

Understanding Your Health Insurance: Certificate of Coverage and Summary of Benefits

What is a health insurance certificate of coverage?

When you enroll in a health insurance plan, you are given a certificate of coverage. It may also be called a *contract*, *evidence of coverage*, or *summary plan description (SPD)*. You can call your insurance customer service department at any point during your coverage and ask for a written copy of your certificate of coverage. This should be provided free of charge.

This document explains the health benefits you and your dependents have under the plan. It details the services that will and will not be covered. Services that are not covered are called *exclusions*. The actions you have to take to receive the health benefits—such as paying a copay, meeting a deductible, or using particular health care providers—are called *conditions*.

The certificate outlines your obligations. It explains:

- when you will be required to make copayments and pay deductible, and how much you will have to pay, both for network and non network providers
- when you will need to obtain a referral from one provider to another
- when you will need to call the insurance company to obtain approval before you receive a service
- out-of-pocket maximums
- lifetime maximums for grandfathered plans (before ACA) or nonessential medical benefits

The certificate also details the process for appealing decisions made by the insurance company. It is important to keep the certificate available, because it should be the first place you look when you have a question about coverage. It includes the phone numbers to call if you have any questions, including the number for the insurance customer representative.

Where should I look to find out whether a service is covered?

Every plan has a different certificate because the benefits under each plan are different. To find out whether a specific service or supply is covered, look for the heading that applies to the situation.

Be sure to look up every service or supply that might apply, so you won't have any surprises (see handout *HIAC-h23, Private Insurance* for more information about areas of potential coverage). For example, if your child is brought to the hospital by an ambulance and then stays in the hospital as an inpatient, the coverage for the ambulance service may be different from the coverage for the hospital stay. You may be required to make a copayment for the ambulance service but not for the hospital stay.

Certificates usually have a section of definitions to explain words that have special meanings. To fully understand your coverage, it is wise to read the definitions section.

How do I know whether I need to obtain approval before my child sees a doctor?

Some insurance plans require you to call for approval (sometimes called *prior authorization*) before your child receives certain services or supplies. If you do not call the insurance company first, it may not provide coverage and you could be required to pay the medical costs yourself. The certificate tells you when you need to call for prior approval. You can also call your insurance customer service department to find out whether prior approval is required.

Sometimes, participating providers, such as your doctor's office, are required to obtain prior approval, so you can also check with them to see if the insurance company has agreed. If there are any doubts or concerns, you should check directly with your insurance company.

My contract provides more coverage for participating providers than nonparticipating providers. What is a participating provider and how do I find one?

Some health insurance plans have a list of participating providers (also called *preferred providers* or *in-network providers*). These are doctors, hospitals, clinics, and other health care providers that are part of the insurance's network. Insurance plans usually provide more coverage for seeing a participating provider than for a nonparticipating provider. For example, you may be required to pay a higher copayment to see someone other than a participating provider.

You generally receive a list of participating providers when you enroll in a plan. Check as soon as possible to find out whether the doctors, clinics, hospitals, and other health care providers you and your family use are listed. You can always call your insurance customer service department to find out whether a particular doctor is a participating provider.

When deciding whether or not to switch health insurance providers or the insurance coverage you receive, check to see if your current physicians or other health care providers are on the new participating provider list. This may help you decide which health insurance provider or insurance coverage to choose.

What should I do if there is an emergency and my child is treated by a nonparticipating doctor?

Many health insurance plans do not require that you pay for a nonparticipating provider in cases of emergency. Your certificate explains the procedures to follow in order to have the services covered.

How do I know if my child needs a referral in order to see a specialist?

Some insurance plans require you to obtain a referral from your child's primary care doctor for your child to see a specialist. The certificate outlines exactly when you need a referral. Some certificates provide information about referral requirements next to the section describing coverage for particular types of specialists. It is important that you look up the referral requirements before you make an appointment with a specialist.

Is there a section in the certificate that talks about coverage for children with special health needs?

Most health insurance certificates of coverage do not have separate sections that talk about coverage for children with special health needs. The coverage limits and requirements are the same for all people in the plan regardless of whether or not they have a disability or special health needs. Most likely, the coverage information for each service or supply that your child may need is discussed in the certificate.

Who should I call if I have a complaint about my insurance company?

Your insurance company is required to give you the phone number for the insurance customer representative to call if you have any complaints.

If your plan is fully insured, you may also contact:

Minnesota Department of Health

(651) 201-5000

(888) 345-0823 toll-free

www.health.state.mn.us

Minnesota Department of Commerce

(651) 539-1600

www.mn.gov/commerce

If your plan is self-insured, you may also contact your regional U.S. Department of Labor Employee Benefits Security Administration (EBSA):

U.S. Department of Labor EBSA

(816) 285-1800