Being A Good Healthcare Consumer

Quick Tips Before Eligibility

Once you've elected your new benefit plan, it may take up to two weeks before you and your dependents become "eligible" for benefits, meaning providers can verify your information with your new insurance carrier. Until this time, keep the following details in mind:

Eligibility & ID Cards

- Benefits are not accessible until you are listed as "eligible" within the new carrier's eligibility system.
- Reminders for after the new policy's effective date but before eligibility:
    - If you need to seek medical services, you can ask the provider if they are willing to postpone billing until your new eligibility has been finalized.
    - Benefits may be accessed prior to being eligible; however, you must pay for the service and submit a claim to the new carrier for reimbursement.
    - Even if you haven't received your new carrier's ID card, you should not use your existing/old ID card after the new policy's effective date.

Prescriptions & Deductibles

- Prescription refills should be completed PRIOR to the new policy's effective date to avoid extra out-of-pocket costs and claim filing.
- Prescriptions must be paid in full if current coverage has expired and the member is not yet eligible.
    - A claim form may be submitted to the new carrier for reimbursement in accordance with the new plan benefits.
    - If a credit card is used for the Rx purchase, some pharmacies are willing to adjust the charge if you become eligible within 10 days of purchase.
- Collect documentation that lists what has been paid toward the plan deductible for the current plan year to obtain deductible credit from the new carrier, if applicable.

Preauthorization & Emergency Care

- Carriers will not preauthorize any medical treatment or prescription until you are loaded into the carrier's eligibility system.
- Emergency care must be administered, regardless of the member's benefit status.

Once you are eligible in your new carrier's system, sign in to their member portal and explore their tools and resources. The next page goes over some simple tips that can help you and your family stay healthy and save money throughout the policy year.

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Quick Tips After Eligibility

Sign up on your insurance carrier's member portal. With your member login, you can view your plan information, ID numbers and search for in-network providers. You can also access "cost of care" information on quality and cost of care for providers as well as the cost of prescription drugs.

Use an in-network provider if enrolled on a PPO plan. Using an in-network provider gives you access to discounted rates and prevents providers from charging you more than the rates negotiated with your insurance carrier. In-network providers are responsible for authorizations and claims processing.

Confirm your ID card reflects the correct Primary Care Physician (PCP) if enrolled on a HMO plan. You must use the PCP listed on your ID card. You can change your PCP, effective the 1st of the month, by calling your insurance carrier. All care must be coordinated through your PCP.

Reference your insurance carrier's formulary. A formulary is a list of preferred/covered drugs for your plan. Some formularies are broken down into tiers; Tier 1 drugs are typically generic whereas Tier 2 and 3 drugs are typically name-brand and may have a greater cost associated with them. Most carriers offer mail order programs that deliver ongoing medications to your home, making it easier for you to better manage medications you take regularly.

Obtain preventive care and immunizations. The best way to minimize medical spending is to minimize the amount of medical care required by promoting good health and taking preventive measures.

Consider using telemedicine or advice lines over Urgent Care or Emergency Rooms for non-emergency care. For the best possible outcomes, ask for help as early as possible.

Take advantage of value added services. Value added services can help you efficiently manage your medical activity and costs through amenities like discount programs.

Don't pay based on the bill from the provider. Wait until your insurance carrier has processed the claim for the correct cost based on discounts and benefits.

If you have non-emergency care out-of-network, ask for a discount or payment plan. The doctor or facility may be willing to work with you on the cost of your care; they may offer a discount if you pay in full or financial assistance if you are in need. Try to discuss your situation with them before your visit.