NAVIGATING HEALTH INSURANCE IN WASHINGTON, DC

IN THIS GUIDE

This handout is a community resource for people who want to learn more about navigating health insurance options in Washington, DC and highlights additional resources for individuals with HIV who may encounter barriers to accessing health insurance.

INSURANCE-RELATED TERMS YOU SHOULD KNOW

This handout uses many technical terms related to health insurance, which are defined in the glossary at the end of this handout. All of the defined terms in the glossary are noted in *italics* throughout the handout. Definitions have been adapted from the Healthcare.gov Glossary, available at https://www.healthcare.gov/glossary/.

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TYPES OF INSURANCE PLANS AND HOW TO GET INSURANCE

Health care, and particularly HIV care, can be expensive. Having health insurance typically means that you will pay less if you need to go to the doctor, seek emergency care, or take medication. In addition, DC law requires all residents to enroll in health insurance or otherwise pay a tax penalty for every individual in your household who is not insured.

There are several different types of health insurance. This section will discuss employer-sponsored insurance, Medicaid, The Alliance and Immigrant Children's Program, DC Health Link, and Medicare. Each subsection will explain who qualifies for that type of insurance, how to sign up, and what to expect after you enroll.

EMPLOYER-SPONSORED INSURANCE

Employer-sponsored health insurance is a common type of health insurance for people in DC.

Who qualifies for employer-sponsored insurance?

Many full-time workers receive an offer of health insurance through their employer. If your employer offers health insurance, you are not required to accept it. Some people choose not to sign up for employer-sponsored insurance because they are insured under their spouse's health plan or because the plans offered are unaffordable.

If you get a new job where you will qualify for employer-sponsored insurance, keep in mind that many companies have a waiting period before you can sign up. The average employer-sponsored insurance waiting period is approximately two months.[1] In general, waiting periods cannot last longer than 90 days after your date of hire. If you know you will need health care during your waiting period, you can apply for Medicaid, The Alliance, or other financial assistance programs to fill the gap in your insurance coverage.

Employers do not typically offer health insurance to part-time or temporary workers. Eligibility rates also vary by industry; for example, it is less common for retail workers to be offered health insurance by their employer.[2]

How to sign up for employer-sponsored insurance

Typically, employees are able to choose an employer-sponsored health plan after they are hired and once a year during a designated enrollment period. For example, some companies hold an enrollment period in the fall, and coverage is effective from January 1 through December 31. If you have a change in your income or life circumstances, such as a birth, gain/loss of employment, or marriage, you may also be able to make changes to your insurance mid-year.

What to expect once you are enrolled

Covered benefits and associated costs vary by employer and by health plan. Most plans will require you to pay a monthly *premium* in order to maintain insurance coverage, which may be deducted from your paycheck. In 2018, the average monthly premium in DC was around $117 for single coverage[3] and $500 for family coverage.[4] Most insurance plans will also require cost-sharing, which means you will pay part of your bill when you go to the doctor's office, pick up your medications, or seek other types of health care. In general, you will pay less for health care if you go to a doctor or pharmacy in your health plan's *provider network*. To find out if your doctor or pharmacy is in your plan's network, visit your health plan website or call the number on the back of your insurance card.

1 Kaiser Family Foundation. 2018 Employer Health Benefits Survey, Section 3: Employee Coverage, Eligibility, and Participation. Available at: https://www.kff.org/report-section/2018-employer-health-benefits-survey-section-3-employee-coverage-eligibility-and-participation/. Published October 3, 2018. Accessed April 2021.

2 *Id.*

3 Kaiser Family Foundation. Average Annual Single Premium per Enrolled Employee For Employer-Based Health Insurance, 2019. Available at: https://www.kff.org/other/state-indicator/single-coverage/. Accessed April 2021.

4 Kaiser Family Foundation. Average Annual Family Premium per Enrolled Employee For Employer-Based Health Insurance, 2019. Available at: https://www.kff.org/other/state-indicator/family-coverage. Accessed April 2021.

DC MEDICAID

DC Medicaid is a free insurance program for Washington, DC residents who are pregnant, living with a disability, or have income below a certain limit. One out of every three DC residents has Medicaid.[5]

Who qualifies for Medicaid?

You can qualify for DC Medicaid if you live in Washington DC, are a United States citizen or have eligible immigration status, and have income below a certain limit (see Table 1).

You can also qualify for Medicaid if you fall under one of the categories below:

- You are age 65 or over, blind, or have a disability, with resources (like a bank account) at or below $4,000 (for a single person)
- You receive social security benefits
- You are a home and community-based services waiver participant
- You receive long term care services (for example, adult day care, adult foster care, nursing home care, or home health aide services)
- You are a Medicare Savings Program participant
- You qualify for Medically Needy Spend-Down because of high medical bills
- You are a current or former foster care child
- You are under 19 years of age and qualify for TEFRA/Katie Beckett
- You have been screened and need treatment for breast or cervical cancer

Many of the categories above have different income or asset limits. If you think that you qualify for Medicaid because you fall under one of these categories, you can visit https://dhcf.dc.gov/service/who-may-be-eligible-medicaid or call 1-202-727-5355 to learn more.

How to sign up for Medicaid

You can apply for Medicaid at any time during the year online or over the phone:

- To apply online, visit https://www.dchealthyfamilies.com
- To apply over the phone, call 1-800-620-7802

You will not need to submit additional documentation, such as proof of residence or income, unless Medicaid is unable to verify information included in the application. The application takes up to 45 days to process, or up to 60 days if you are applying because you have a disability. If you are approved, you will receive a membership card in the mail. You must also choose or be automatically assigned to one of DC's managed care health plans. **You can choose or change your health plan by visiting https://www.dchealthyfamilies.com or calling 1-800-620-7802.**

What to expect once you are enrolled

DC Medicaid does not charge monthly *premiums* or *cost-sharing*, meaning you will not need to pay anything when you go to the doctor's office, pick up your medications, or seek other types of health care, as long as you go to a doctor or pharmacy in your health plan's provider network. To find out if your doctor or pharmacy is in your plan's network, visit your health plan website or call the number on the back of your insurance card.

Insurance coverage typically lasts a year after enrollment. After a year, you will need to re-enroll in Medicaid.

TABLE 1. MONTHLY INCOME LIMIT FOR MEDICAID, 2021

	MONTHLY INCOME LIMIT				
HOUSEHOLD SIZE	CHILDREN 18 AND UNDER	19- AND 20-YEAR-OLD ADOLESCENTS	PREGNANT PEOPLE	ADULT PARENTS AND CAREGIVERS	ADULTS WITHOUT DEPENDENTS
1	$3,478	$2,372	$3,478	$2,372	$2,308
2	$4,703	$3,208	$4,703	$3,208	$3,121
3	$5,929	$4,044	$5,929	$4,044	$3,935
4	$7,155	$4,880	$7,155	$4,880	$4,748
5	$8,381	$5,717	$8,381	$5,717	$5,561
6	$9,607	$6,553	$9,607	$6,553	$6,375
7	$10,832	$7,389	$10,832	$7,389	$7,188
8	$12,058	$8,225	$12,058	$8,225	$8,002

Source: Figures based on 210% FPL (for adults without dependents), 216% FPL (for parents, caretakers and 19- and 20-year-olds), and 319% FPL (for children and pregnant people) plus 5% income disregard in 2021. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. U.S. Federal Poverty Guidelines Used to Determine Financial Eligibility for Certain Federal Programs: A chart with percentages (e.g., 125 percent) of the guidelines. https://aspe.hhs.gov/system/files/aspe-files/107166/2021-percentage-poverty-tool.xlsx. Accessed April 2021.

5 DC Department of Health Care Finance. What is Medicaid? Available at: https://dhcf.dc.gov/service/what-medicaid. Accessed April 2021.

DC HEALTH CARE ALLIANCE AND THE IMMIGRANT CHILDREN'S PROGRAM

Washington, DC offers free health insurance for people who are uninsured and are not eligible for Medicare or Medicaid, regardless of their immigration status. This means that undocumented immigrants can get insurance through these programs. There are two programs: the DC Health Care Alliance and the Immigrant Children's Program.

Who qualifies for the Alliance and the Immigrant Children's Program?

In order to be eligible for The Alliance, you must:

- Be 21 years old or older
- Live in Washington, DC
- Have income below a certain limit (See Table 2)
- Have resources (for example, a bank account) at or below $4,000 for one person and $6,000 for couples or families
- Not qualify for insurance through Medicare or Medicaid

In order to be eligible for the Immigrant Children's Program, you must:

- Be under 21 years old
- Live in Washington, DC
- Have income below a certain limit (See Table 2)
- Not qualify for insurance through Medicare or Medicaid

How to apply for the Alliance and the Immigrant Children's Program

You can apply for insurance through The Alliance or the Immigrant Children's Program at any time during the year. **To apply, you must fill out a paper application and complete an interview at an Economic Security Administration (ESA) Service Center. You must also provide certain documents to prove your income, residence, and citizenship or green card status (if you are not a citizen or green card holder, you can still apply).** For more information on applying for these programs or to get help filling out an application, call 1-202-727-5355 or visit the links below:

- Print the application: https://dhs.dc.gov/publication/combined-application-benefits
- Find a service center: https://dhs.dc.gov/service/find-service-center-near-you
- Review the list of supporting documents you may need: https://dhs.dc.gov/service/documents-you-may-need-your-interview

If you are eligible for The Alliance or the Immigrant Children's Program, you will be automatically enrolled in a health plan. If you want to switch to a different health plan, you have 90 days to do so. **You can change your health plan by visiting https://www.dchealthyfamilies.com or calling 1-800-620-7802.**

What to expect once you are enrolled

The Alliance and the Immigrant Children's Program do not charge monthly *premiums* or *cost-sharing*, meaning that you will not need to pay anything when you go to the doctor's office, pick up your medications, or seek other types of health care, as long as you go to a doctor or pharmacy in your health plan's *provider network*. To find out if your doctor or pharmacy is in your plan's network, visit your health plan website or call the number on the back of your insurance card.

Insurance coverage typically lasts a year after enrollment. However, you will need to confirm that you are still eligible for these programs every six months.

TABLE 2. MONTHLY INCOME LIMIT FOR THE ALLIANCE AND THE IMMIGRANT CHILDREN'S PROGRAM, 2021

IF YOU HAVE THIS MANY PEOPLE IN YOUR HOUSEHOLD...	...YOU MUST EARN BELOW THIS AMOUNT EACH MONTH TO QUALIFY
1	$2,200
2	$2,976
3	$3,752
4	$4,527
5	$5,303
6	$6,078
7	$6,854
8	$7,629

Source: Figures based on 200% FPL plus 5% income disregard in 2021. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. U.S. Federal Poverty Guidelines Used to Determine Financial Eligibility for Certain Federal Programs: A chart with percentages (e.g., 125 percent) of the guidelines. https://aspe.hhs.gov/system/files/aspe-files/107166/2021-percentage-poverty-tool.xlsx. Accessed April 2021.

DC HEALTH LINK

The Affordable Care Act (ACA) Marketplace offers a range of health insurance plans for people who do not have affordable employer-sponsored insurance and earn too much to qualify for Medicaid, The Alliance, or the Immigrant Children's Program. DC's Marketplace is called DC Health Link.

Who qualifies for DC Health Link?

To qualify for a health plan through DC Health Link, individuals must:

- Live in Washington, DC
- Be a United States citizen, United States national, or lawfully present immigrant
- Not be incarcerated
- Not qualify for Medicare or Medicaid

The federal government also offers financial assistance, called premium tax credits, to help make DC Health Link insurance more affordable. To qualify for premium tax credits, applicants must:

- Have a household income above 100% of the federal poverty level and below 400% of the federal poverty level[6] (See Table 3)
- Not have access to affordable coverage through an employer
- Not be eligible for coverage through Medicare, Medicaid, CHIP, or other forms of public assistance

How to sign up for DC Health Link

You can sign up for DC Health Link insurance during the annual open enrollment period, which typically begins in late fall and ends early the next year. You can also sign up if you experience a qualifying life event, such as a birth or adoption, marriage, death, change in income, or change in work status.

You can compare plan options and sign up for insurance online, in person, or over the phone:

- To apply online, visit https://www.dchealthlink.com
- To apply over the phone, call 1-855-532-5465
- To find an enrollment center where you can apply in person, visit https://dchealthlink.com/enrollmentcenters or call 1-855-532-5465

You will not be required to submit proof of residence, proof of income, or other supporting documents unless the DC Health Link is unable to verify information included in the application. Your insurance will go into effect two-to-six weeks after you select a plan.

What to expect once you are enrolled

DC Health Link plans must cover *preventive services*, including HIV testing, without requiring you to pay anything. They must also cover the ACA's 10 essential health benefits, which include emergency services, hospitalization, maternity care, mental health/substance use disorder services, laboratory services, preventive services, and pediatric services. Otherwise, coverage varies by health plan.

You will be required to pay a monthly *premium* in order to maintain insurance coverage, which may be deducted from your paycheck. Most insurance plans will also require cost-sharing, meaning that you will need to pay part of your bill when you go to the doctor's office, pick up your medications, or seek other types of health care. In general, you will pay less for health care if you go to a doctor or pharmacy in your health plan's *provider network*. To find out if your doctor or pharmacy is in your plan's network, visit your health plan website or call the number on the back of your insurance card.

Insurance coverage typically lasts for a year. At the end of your plan year, you can either select a new plan or be automatically re-enrolled in your current DC Health Link plan.

TABLE 3. MONTHLY INCOME MINIMUM AND MAXIMUM FOR PREMIUM TAX CREDITS, 2021

IF YOU HAVE THIS MANY PEOPLE IN YOUR HOUSEHOLD…	…YOU MUST EARN ABOVE THIS AMOUNT…	…AND BELOW THIS AMOUNT EACH MONTH TO QUALIFY
1	$1,127	$4,347
2	$1,524	$5,879
3	$1,922	$7,412
4	$2,319	$8,944
5	$2,716	$10,476
6	$3,113	$12,008
7	$3,511	$13,541
8	$3,908	$ 15,073

Source: Figures based on 100% and 400% FPL plus 5% income disregard in 2021. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. U.S. Federal Poverty Guidelines Used to Determine Financial Eligibility for Certain Federal Programs: A chart with percentages (e.g., 125 percent) of the guidelines. https://aspe.hhs.gov/system/files/aspe-files/107166/2021-percentage-poverty-tool.xlsx. Accessed April 2021.

6 From January 1, 2021 through September 30, 2023, eligibility for premium tax credits has been extended to include individuals who earn more than 400% of the federal poverty level.

MEDICARE

You may qualify for Medicare if you are a United States citizen or Legal Permanent Resident (also known as a green card holder) and if you:

- Are age 65 or older
- Have a permanent disability and have received social security benefits for at least two years

To learn more about what Medicare pays for and how you can get Medicare, visit https://www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227).

WHAT TO CONSIDER WHEN CHOOSING AN INSURANCE PLAN

Different insurance plans often have trade-offs between how much you pay in monthly *premiums*, how much you pay to receive health care, and which doctors or hospitals you can use. This section discusses options to keep in mind when choosing an insurance plan to make sure you have a plan that fits your needs.

ARE YOUR HEALTH CARE PROVIDERS INCLUDED IN THE PLAN'S PROVIDER NETWORK?

When choosing a health plan, you may encounter the terms "Health Maintenance Organization (HMO)" and "Preferred Provider Organization (PPO)."

An HMO plan typically has lower monthly *premiums* but will only pay for care from a *health care provider* in the plan's *provider network* (also known as an "in-network" provider). An HMO will not pay for any care you receive from a health care provider who is not in the plan's provider network.

On the other hand, a PPO plan typically has higher monthly premiums but will pay for some of the cost of care from an out-of-network health care provider. However, you will still pay less if you receive care from an in-network provider.

Most plans will have a searchable directory of health care providers available online, so you see whether your *health care providers* are in the plan's *provider network* before you choose to sign up. Here are some questions to consider when deciding between an HMO and a PPO:

- If you already have health care providers who you like and trust, are they included in the plan's provider network?
- Are the health care providers in the plan's network conveniently located?
- Do you know that you will need to find a specialist for your care in the coming year? If so, does the plan network include a good selection of different specialists you can choose from?

If you answer "no" to any of these questions, you may wish to choose a PPO plan so you can see an out-of-network health care provider without being responsible for the full cost of your care. If you sign up for an HMO plan, you may need to change some of your health care providers or travel further to get in-network care, but you will have lower monthly premiums in exchange.

WHAT HEALTH CARE SERVICES DO YOU THINK YOU WILL NEED IN THE NEXT YEAR?

When comparing health plans, it may be tempting to choose the option with the lowest monthly *premium*. However, this might not be the best option for you if you know you will need to visit the doctor or pay for medications a lot over the next year. In general, plans with lower monthly *premiums* have higher *cost-sharing*, and plans with higher monthly *premiums* have lower *cost-sharing*. So, if you know that you will need regular or very expensive health care over the next year, you may want to select a plan with higher monthly premiums and lower cost-sharing. Although you may pay more each month for your insurance, each time you visit a health care provider or pick up medication your plan will pay for more of the costs of your care.

In order to compare plans, you should make a list of which health care items and services you will likely need over the next year, how often you will need them, and what your *cost-sharing* responsibilities might be under each of the plans you are considering. Then, you can add up your *premiums* and anticipated *cost-sharing* for each plan to see which one will be most affordable.

Here are some questions to consider when comparing plan costs and coverage:

- What routine health care services do you know you will need in the next year? This includes *primary care* visits, *specialist* visits, and medications.
- How often do you anticipate needing these items or services over the next year? Every month? Twice a year?
- Review the plan's *covered services*. Do the plans you are considering cover the types of services you need? If so:
  - What is the plan's *deductible* for in-network and out-of-network care? You will need to pay this amount before your insurance plan kicks in.
  - Are some or all of the services you need covered before you meet the plan's *deductible*?
  - Does the plan require *copayments* or *coinsurance* for the services you need?
- Review the plan's *drug list*. Do the plans you are considering cover the medications you need? If so:
  - What is the plan's *deductible* for medications? You will need to pay this amount before your insurance plan kicks in.
  - Are some or all of the medications you need covered before you meet the plan's *deductible*?
  - Does the plan require *copayments* or *coinsurance* for the medications you need?

HELP WITH SELECTING A HEALTH PLAN

Selecting a health plan can be a complicated process. If you have questions, you can reach out to any of the following resources for help:

- If you have questions about your employer-sponsored insurance plan, talk to someone at your company's human resources or employee benefits department.
- If you have questions about Medicaid, The Alliance, or the Immigrant Children's Program, visit https://www.dchealthyfamilies.com/Home/ComparePlans.aspx or call 800-620-7802. Remember that these plans do not have *premiums*, *deductibles*, *coinsurance*, or *copayments* for *covered benefits*! However, you may still want to compare *provider networks* for these plans.
- If you have questions about DC Health Link plans, visit https://dchealthlink.com/find-expert or call 1-855-532-5465.
- If you have questions about Medicare, visit https://www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227).

FINANCIAL ASSISTANCE FOR HEALTH CARE VISITS, MEDICATIONS, AND RELATED NEEDS

Even if you have health insurance, the cost of HIV care can still be expensive. This section discusses four types of programs that provide financial assistance for HIV-related health care visits, medications, and other needs.

THE RYAN WHITE HIV/AIDS PROGRAM

More than half of all people with HIV in DC receive services through the Ryan White HIV/AIDS Program.[7] The Ryan White HIV/AIDS Program pays *health care providers* for a range of health services provided to people with HIV, including medical case management, home health care, hospice care, mental health services, dental care, and office visits. The program also pays social service providers for support services for people with HIV, like transportation to medical visits, respite care for caregivers, and non-medical case management. Because the program pays *health care providers* and social service providers directly, you do not need to sign up for the Ryan White HIV/AIDS Program. Instead, you should be aware that you may be able to receive free or low-cost services related to your HIV care if you visit a Ryan White provider, whether or not you have insurance. **To find a Ryan White provider in your area, visit https://findhivcare.hrsa.gov, or in DC, visit https://linkudmv.org.**

DC AIDS DRUG ASSISTANCE PROGRAM (ADAP)

The DC AIDS Drug Assistance Program (ADAP) can help offset the cost of antiretroviral therapy (ART) for HIV. If you do not have insurance, ADAP can pay for the cost of your HIV medications. ADAP can also help if you have insurance but still need help affording your monthly premiums or medication costs.

In order to qualify for DC ADAP, you must live in Washington, DC, be diagnosed with HIV, and have income below a certain limit (see Table 4). Most people are referred to the program through a case manager who can assist them in completing the ADAP application. Keep in mind that you will need to provide proof of residence, medical verification of your HIV status, and proof of income. Typically, applications are processed within the same day, though the process may take two-to-three days if your application is missing information. **To learn more about how to apply for ADAP, visit https://dchealth.dc.gov/DC-ADAP or call 1-202-671-4815.**

PRE-EXPOSURE PROPHYLAXIS DRUG ASSISTANCE PROGRAM (PrEP DAP)

Pre-exposure prophylaxis (PrEP) is a biomedical intervention to prevent HIV infection. DC offers a Pre-Exposure Prophylaxis Drug Assistance Program (PrEP DAP) for insured and uninsured DC residents who are HIV negative and need assistance affording PrEP. To qualify for DC PrEP DAP, you must live in Washington, DC, have income below a certain level (see Table 4), have a high risk of HIV infection, and have a prescription for a PrEP medication. If you do not have insurance and meet all of the other eligibility requirements listed above, you can qualify for PrEP DAP regardless of your immigration status.

To apply, you must complete an application form and submit proof of DC residence, proof of income, proof of HIV negative status, proof of insurance (if applicable), and a doctor's note stating that you have a high risk of HIV infection. **To apply for PrEP DAP, visit https://dchealth.dc.gov/DCPrEPDAP or call 202-671-4815.**

OTHER FINANCIAL ASSISTANCE FOR MEDICATION COSTS

Patient assistance programs, offered by pharmaceutical companies and nonprofit organizations, can help offset some of the cost of HIV medications, including PrEP. The National Alliance of State & Territorial AIDS Directors (NASTAD) maintains lists of patient assistance programs for people with HIV.

- Patient assistance programs for people with HIV: https://www.nastad.org/sites/default/files/Uploads/2019/hiv-and-paps-caps-resource-document-093019.pdf

TABLE 4. MONTHLY INCOME LIMIT FOR DC ADAP AND PREP DAP

IF YOU HAVE THIS MANY PEOPLE IN YOUR HOUSEHOLD…	…YOU MUST EARN BELOW THIS AMOUNT EACH MONTH TO QUALIFY
1	$5,420
2	$7,331
3	$9,242
4	$11,152
5	$13,063
6	$14,973
7	$16,884
8	$18,794

Source: Figures based on 500% FPL plus 5% income disregard in 2021. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. U.S. Federal Poverty Guidelines Used to Determine Financial Eligibility for Certain Federal Programs: A chart with percentages (e.g., 125 percent) of the guidelines. https://aspe.hhs.gov/system/files/aspe-files/107166/2021-percentage-poverty-tool.xlsx. Accessed April 2021.

7 District of Columbia Department of Health, HIV/AIDS, Hepatitis, STD, and TB Administration (HAHSTA). Annual Epidemiology & Surveillance Report: Data Through December 2019. Available at: https://dchealth.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/2020-HAHSTA-Annual-Surveillance-Report.pdf. Published 2020. Accessed April 2021.

WHAT IS AN EXPLANATION OF BENEFITS (EOB) AND HOW TO UNDERSTAND IT

After you sign up for health insurance and start receiving health care, you may start to receive a document from your insurance company called an explanation of benefits (EOB). An EOB explains how much your insurance paid for your medical care. It is not a bill.

An EOB usually contains the following information:

- **Service Description**: A brief description of the type of service you received. Sometimes the service description will use codes or abbreviations that are difficult to understand. If you do not understand the service description in your EOB, you can call your insurance company and ask them to explain it to you in plain language.
- **Date of Service**: The date you received the service
- **Provider Charges**: How much your *health care provider* charged your insurance plan for the service you received
- **Allowed Charges**: The maximum amount your health plan will pay for the type of service you received
- **Amount Paid By Insurer**: How much your insurance actually paid your *health care provider*
- **What You Owe**: How much you ***may*** owe to your *health care provider*. The amount you ***may*** owe could include a bill, *copayment*, or *coinsurance* amount that you have already paid. In that case, you do not need to pay your *health care provider* anything else.

Your insurance company will typically send you an EOB after you get medical care or at the end of each month. You may receive your EOB in the mail or access it on your insurance company's website. When you read your EOB, you should consider the following questions:

- Do you remember receiving medical care on the date of service listed on the EOB?
- Did you receive all of the services listed on the EOB?
- Did you already pay for the service, or do you still owe money to your *health care provider*?

If you are not sure about the answers to these questions or believe there may be an error on the EOB, you should contact your insurance company by calling the number on the back of your insurance card (see the section on "How to advocate for yourself").

EXPLANATION OF BENEFITS (EOB)

Customer Service: 1-800-555-1963

LEADWORTH COMMUNITY HEALTH PLAN

Statement Date: 05/17/2021
Document Number: 1204172010-00

Melanie J. Sample
1705 Pollard St NW
Washington, DC 20010

THIS IS NOT A BILL

Member Number: 26062010 **Group:** AJDS **Group Number:** 9037

Patient Name: Melanie J. Sample **Provider:** Leadworth Cottage Hospital **Claim Number:** 2864016-36
Date Received: 04/01/2021 **Payee:** Leadworth Hospital Foundation **Date Paid:** 05/01/2021

Claim details				What your provider can charge you		Your responsibility				Total claim cost	
Item	Date of Service	Service Description	Claim Status	Provider Charges	Allowed Charges	Co-Pay	Deductible	Co-Insurance	Paid by Insurer	What You Owe	Remark Code
1	3/20/21 – 3/20/21	Medical care	Paid	$31.60	$2.15	$0.00	$0.00	$0.00	$2.15	$0.00	PDC
2	3/20/21 – 3/20/21	Medical care	Paid	$375.00	$118.12	$0.00	$0.00	$0.00	$83.12	$35.00	PDC
			TOTAL	$406.60	$120.27	$0.00	$0.00	$0.00	$85.27	$35.00	PDC

Remark Code: PDC – Billed amount is higher than the maximum payment insurance allows. The payment is for the allowed amount.

Sample EOB: Not a real person

HOW TO ADVOCATE FOR YOURSELF IF YOU ENCOUNTER ISSUES WITH YOUR INSURANCE

Health insurance can be complicated, and it is not uncommon to encounter issues. Sometimes these issues can be frustrating or time-consuming, but it is often possible to resolve them if you are persistent. This section provides advice for avoiding and dealing with common issues related to health insurance.

HOW TO AVOID UNEXPECTED CHARGES

Nobody wants to receive an unexpected bill, and unexpected bills for health care can be very expensive. When you go to get health care, you should take the following steps to avoid unexpected charges:

- Before you see a *health care provider*, call the provider in advance to make sure that they accept your insurance. This is especially important to do if you are seeing a new *health care provider* or if you recently switched your health plan.
- If you know you will be receiving a particular service (for example, a specialist visit or a blood draw), review your health plan documents or call your insurance company before seeing your health care provider. If you speak to an insurance representative, keep notes on who you spoke with and the date of your call. Questions to ask include:
  - Is this service a *covered benefit*?
  - Have you already reached your plan's *deductible*?
  - Is there a *copayment* or *coinsurance* associated with the service?
  - Is this service considered a *preventive service*? If so, does that change any costs associated with the service?
- If your health care provider orders an unexpected test or procedure during a medical visit, you can ask them to call your insurance company to make sure that the service is a *covered benefit* before they proceed.

WHAT TO DO IF A SERVICE OR MEDICATION REQUIRES PRIOR AUTHORIZATION

Typically, the *prior authorization* process is managed by your health care provider and your insurance company. However, it is still a good idea to understand this process in case your prior authorization request is denied.

Sometimes health plans will only cover a service or item in specific circumstances. In such cases, your *health care provider* (or sometimes, you) will need to submit a *prior authorization* request to your health plan to demonstrate that the service or item is medically necessary. The process may take a few days, so it is important that your health care provider submit the *prior authorization* request as soon as possible.

Your health plan will notify you if your *prior authorization* request has been approved or denied. If your health plan rejects your *prior authorization* request, you can typically complete an appeals process to try to overturn the decision. If you receive the medication or service before your health plan has approved your *prior authorization* request, your plan may issue a claim denial and not pay for your care.

WHAT TO DO IF YOU RECEIVE AN EXPENSIVE BILL

The first thing you should do if you receive an expensive medical bill is to check for billing mistakes made by your *health care provider* or insurance plan. Billing errors are more common than you may think and can often be fixed if you find one. If you think that you may have been billed in error, take the following steps:

- One sign of a billing error is if the services or charges listed on an EOB do not match the services or charges that your *health care provider* billed you. Review your EOB and medical bill to make sure that the services and charges match, that you received all the services that were billed, and that you were not billed twice for the same service. You should also make sure that your name, insurance policy number, and dates of service are correct.

  Sometimes the service description in a medical bill or EOB will have codes or abbreviations that are difficult to understand. If you do not understand the service description in your EOB, you can call your insurance company and ask them to explain it to you in plain language. If you do not understand the service description on your medical bill, you can call your *health care provider* and ask them to explain it to you in plain language. You can also ask your *health care provider* to send you an itemized bill which lists every service you were billed for separately.
- Review your health plan documents to make sure that your plan paid the appropriate amount for the services or items you received. For example, your plan documents may state that your health plan will pay for 100% of your annual check-up before you reach your *deductible*, because an annual check-up is a *preventive service*. If you were billed for a check-up anyway, your health plan or *health care provider* may have made a billing mistake.
- If you notice any differences or mistakes, contact your insurance company by calling the phone number on the back of your insurance card. Ask about any differences between the medical bill and the EOB. Tell your insurance company if you were billed twice or billed for any services or items you did not receive. Ask what needs to be done to correct any errors. If the error was made by your *health care provider*, you may also need to contact them and have them resubmit your *claim*.

If your bill does not have any errors and you are unable to pay the full amount, contact your health care provider to see if the amount can be negotiated down or set up a payment plan.

WHAT TO DO IF YOU RECEIVE A SURPRISE OUT-OF-NETWORK BILL

You may receive a *surprise bill* if you go to a health care facility (like a doctor's office or hospital) that is in your plan's *provider network*, but unknowingly receive care from an out-of-network health care professional (like a doctor or nurse). Surprise bills are often much higher than you would expect they would be, because your insurance plan will not cover the total costs of your out-of-network care above a certain *allowed amount*. As a result, the health care provider will bill you for the amount that the insurance did not pay. For example, if the provider's charge is $100 and the *allowed amount* is $70, the provider may *balance bill* you for the remaining $30. This can be especially frustrating if you made an effort to go to a facility in your plan's *provider network* and were expecting to receive a much lower bill. It can also be frustrating if you were seeking health care in an emergency and could not make sure your *health care provider* was in your plan's network.

Beginning in January 2022, insurance companies will no longer be allowed to charge you out-of-network rates for emergency services or for services delivered by an out-of-network health care professional who works in an in-network health care facility. This means that beginning in 2022, it will be illegal for health plans to send you a surprise out-of-network bill.

WHAT TO DO IF A CLAIM IS REJECTED

Your health plan may reject a *claim* if it is missing important information or if it contains incorrect information. If this happens to you, contact your insurance plan and ask why the *claim* was rejected and what needs to be done to fix the *claim*. After you receive this information, you may also need to contact the health care provider who submitted the *claim* to tell them what needs to be fixed.

WHAT TO DO IF A CLAIM IS DENIED

If your health insurer denies a *claim* and requires you to pay the full amount of an item or service, you have the right to appeal their decision. Your health plan must tell you why the *claim* was denied and how to start the appeal process. If you do not understand why your *claim* was denied or what to do next, call the number on the back of your insurance card and ask. Pay close attention to any deadlines: for example, some plans may require you to submit an appeal within six months of receiving notice that your *claim* was denied. As soon as you receive a *claim denial* and decide to start an appeal, you should start keeping copies of all information related to your denied *claim* and the appeals process.

Most health plans will require you to submit an appeal in writing and mail it to a specific address. Some health plans will provide a form for you to complete, while others will require you to write an appeal letter. Your appeal letter should include the following information:

- What was the service or item that your plan refused to pay for?
- Who delivered or requested the service or item and on what date?
- What was the reason your health plan gave for the *claim denial*?
- Why do you believe that the *claim* should have been approved? For example, was the service or treatment listed as a *covered benefit* in your plan documents? Does your *health care provider* believe the service or item is medically necessary?
- Any supporting information from your health care provider

If your insurance company denies your appeal, the next step is to request a review from a third-party organization. Your insurance company should provide information on how to do this as part of the denial notice. Again, pay close attention to any instructions or deadlines and be sure to send your appeal to the correct address.

Filing an appeal can be a complicated process. If you need assistance, contact the DC Office of Health Care Ombudsman at healthcareombudsman@dc.gov or 1-877-685-6391.

GLOSSARY

TERMS RELATED TO HEALTH PLAN COSTS

Premium
The amount you pay for your health insurance every month. In addition to your premium, you usually have to pay other costs for your health care, such as *cost-sharing* (*deductibles*, *copayments*, and *coinsurance*).

Cost-Sharing
The share of costs covered by your insurance that you pay out of your own pocket. This term generally includes your *deductible*, *coinsurance*, and *copayments*.

Deductible
The amount you pay for covered health care services before your insurance plan starts to pay. With a $2,000 deductible, for example, you pay the first $2,000 of *covered benefits* yourself. After you pay your deductible, you usually pay only a *copayment* or *coinsurance* for covered benefits. Your insurance company pays the rest.

Keep in mind that many plans have exceptions and will pay for certain services, like a checkup or disease management programs, before you've met your deductible. All DC Health Link plans will pay the full cost of certain *preventive services* even before you meet your deductible. In addition, some plans will have separate deductibles for certain services, like medications.

Coinsurance
The percent of costs of a *covered benefit* that you pay after you have met your *deductible*. For example, if you receive a *covered benefit* that costs $2,000 and your plan has *coinsurance* of 20% for that service, you would pay $400 and your plan would pay $1,600 if you have already met your plan's *deductible*. If you have not met your plan's *deductible*, you would be responsible for all costs up to $2,000.

Copayment
Also known as *copay*. A fixed dollar amount you pay for a *covered benefit*, after you have met your *deductible*. For example, let's say your plan has a $20 copay for doctors' office visits. The full cost of a doctor's office visit is $100. If you have already met your *deductible*, you would pay $20 for a doctor's visit and your plan would pay $80. If you have not met your *deductible*, you would be responsible for all costs up to the plan's *deductible*.

Out-of-pocket Maximum/Limit
The most you have to pay for *covered benefits* 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% of the costs of *covered benefits*. This limit does not include amounts you spend on monthly *premiums* or out-of-network care.

TERMS RELATED TO HEALTH CARE PROVIDERS

Health Care Provider
This is a general term that includes many types of professionals and organizations that provide health care, such as doctors, nurses, dentists, social workers, hospitals, doctors' offices, and more.

Provider Network
A network of health care providers who have a contract with your health plan to provide services to you at a discount. This means that you will pay less if you get health care from an "in-network" provider. Some plans will not pay for any services you receive at an "out-of-network" provider.

Primary Care Provider
Primary care providers include doctors, nurses, nurse practitioners, and physician assistants. They provide services to help prevent and treat common illnesses. They often maintain long-term relationships with you and advise and treat you on a range of health-related issues. They may also coordinate your care with specialists.

Specialist
Unlike a primary care provider, a specialist focuses on a specific area of medicine or type of patient. For example, an HIV specialist will focus specifically on people with HIV and HIV treatments. Other types of specialists include gynecologists, cardiologists, allergists, dermatologists, oncologists, and many others.

TERMS RELATED TO YOUR PLAN'S COVERED BENEFITS

Covered Benefit
An item or service that your health plan will pay for, in part or in full.

Excluded Benefit
An item or service that your health plan will not pay for.

Claim
A request for payment submitted to your health insurer when you get items or services you think are covered.

Claim Denial
When your health plan rejects a claim and refuses to pay for an item or service you received. This can happen if you receive a service that is not covered by your health plan, if you receive a service from an out-of-network provider, or if you do not receive necessary prior authorization for a service.

Prior Authorization
Sometimes health plans will only cover a service or item in specific circumstances. In such cases, your health care provider (or sometimes, you) will need to submit a prior authorization request to your health plan to demonstrate that the service or item is medically necessary. If you do not submit the necessary prior authorization requests, your plan may issue a claim denial and not pay for your care. If your health plan rejects your prior authorization request, you can typically complete an appeal process to try to overturn the decision.

Drug List
A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. Also called a formulary.

Explanation of Benefits (EOB)
A statement sent from your health plan listing services that were billed by a health care provider, how much the plan paid for these services, and how much you may owe. An explanation of benefits is not a bill.

Preventive Service
A preventive service is a service that you receive to prevent you from getting sick, like a check-up, shot, or cancer screening. Many health plans will cover 100% of the cost of preventive services even before you meet your deductible, as long as you receive your care at an in-network provider.

TERMS RELATED TO BILLING

Allowed Amount
The maximum amount your health plan will pay for a covered benefit. May also be called "eligible expense," "payment allowance," or "negotiated rate." If your provider charges more than the plan's allowed amount, you may have to pay the difference.

Balance Billing
When a provider bills you for the difference between the health care 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. Typically, in-network providers may not balance bill you for covered services. Medicare and Medicaid prohibit balance billing.

Surprise Bill
A bill resulting from a situation where you go to a health care facility (like a doctor's office or hospital) that is in your plan's provider network, but unknowingly receive care from an out-of-network health care professional (like a doctor or nurse).

EFFI BARRY TRAINING INSTITUTE

Led by HealthHIV, the Effi Barry Training Institute strengthens the capacity of the HIV care and prevention workforce to optimally plan, implement, and sustain high-impact HIV prevention (HIP) and HIV care interventions across the Greater Washington regional area.

EBTI provides free trainings and technical assistance (TA) to support the work of HAHSTA grantees and community-based organizations. Areas covered by TA include:

- Navigating the fee-for-service business process
- Basic HIV service competencies
- Advanced skills in health care systems, data, and health informatics
- High-impact prevention programs, including biomedical programs
- Emerging evidence-based or informed approaches to comprehensive HIV care coordination

To request capacity building assistance, visit effibarryinstitute.org/requestcba/

HealthHIV

HealthHIV, one of the largest national HIV capacity building organizations, delivers education to, and builds the capacity of health departments, AIDS directors, Ryan White administrators, HIV prevention program managers, AIDS service organizations, municipal leaders, health centers, faith and community-based organizations, primary care providers, HIV care providers, and other allied health professionals.

If you are interested in requesting capacity building assistance, visit healthhiv.org/requestcba

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