Sign up, renew, or change health plans at HealthCare.gov

Don't have health insurance? We are here to help.

- Learn about what plan might be **best and most affordable** for you.
- See if you can get **financial help** to pay for your plan.

Did you buy health insurance last year?

Nov. 1 through Jan. 15 is the time to renew or change plans. Review your plan. Compare your options.

- Your **health care needs can change.**
- **Each year, new plans are offered, benefits can change,** and some plans are discontinued.
- Changes in income and family size can affect your **financial assistance.**
- Check to see if you will be automatically **re-enrolled** in your plan. You may need to **resubmit** your information to continue your benefits.

Visit OregonHealthCare.gov to find free local help from an expert.

OREGON HEALTHCARE.GOV
855-268-3767 (toll-free)

HIM-5079 (02/2024)

Using your health insurance

A step-by-step guide to understanding health insurance

Visit OregonHealthCare.gov

Take the next step

You have taken the first step to better your health by enrolling in a health insurance plan. This is the best time to ask questions and take action so you will know how to use your insurance when you are sick.

This guide explains the basics of understanding your insurance plan and what to do when you have questions.

Understanding your coverage

Once you sign up and **pay your first month's premium** (before the effective date of coverage), your insurance company should send you a membership package that includes:

1. **Summary of benefits and coverage:** A document that explains the key features of your plan, such as what is covered and what is not. Be familiar with your costs (premiums, co-payments, deductibles, and coinsurance).
2. **Insurance card or other document:** This is your proof of insurance with information medical providers need to provide services. Your card or document may look different from this one, but will have the same type of information.

Preparing for your health care

While you are thinking about health insurance, get ready for your health care needs by:

Finding a provider:

- Call your insurance company, search its website, or check the member handbook for providers in your network. Networks can change, so double check with your health plan.
- Once you decide which provider you want to see, check to see if you need to ask your insurance company before you make an appointment.

Scheduling an appointment:

- Call to make the appointment. Say you are looking for a new primary care provider and ask for a yearly exam or a wellness visit.

Working with your provider

- When you meet with your provider, share your family health history, current medications you take, and questions or concerns you have about your health.

Deciding if the provider is the right one for you:

- You need a provider you can trust and feel comfortable talking to. After your first visit, if you have concerns about your provider, decide if you want share your concerns with the provider or research other providers in your network.

Planning your next steps:

- Follow through with your provider's recommendations. For example, if your provider recommended a specialist, did you make an appointment?

Understanding insurance billing

You and your insurance company share the costs of care covered by your plan. Call the member services for your health plan to find out details or read the summary of benefits.

How health insurance typically works:

1. You give your provider your insurance card at the time you seek medical care.
2. You pay the provider any co-payment required by the plan.
3. Usually, the provider bills the insurer.
4. The insurer sends you an Explanation of Benefits (or EOB). This is an overview of the total charges for your visit. It lists what the provider charged, the maximum amount the insurer allows for that procedure and what it paid as its share, and your share of costs. An EOB is not a bill.
5. You will most likely get a bill separately from the provider. You pay your share of the bill.

Knowing your rights

After reviewing your EOB, you may have questions about the details or think that certain services should be covered by the plan when they were not. You may be able to file a complaint and get the services covered.

You can contact your insurer directly. Insurers have call centers to help plan members. This number is listed on your insurance card or in the plan handbook.

If you want third-party help, have questions about your rights, or need help to understand insurance billing or coverage, call the Oregon Division of Financial Regulation to speak with a consumer advocate, free of charge at 888-877-4894 (toll-free).

You can also email DFR.InsuranceHelp@dcbs.oregon.gov or look up insurance tips at: bit.ly/DFRcomplaint.

Glossary of insurance terms: Key terms you may come across in the summary of benefits or when seeking medical services.

Coinsurance: The percentage of costs of a covered health care service you pay; 20 percent for an X-ray, for example.

Copayment (or copay): A fixed amount you pay for a covered health care service; $20 for a visit with the doctor, for example.

Deductible: The amount you pay before the plan starts to pay for some covered services. In Oregon, many plans do not require that the enrollee pays the deductible when they have office visits, but they will pay the deductible for services such as hospital stays or surgeries. It is extremely important to remember that there are many services covered by health plans, either in full or at least in part, before meeting the deductible.

Network: The clinics, facilities, pharmacies, providers and suppliers your health insurance company has contracted with to provide health care services, prescriptions and supplies. Contact your insurance company to find out which doctors, therapists and facilities are in-network. It might cost you more to see an out-of-network provider.

Out-of-pocket maximum: The most you have to pay for covered services in a plan year. After you spend this amount on deductibles, copayments, and coinsurance for in-network care and services, your health plan pays 100 percent of the costs of covered benefits. Things that do not count towards the out-of-pocket maximum are: your monthly premium, anything you spend for services your plan doesn't cover, and out-of-network care and services.

Premium: The amount you pay for your health insurance each month. You usually pay it monthly. It does not count toward your deductible or your out-of-pocket maximum. If you don't pay your premium, you could lose your coverage.

Preventive services: Routine health care, including screenings, check-ups,and patient counseling, to prevent illnesses, disease or other health problems; or to detect illness at an early stage when treatment is likely to work best. This can include flu shots, vaccines and screenings.