

Consumer Guide To Health Insurance



This guide was produced by the Department of Consumer and Business Services and the Oregon Health Authority through a federal grant provided by the U.S. Department of Health and Human Services.

The Oregon Health Authority is leading Oregon's health care reform efforts and oversees key health programs, including the Oregon Health Plan. Find more information at <http://www.oregon.gov/OHA>.

The Department of Consumer and Business Services is Oregon's largest business regulatory agency. It protects consumers and workers in areas ranging from insurance to financial services to building codes. Its consumer insurance advocates offer personalized help with your insurance questions and complaints.

Toll-free: 1-888-877-4894

Salem area: 503-947-7984

Website: insurance.oregon.gov

To order copies of this guide,
e-mail DCBS.inmail@state.or.us

This guide was printed in April 2011.

Portions of the text may be out of date so be sure to check with specific agencies or programs for the most current information.

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Introduction

Roughly half of Oregonians get health insurance through an employer or buy an individual/family policy on their own. More than a quarter of Oregonians are covered through public programs such as Medicare and Medicaid. An estimated 17 percent are currently uninsured.

The Oregon Health Authority offers a variety of programs — from health care to prescription drug discounts to insurance for people with pre-existing conditions. Not all programs are income-based. Find an index of these public programs under ***Oregon health programs*** on page 24 of this guide.

The Oregon Department of Consumer and Business Services regulates commercial insurance in Oregon to protect consumers. The department's consumer advocates help Oregonians understand insurance and resolve complaints against their insurer or agent. Advocates can be reached at 888-877-4894 (toll-free) or 503-947-7984. Their e-mail address is cp.ins@state.or.us. You can also find insurance tips on a variety of topics at insurance.oregon.gov. Click on "consumers."

Through the Insurance Division, the department also licenses insurance companies and agents, makes sure insurers are financially sound, reviews policies for consumer protections, and investigates potential violations of insurance law by companies and agents. The division approves health insurance rates for people with individual health plans or coverage through a small employer. Learn more about the rate review process at tinyurl.com/orhealthrates.

This guide offers basic information about commercial health insurance at a time of transition following passage of the federal Affordable Care Act. While key health reforms will not take effect until Jan. 1, 2014, some began in 2010. We touch on those reforms in this booklet but you can find more current information at insurance.oregon.gov.

● ● ● Medicare ● ● ●

This guide *does not* explain Medicare. If you have Medicare coverage, the Department of Consumer and Business Services publishes the *Oregon Guide to Medigap, Medicare Advantage, and Prescription Drug Plans*. It is updated annually and explains rules and plan choices that apply to Medicare coverage.

How does employer (group) insurance work?

Employers decide on coverage and costs

- Today, employers are not required to provide or pay for health insurance for employees or their family members.
- If an employer offers health insurance, it must be available to all *eligible* employees. Generally, the employer determines which categories of employees are eligible.
- Employers decide how much of the insurance premium they will pay for employees and family members, and the amount employees must pay. Under some circumstances, the insurance company can require that the employer pay a specific percentage of the premium.
- Employers pick the insurance company and choose the benefits available to employees. There may be one plan or several plans. Employers can also *require* employees to take the employer's health plan and to pay their share of the costs.

Pre-existing conditions

A pre-existing condition is a medical condition for which medical advice, diagnosis, care, or treatment was received before applying for medical insurance.

- A group health insurer cannot decline coverage to an employee or the employee's family members (if the employer offers family coverage) because of a pre-existing medical condition.
- A health insurer, however, can impose a waiting period for coverage of pre-existing conditions for members age 19 and older. Insurers only look at the past six months of your medical history to see if there are pre-existing conditions they will not



cover immediately. Insurers cannot require children under age 19 to wait for coverage. The waiting period for adults age 19 and older generally cannot exceed six months. However, it can be 12 months if you work for a self-insured employer or if you don't sign up when first eligible.

- If you had health insurance within 63 days of the start of a new policy, you get credit for that coverage and the *pre-existing condition waiting period* is reduced one month for every month of coverage you had. This may reduce or even eliminate a waiting period.
- Small-group health insurers cannot treat pregnancy as a pre-existing condition.
- In general, aside from pre-existing conditions, employers can require new employees and their dependents to wait up to 90 days before they can enroll in the employer's health insurance plan.

When you sign up or change insurance choices

When you are hired, ask about your deadline for enrolling in your employer's health plan. After this initial enrollment period, you generally must wait until the annual **open enrollment** to change coverage. However, special enrollments are allowed when there are certain events such as marriage, births, loss of job, etc.

Premiums

A group health insurance company may change coverage options or increase rates annually. Your employer decides whether your share of the costs go up. Any changes in coverage and cost are typically communicated to employees during the annual **open enrollment**. This is the time when you make decisions about the insurance choices your employer offers.

How does individual health insurance work?

Buying a policy

- You can buy an individual plan for you and your family through an agent or directly from an insurance company. Find a list of companies selling individual insurance plans in Oregon at healthcare.gov.
- Anyone who is 19 and older and applies to be on your policy must complete a detailed health application called the “Oregon Standard Health Statement.” All companies must use this statement to decide if adult family members qualify based on health.
- The company will ask whether in the past five years you have had any medical advice; diagnosis; care or treatment, including any prescribed medications; or surgery or hospitalization. You may need to check with your doctor or review your medical records to accurately complete this form.
- If you are under age 19, you cannot be denied coverage because of pre-existing conditions. However, insurers may limit enrollment to certain periods every year. In Oregon, these periods are February and August of every year. A bill before the 2011 Legislature may result in companies once again offering year-round enrollment as early as the fall of 2011. See the Insurance Division website for updates: insurance.oregon.gov.
- If you are pregnant when you apply for an individual plan, an insurance company may legally decide not to insure you and the child’s father unless you are under age 19. In that case, you cannot be turned down for coverage if you apply during an open enrollment period.
- If an insurance company declines to cover you or a family member, you can apply for coverage through the Oregon Medical Insurance Pool (OMIP). This program operates state and federally funded high-risk pools. Coverage through the federal pool began Aug. 1, 2010, and offers new options for people with pre-existing conditions.



These programs will end after January 2014, when insurers no longer can deny insurance to people with pre-existing conditions. Learn more at omip.state.or.us or call 1-800-848-7280 (toll-free).

Pre-existing conditions

- If you are accepted for coverage and are age 19 or older, insurers look at the past six months of your medical history to see if there are pre-existing conditions they will not cover immediately. If so, you may have to wait up to six months before that pre-existing condition will be covered.
- If you had health insurance within 63 days of the start of a new policy, you get credit for that coverage and the *pre-existing condition waiting period* is reduced one month for every month of coverage you had. This may reduce or even eliminate a waiting period.
- If you are under age 19, insurers cannot deny you coverage or make you wait for coverage based on pre-existing conditions.

Premiums

- Your monthly premium for health insurance and any rate changes depend on your plan choices, your age, where you live in the state, and your family size. Your rates cannot be based on your health or claims history.
- Your rates can be increased annually and will typically reflect increases in medical costs. You may see additional rate increases if you or members of your family move into a new age bracket.

There are many types of insurance policies with varying price tags. The key is to find the policy that best fits your medical needs and your budget. For example, if you are young and healthy, you may want a higher deductible plan with a lower premium. Do you want the freedom to select your doctor or pay a little less for the type of managed care that requires a primary physician to coordinate your care?

Once you have insurance

- A company can't end your coverage if you get sick.

Types of health plans

Whether you get insurance at work or buy a plan on your own, understanding how your policy works will help you make the best use of your benefits.

Most people have some type of managed care such as a

● ● ● **Managed care lowers your costs** ● ● ●

Preferred Provider Organization (PPO) plan or Health Maintenance Organization (HMO) plan. These plans control health care costs by tying insurance policy benefits to a network of “preferred providers” such as doctors and hospitals. These providers contract with the insurance company.

PPO plans, for example, sign contracts with selected hospitals, physicians, and others who agree to provide services at a discounted rate. If you use non-preferred doctors outside this “network,” you will generally pay more. You may need approval from the insurance company before you obtain services from a non-preferred provider. If you do not get approval in advance, the insurance company may refuse payment.

An HMO plan usually requires you to choose a primary care provider from a list of in-network providers. Your primary care provider manages all of your health care. Except for emergencies, if you need care from another provider, your primary care provider may need to give you a referral.



Limited benefit plans

These types of plans are intended to be used with comprehensive health insurance plans. They are not intended to be your only health insurance.

- **Basic hospital expense plans:** These plans cover a specific number of days of continuous inpatient hospital care and specific outpatient hospital services.
- **Basic medical-surgical expense plans:** These plans only pay for medically necessary surgery costs and a specific number of hospital care days.
- **Hospital confinement indemnity plans:** These plans pay a fixed amount for each day that you are in the hospital.
- **Accident-only plans:** These plans pay for death, dismemberment, disability, hospital, and medical care caused by an accident.
- **Specified disease plans:** These plans pay for diagnosis and treatment of a specific disease or diseases, such as cancer.
- **Other limited plans:** You may purchase insurance covering only dental or vision or other specified care.



Comparing health plans

Here are some questions you might ask to help you compare health insurance plans if you are buying individual insurance or have a choice of employer group plans.

Costs and coverage limits

- What will your premiums cost? How much is the deductible, co-pay, or co-insurance? How often will you have to pay the deductible or co-payment (yearly or each time you use a service)? Is the deductible per person or per family? Are there separate deductibles for medical and prescription costs?
- Are there limits, such as daily or annual benefit caps?
- Are there limits on the number of visits for certain types of care?
- In the worst-case scenario, what is the most you will pay in a calendar year for covered services (the out-of-pocket maximum)? Don't overlook any non-covered services that you will have to pay.

Typically, the higher the deductible, the lower the monthly premium.

Benefits

- What does the plan pay for? What does the plan exclude?
- Does the plan cover prescriptions? Are your prescriptions on the list of covered drugs? How about alternative or chiropractic care?

Pre-existing conditions

- If applying for individual health insurance (not through an employer), do you have a medical condition that allows you to apply to the state program (Oregon Medical Insurance Pool) for people with pre-existing medical conditions? Call 1-800-848-7280 for information.

Doctor choice

- Is your doctor in the plan's network, so you pay the least possible amount? If you don't have a doctor, are the doctors in your area who are taking new patients approved under the plan? How big is the plan's network?

- Can you choose your own doctor? Do you need referrals for specialists? Does the plan require prior authorization for certain services?
- Does the plan have doctors, pharmacies, and hospitals near your home or work?
- If you travel frequently, what kind of coverage can you expect in those areas outside of your network?

Service

- How long does it take to reach a real person when you call the company? Does the company get a lot of consumer complaints? The Insurance Division consumer advocates can tell you how a company ranks in complaints. You can reach an advocate at 503-947-7984 or toll-free at 1-888-877-4894.

●●● Alert: Limited-benefit plans ●●●

If you watch late-night television, you may see ads for low-cost, affordable health insurance. You may wonder if these offers are right for you. Often, these ads are for limited-benefit plans — bare-bones policies with reduced benefits and higher costs for you.

A limited-benefit plan, for example, might limit the amount of coverage the company will pay per episode of illness. This sometimes is as low as \$1,500 to \$5,000 (not counting co-insurance and deductibles paid out-of-pocket by you). These policies also provide limited surgical, preventive care, testing, and emergency benefits. Low benefit limits called “caps” may leave you with a big bill.

●●● Alert: Discount plans ●●●

Medical discount plans are not health insurance. They simply offer a discount from doctors, pharmacists, and others who contract with the plan. Learn more from an Insurance Division consumer advocate.

What medical care must my insurer pay for?

- Insurers pay for the medical treatments defined in your policy. They do not pay for medical treatments listed in the policy exclusions.
- Insurers only pay for medical treatments that are medically necessary. Medically necessary is defined in your insurance policy.
- Insurers do not pay for medical treatments that are experimental or investigational.
- Certain (non-grandfathered) plans under federal health reform must cover specific preventive care services without cost-sharing to consumers. This means you will not have co-pays, co-insurance, or deductibles for certain services as long as they are provided by in-network doctors or medical staff. Some examples of preventive services are breast and colon cancer screenings, screenings for diabetes, high cholesterol and high blood pressure, routine vaccines, regular pediatrician visits, vision and hearing screening, and counseling to address obesity. Grandfathered plans, which do not have to meet this requirement, are plans that existed before the law took effect and meet other criteria.
- If you are age 19 or older, insurers may deny payment for treatment of pre-existing medical conditions for six months or up to 12 months if you work for a business that self-insures (pays claims itself rather than buying insurance). If you had health insurance within 63 days of the start of a new policy, you get credit for that coverage and the *pre-existing condition waiting period* is reduced one month for every month of coverage you had. This may reduce or even eliminate a waiting period.
- Insurers may require that you get prior approval for medical treatment from the insurance company before the insurance company will pay for the treatment.



- However, you are not required to get preauthorization for emergency medical treatment. Insurance companies must give you a written explanation about emergency medical treatment.
- Oregon requires insurance payment for specific medical treatments (mandates) for some insurance plans. To see the list, visit insurance.oregon.gov/sehi/mandated_health_provisions.pdf. Self-insured employers are not subject to these requirements. They are subject to many of the Affordable Care Act requirements, however. Self-insured employers are regulated by the U.S. Department of Labor and not the state Insurance Division. See dol.gov/ebsa.

● ● ● Tip: What medical bills are covered ● ● ●

Insurance companies have detailed, procedure-by-procedure guidelines on when coverage is allowed. You can ask for the guidelines for your particular treatment. Often, however, advance information is incomplete. Final coverage decisions are usually based on details in the medical records.

What an agent or company representative says does not change how the policy covers a procedure. The company may, in fact, say that prior authorization isn't needed. That doesn't mean it will cover the procedure. The procedure still must meet medical guidelines. On the other hand, if prior authorization is required and obtained, the company may be required to cover the care you received.

Paying the bills

You and your insurance company share the costs of care covered by your policy and your policy explains exactly who pays for what. Call the customer service number on your insurance card to find out how your policy works. Here is an example of how health insurance typically works:

1. You give the doctor or hospital your insurance card at the time you seek medical care.
2. You pay the doctor or hospital any co-payment required by the insurance plan.
3. Usually, the doctor bills the insurance company. You must bill your insurance if the doctor doesn't do this for you.
4. The insurance company sends you an explanation of benefits. It lists what the doctor or hospital charged, the maximum amount the insurance company allows for that procedure, what the insurance company paid as its share, and your share of costs.

Note: If you have more than one group health insurance plan, insurance companies coordinate payment of benefits. This means that the companies determine how much each of them will pay toward your medical treatment.

5. You pay your share of the bills.

●●● *Tip* ●●●

Many Oregonians can now call their insurance company or visit the company's website to find out in advance what their share of costs would be for an office visit, diagnostic test, birth, immunization, or certain other common procedures.

Common billing terms

Allowed amount: Maximum amount on which payment is based for covered health care services. This may be called “eligible expense,” “payment allowance,” or “negotiated rate.” If your provider charges more than the allowed amount, you may have to pay the difference. (See balance billing.)

Balance billing: When a provider bills you for the difference between the provider’s charge and the allowed amount. 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.

Co-insurance: Your share of the costs of a covered health care service, calculated as a percent (for example, 20 percent) of the allowed amount for the service. You pay co-insurance 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 co-insurance payment of 20 percent would be \$20. The health insurance or plan pays the rest of the allowed amount.

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

Deductible: The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is \$1,000, your plan won’t pay anything until you’ve met your \$1,000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

Excluded services: Health care services that your health insurance or plan doesn’t pay for or cover.

In-network co-insurance: The percent (for example, 20 percent) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-insurance.

In-network co-payment: A fixed amount (for example, \$15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network co-payments usually are less than out-of-network co-payments.

Medically necessary: Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, disease, or its symptoms and that meet accepted standards of medicine.

Network: The facilities, providers, and suppliers your health insurer or plan has contracted with to provide health care services.

Non-preferred provider: A provider who doesn’t have a contract with your health insurer or plan to provide services to you. You’ll pay more to see a

non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your coverage has a “tiered” network and you must pay extra to see some providers.

Out-of-network co-insurance: The percent (for example, 40 percent) you pay of the allowed amount for covered health care services to providers who do not contract with your health insurance or plan. Out-of-network co-insurance usually costs you more than in-network co-insurance.

Out-of-network co-payment: A fixed amount (for example, \$30) you pay for covered health care services from providers who do not contract with your health insurance or plan. Out-of-network co-payments usually are more than in-network co-payments.

Out-of-pocket limit: The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100 percent of the allowed amount. This limit never includes your premium, balance-billed charges, or health care your health insurance or plan doesn’t cover. Some health insurance or plans don’t count all of your co-payments, deductibles, co-insurance payments, out-of-network payments, or other expenses toward this limit.

Preauthorization: A decision by your health insurer or plan that a health care service, treatment plan, prescription drug, or durable medical equipment is medically necessary. It is sometimes called prior authorization, prior approval, or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn’t a promise your health insurance or plan will cover the cost.

Preferred provider: A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a “tiered” network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also “participating” providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

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

Provider: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional, or health care facility licensed, certified, or accredited as required by state law.

UCR (Usual, customary, and reasonable): The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Understanding insurance billing

How you and your insurer share in-network costs

Deductible: \$1,500	Co-insurance: 20%	Out-of-pocket limit: \$5,000
Jan. 1 Start of policy year	Mid-year	Dec. 31 End of policy period
Jane hasn't reached her \$1,500 deductible yet	Jane reaches her \$1,500 deductible; co-insurance begins	Jane reaches her \$5,000 out-of-pocket limit by fall
Her plan doesn't pay any of the costs	Now her plan pays some of the costs for her next visits	Now her plan pays the full cost of covered health care for the rest of the year
Office visit costs . \$125 Jane pays \$125 Plan pays \$0	Office visit costs .. \$75 Jane pays 20% of \$75 = \$15 Plan pays: 80% of \$75 = \$60	Office visit costs \$200 Jane pays \$0 Plan pays \$200

The chart above shows cost savings if you use in-network preferred providers — doctors and others who contract with your insurer so you get discounted rates. The chart below shows how your costs might increase if you use an out-of-network provider. It's easy to end up with an out-of-network provider if you are not careful. Doctors move in and out of networks. Even if your doctor is in-network, some services (for example, lab work your doctor orders or anesthesiology at a hospital) may be provided by out-of-network providers. Knowing whether services will be from in-network or out-of-network providers will help you understand your potential bills.

How in-network and out-of-network costs compare

	In-network preferred provider	Out-of-network preferred provider
Provider charge	\$1,000	\$1,000
Maximum insurance allowed amount	\$700	\$700
Insurance payment	\$560 (80% of \$700)	\$420 (60% of \$700)
You pay	\$140 (\$700-\$560)	\$280 (\$700-\$420)
Amount you pay above allowed amount	\$0	\$300
Your total cost:	\$140	\$580

My claim was denied: Now what?

Health benefit plans define appeal procedures in your policy. You can appeal an insurance company's decision to deny a claim or a decision to pay less than the amount billed.

You have the right to:

- Receive an explanation of your insurance company's grievance (appeal) procedures.
- Receive an easy-to-understand written decision for each appeal.
- File a complaint with the Oregon Insurance Division: www.insurance.oregon.gov or call 1-888-877-4894 (toll-free). The division helps consumers with language, literacy, or other barriers; complete insurance appeals paperwork; file complaints; or enroll in a health plan.

Types of appeals

Your first appeals are through the insurance company, and are called internal reviews. If your dispute is not resolved satisfactorily, some disputes qualify for an external review by an outside group.

Internal review

- For group and individual health benefit plans, you have a right to an internal review (appeal) by people not previously involved in the dispute.
- Generally, your insurance company must make a decision and respond within 30 days.
- If your insurance company needs more time, it must notify you of the reason and send a decision within 15 additional days. No further extension is allowed.
- If your insurance company denies your internal appeal, you may have the right to seek an impartial external review.

External review (review by independent third party)

If your insurance company rejects your appeal, you have the right to an independent external review of any "adverse benefit determination." An "adverse benefit determination" occurs any time an insurer denies, terminates, or refuses to pay for all or part of a medical service because:

- It has terminated or rescinded your plan.
- The service it denied would normally be covered, but it has imposed a pre-existing condition exclusion, a provider network exclusion, or other exclusion or limitation.

- It has refused to pay for the service because it's experimental, investigational, or not medically necessary.
- It has determined that the claim is part of an active course of treatment and should be paid by your previous health care provider, due to Oregon's continuity of care law.

For more information on external reviews, go to insurance.oregon.gov/consumer/exreview/external_review_overview.html.

Expedited review

Your insurance company must have a process for responding to emergencies more quickly. This is called "Expedited Review." The whole process, including external review, must be conducted within 72 hours or sooner, if necessary.



What if I lose my job?

Public and private insurance programs may help you stay insured if you lose your job and your health insurance. It's important not to delay a decision because some choices have deadlines.

Also, if you go more than 63 days without health insurance, you may have a waiting period before an insurance company pays for treatments of any pre-existing medical conditions.

● ● ● *Tip* ● ● ●

You can now visit [healthcare.gov](https://www.healthcare.gov) to see your insurance options in Oregon and to learn more about federal health care reform.

Insurance through a spouse or domestic partner

- If a spouse or domestic partner gets insurance at work, he or she may be able to add you and family members to his or her insurance policy. Contact the employer as soon as possible.

Continue your former employer's health plan

COBRA

- If you lose your job and your employer stays in business and has 20 or more employees, a federal law known as COBRA allows you to purchase and continue your same insurance plan. You are eligible to keep your insurance for 18 months as long as you pay the premium. In some cases, you can keep your insurance for 36 months. Your insurance company will send you a notice of your COBRA options.
- You pay the full cost of the insurance.
- COBRA is also available when you divorce, legally separate, or the employed spouse dies.
- If you are age 55 or older and were insured through a spouse but become widowed, divorced, or legally separated, Oregon law allows you to keep the employer's insurance until you become Medicare eligible. This applies only to employers with 20 or more employees.

State continuation

- If you lose your job and your employer has fewer than 20 employees, you can purchase and continue your same employer plan for nine months. You pay the full cost of the insurance.

- You should notify your employer immediately if you are interested in this option. You must have been covered for at least three months and cannot be eligible for Medicare.
- This option is also available when you divorce, legally separate, or the working spouse dies.

For information, contact your employer or insurance company.

Portability

- Portability is an individual policy offered by the same insurance company that provided your group policy at work. Portability is guaranteed regardless of your medical condition and begins the day after your group coverage ended with no waiting period. You must have been covered for six months on the group plan and not be eligible for Medicare.
- You may be able to purchase portability insurance instead of using COBRA or state continuation. Or, if you used COBRA, you can purchase portability insurance after your COBRA coverage ends. Unlike COBRA, you can keep your portability insurance as long as you want.
- Portability plans have different benefits and costs than your former employer's plan and may not pay all of the same medical care as your employer's plan. Insurers are required to offer you a choice of plans – one with a \$750 deductible and one with a \$1,500 deductible.
- You pay the full cost of the portability policy.
- Self-insured plans (typically offered through large employers) do not offer portability. You may be eligible for a portability plan through the Oregon Medical Insurance Pool.

Individual insurance (self and family)

- You can apply directly to an insurance company for a policy to cover you and your family or work with an agent to find a policy.

Oregon Medical Insurance Pool (OMIP)

- If a family member is rejected for coverage, he or she can apply to this program, which operates state and federally funded high-risk insurance pools. Learn more at omip.state.or.us/.

Short-term medical insurance

- You may be able to purchase temporary insurance by the month or sometimes by the day. Typically, you are limited to buying six months of coverage. This insurance won't cover pre-existing conditions. Ask insurance companies about their plans.

Public programs

- The section on ***Oregon health programs*** lists programs that help people with limited incomes.

● ● ● *Tip* ● ● ●

Use in-network doctors and hospitals to save money!



Key insurance reforms

While most reforms start in 2014, the Affordable Care Act of 2010 made some changes to insurance policies or practices that started in 2010. Here are some of these key reforms.

Check with your plan to see if they apply to you, and when. Not all plans have to include all reforms. Plans that must include some or all reforms may not have to do so until the policy first renews **after** September 2010.

- Insurance companies and employers that offer dependent coverage to children must cover adult children up to age 26.
- Insurance companies can no longer deny coverage to children under age 19 who have pre-existing conditions and who apply during open enrollment periods. In Oregon, these periods are February and August of every year. A bill before the 2011 Legislature may result in companies once again offering year-round enrollment. If the bill passes and is signed by the Governor, new rules may be in place as early as the fall of 2011. See the Insurance Division website for updates: insurance.oregon.gov. Also, the plan cannot make children wait for coverage of pre-existing conditions.
- Plans must provide certain preventive benefits (such as immunizations) to you without any co-pays or co-insurance (percentage of costs).
- Policies may not include any **lifetime** limits on how much they will pay to cover essential benefits.
- **Annual** limits on essential benefits will be phased out over three years.
- Rescissions, or the retroactive cancellation of a policy, are limited to cases of fraud and intentional misrepresentation of material fact (if you intentionally misrepresent or omit information on your application, for example).
- Insurance companies and employer plans cannot require you to get a referral for pregnancy or gynecological care, as long as you go to a provider who contracts with your insurance company.

Oregon health programs

Healthy Kids is Oregon's newly expanded health coverage program providing no-cost and low-cost health coverage to uninsured Oregon kids and teens. Even middle-income families qualify. Families with uninsured children should apply for Healthy Kids today.

Phone: 1-877-314-5678 (toll-free)

Website: www.OregonHealthyKids.gov

OHP (Oregon Health Plan) Standard: Provides free or low-cost health care coverage to Oregon residents who have limited income, are ages 19 and older, and do not qualify for traditional Medicare.

Phone: 1-800-359-9517 (toll-free)

E-mail: dmap.info@state.or.us

Website: oregon.gov/DHS/healthplan/

OHP Plus: Provides free health care coverage (there are co-payments for certain services) to low-income Oregon residents who are aged, blind, disabled, under age 19, pregnant, or receiving Temporary Assistance for Needy Families benefits. OHP Plus includes the no-cost public assistance option of the Healthy Kids Program, the Children's Health Insurance Program (CHIP).

Phone: 1-800-359-9517 (toll-free)

E-mail: dmap.info@state.or.us

Website: oregon.gov/DHS/healthplan/

Oregon ContraceptiveCare Program: Provides free reproductive health care services and contraceptive supplies to eligible women, men, and teens.

Phone: 1-800-723-3638 (toll-free)

Website: <http://ccare.oregon.gov>

Oregon Public Health: Administers a variety of programs to improve the health of Oregonians through preventive health programs and services, including immunizations.

Phone: 971-673-1222

Website: oregon.gov/DHS/ph/

Oregon Family Health Program: Administers programs to women, infants, and children; WIC supplemental nutrition services; reproductive and family planning services.

Phone: 971-673-0232

Website: www.oregon.gov/DHS/ph/ofhs/

County health clinic and other county health services

Website: www.oregon.gov/DHS/ph/lhd/lhd.shtml

CAREAssist: Oregon's AIDS Drug Assistance Program, provides people living with HIV or AIDS with assistance paying for medical care expenses.

Phone: 1-800-805-2313 (toll-free)

Website: www.oregon.gov/DHS/ph/hiv/careassist/index.shtml

Family Health Insurance Assistance Program: This state program helps Oregonians pay the premiums for health insurance through their employer or through an individual health plan.

Phone: 503-373-7419 (Salem area) or 1-888-564-9669 (toll-free)

E-mail: ophp.mail@state.or.us

Website: fhiap.oregon.gov

Oregon Prescription Drug Program:

This state program provides discounts on prescription drugs, especially generics. It is available to all Oregonians, regardless of age, income, or insurance status.

Phone: 1-888-411-6737 (toll-free)

Website: www.oregon.gov/OHA/OPDP/index.shtml

Turned down for health insurance?

Pre-existing condition programs: The Oregon Medical Insurance Pool (OMIP) and the Federal Medical Insurance Pool cover Oregonians who are turned down for health insurance because of health conditions.

OMIP also provides coverage to Oregonians who have exhausted COBRA benefits and have no other options available.

Phone: 503-225-6620 (Portland area) or 1-800-848-7280 (toll-free)

E-mail: omip.mail@state.or.us

Website: www.omip.state.or.us

Free or reduced-price clinics: Federally funded health centers offer free or low-cost health care in urban and rural areas. The **Find A Health Center Tool** locates these centers. Enter an address, city, or county, and the tool finds nearby health centers.

Website: http://findahealthcenter.hrsa.gov/Search_HCC.aspx

Key insurance contacts

U.S. Department of Health and Human Services (HSS): This agency provides a website that lists private and public insurance options to make it easier for you to find affordable coverage.

Website: [healthcare.gov](https://www.healthcare.gov)

Oregon Insurance Division: This state agency protects consumers through regulation of the insurance industry. Consumer advocates can answer general insurance questions and help you file a complaint against an insurance company or agent.

Phone: 503-947-7984 (Salem area) or 1-888-877-4894 (toll-free)

E-mail: cp.ins@state.or.us

Website: [insurance.oregon.gov](https://www.insurance.oregon.gov)

U.S. Department of Labor (Employee Benefits Security Administration): Information and rules for people whose employers are self-insured.

Phone: 1-866-444-3272 (toll-free)

Website: www.dol.gov/ebsa

Senior health insurance resources

Medicare: Health insurance for people age 65 or older, some people under age 65 with disabilities, and people with kidney failure.

Phone: 1-800-633-4227 (24 hours a day, seven days a week) (toll-free)

Website: [medicare.gov](https://www.medicare.gov)

Senior Health Insurance Benefits Assistance (SHIBA): State program that offers personalized help understanding Medicare choices.

Phone: 1-800-722-4134 (toll-free)

E-mail: shiba.oregon@state.or.us

Website: [oregonshiba.org](https://www.oregonshiba.org)

Social Security Administration: Where Medicare beneficiaries apply for “extra help” with Part D prescription drug costs.

Phone: 1-800-772-1213 (7 a.m. to 7 p.m. Monday to Friday, toll-free)

Website: [ssa.gov](https://www.ssa.gov)

Don't know where to turn?

Oregon Health Connect is a new state website that links you to information about health care and health insurance in Oregon. Use the Resource Directory to search for state and local insurance programs and to connect to community organizations that provide health services. Learn how health insurance works, including your appeal rights. The Oregon Insurance Division maintains a toll-free number for people who would like assistance understanding insurance options and resolving complaints against their insurer or agent.

Phone: 1-855-999-3210 (toll-free)

E-mail: health.connect@state.or.us

Website: www.oregonhealthconnect.org



● ● ● **Consumer Insurance Advocates** ● ● ●

**Free, personalized help with your
insurance questions and complaints**

Toll-free: 1-888-877-4894

Salem area: 503-947-7984

insurance.oregon.gov



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