member-owners. Co-ops offer insurance through the Marketplace.

Coinsurance - Your share of the costs of a covered health care service, calculated as a percentage (for example, 20 percent) of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20 percent would be $20. The health insurer pays the rest of the allowed amount.

Coordination of Benefits - A way to figure out who pays first when two or more health insurance plans are responsible for paying the same medical claim.

Copayment - A fixed amount (for example, $15) you pay for a covered health care service, usually when you get the service. The amount can vary by the type of covered health care service.

Covered Expenses – Most insurance plans do not pay for all services. Covered services are those medical procedures the insurer agrees to pay for. They are listed in the policy.

Covered Person - A policyholder, subscriber, enrollee or other individual participating in a health benefit plan.

Deductible - The amount you owe for health care services before your health insurance or plan begins to pay. For example, if your deductible is $1,000, your plan will not pay anything until you've met your $1,000 deductible for covered health care services listed in the plan.

Emergency Medical Condition - An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Essential Health Benefits - A set of health care service categories that must be covered by certain plans, starting in 2014. (See page 6)

Excluded Services - Health care services that your health insurer or plan doesn't pay for or cover.

Exclusive Provider Organization - A managed care plan where services are covered only if you go to doctors, specialists, or hospitals in the plan's network (except in the case of an emergency).

External Review - A review by an independent third-party of a plan's decision to deny coverage for or payment of a service. If the plan denies an appeal, an external review can be requested. In urgent situations, an external review may be requested even if the internal appeals process isn't yet completed. External review is available when

the plan denies treatment based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, when the plan determines that the care is experimental and/or investigational, or for rescissions of coverage. An external review either upholds the plan's decision or overturns all or some of the plan's decision. The plan must accept this decision.

Fee For Service - A method in which doctors and other health care providers are paid for each service performed. Examples of services include tests and office visits.

Final Adverse Determination - An adverse determination involving a covered benefit that has been upheld by an insurer, or by a utilization review organization acting on an insurer's behalf, at the completion of the health insurer's internal appeals process procedures.

Group Health Plan - In general, a health plan offered by an employer or employee organization that provides health coverage to employees and their families.

Habilitative/Habilitation Services - Health care services that help you keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance Marketplace - A resource where individuals, families, and small businesses can compare and purchase health insurance plans. In Louisiana, the Marketplace is run by the Centers for Medicare and Medicaid Services and can be accessed through www.healthcare.gov.

Health Maintenance Organization (HMO) - A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness.

Health Savings Account - A medical savings account available to taxpayers who are enrolled in a High Deductible Health Plan. The funds contributed to the account are not subject to federal income tax at the time of deposit. Funds must be used to pay for qualified medical expenses. Unlike a Flexible Spending Account (FSA), funds roll over year to year if you don't spend them.

High Deductible Health Plan (HDHP) - A plan that features higher deductibles than traditional insurance plans. HDHPs can be combined with a health savings account or a health reimbursement arrangement to allow you to pay for qualified out-of-pocket medical expenses on a pre-tax basis.

Independent Review Organization - An entity licensed by the Louisiana Department of Insurance to conduct independent reviews or appeals of adverse determinations and final adverse determinations.

LaCHIP - The Louisiana Children's Health Insurance Program (LaCHIP) provides health coverage to uninsured children up to age 19. To qualify, your household income must be below certain income limits. You can apply through the Louisiana Department of Health and Hospitals.

Lifetime Limit - A cap on the total lifetime benefits you may get from your insurance company. An insurance company may impose a total lifetime dollar limit on benefits (like a $1 million lifetime cap) or limits on specific benefits (like a $200,000 lifetime cap on organ transplants or one gastric bypass per lifetime) or a combination of the two. After a lifetime limit is reached, the insurance plan will no longer pay for covered services. The ACA ends lifetime limits on coverage of essential health benefits.

Managed Care Plan - A health plan that uses managed care arrangements and has a defined system of selected providers that contract with the plan. It is a way to manage costs and use while maintaining the quality of the health care system. Most health care plans have managed care features. Individuals have a financial incentive to use participating providers that agree to furnish a broad range of services to them. Providers may be paid on a pre-negotiated basis.

Minimum Essential Coverage - The type of coverage an individual needs to have to meet the individual responsibility requirement under the ACA. This includes individual market policies, job-based coverage, Medicare, Medicaid, CHIP, TRICARE and certain other coverage.

Navigator - An individual or organization that's trained and able to help consumers, small businesses, and their employees as they look for health coverage options through the Marketplace, including completing eligibility and enrollment forms. These individuals and organizations are required to be unbiased. Their services are free to consumers.

Open Enrollment Period - This is the time period when people may enroll in or transfer between available health care plans.

Out-of-pocket Maximum/Limit - The most you pay during a policy period (usually one year) before your health insurance or plan starts to pay 100 percent for covered essential health benefits. This limit must include deductibles, coinsurance, copayments, or similar charges and any other expenditure required of an individual which is a qualified medical expense for the essential health benefits. This limit does not have to count premiums, balance billing amounts for non-network providers and other out-of-network cost-sharing, or spending for non-essential health benefits. The maximum out-of-pocket cost limit for any individual Marketplace plan for 2014 can be no more than $6,350 for an individual plan and $12,700 for a family plan.

Point of Service (POS) Plans - A type of plan in which you pay less if you use doctors, hospitals, and other health care providers that belong to the plan's network. POS plans also require you to get a referral from your primary care doctor in order to see a specialist.

Pre-Existing Condition - A health problem you had before the date that new health coverage starts.

Preferred Provider Organization (PPO) - A type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. You pay less if you use providers that belong to the plan's network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

Premium - The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

Premium Tax Credit - The ACA provides a new tax credit to help you afford health coverage purchased through the Marketplace. Advance payments of the tax credit can be used right away to lower your monthly premium costs. If you qualify, you may choose how much advance credit payments to apply to your premiums each month, up to a maximum amount. If the amount of advance credit payments you get for the year is less than the tax credit you're due, you'll get the difference as a refundable credit when you file your federal income tax return. If your advance payments for the year are more than the amount of your credit, you must repay the excess advance payments with your tax return.

Preventive Services - Routine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems.

Primary Care Physician - A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider - A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Prospective Review - A review that is conducted prior to an admission or course of treatment.

Referral - A written order from your primary care doctor for you to see a specialist or get certain medical services. In many Health Maintenance Organizations (HMOs), you need to get a referral before you can get medical care from anyone except your primary care doctor. If you don't get a referral first, the plan may not pay for the services.

Rehabilitative/Rehabilitation Services - Health care services that help you keep, get back, or improve skills and functioning for daily living that have been lost or impaired because you were sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Retrospective Review - A review of medical necessity conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication of payment.

Special Enrollment Period - A time outside of the open enrollment period during which you and your family have a right to sign up for job-based health coverage. Job-based plans must provide a special enrollment period of 30 days following certain life events that involve a change in family status (for example, marriage or birth of a child) or loss of other job-based health coverage.

Utilization Review - A set of formal techniques to monitor the use of or evaluate the clinical necessity, appropriateness, efficacy or efficiency of health care services, procedures or settings.

Utilization Review Organization - An entity licensed by the Louisiana Department of Insurance to conduct utilization review, other than a health insurer performing a review for its own health benefits plans.

Contact Us

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