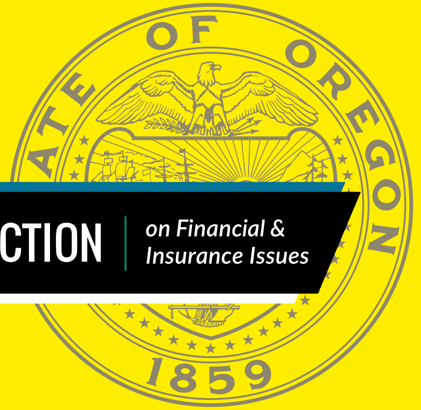
TOP TEN HEALTH INSURANCE MYTHS



1

All preventive care is covered at 100 percent under the new health care laws.

Only certain preventive care is covered at 100 percent. While most plans must offer some level of coverage for preventive care under the Affordable Care Act, only a few are covered with zero co-pay. For more information about what is fully covered, visit www.healthcare.gov/what-are-my-preventive-care-benefits.

2

I can see any doctor I want, and my health insurance will cover it.

You need to check first. Most plans have a network of preferred providers and, if you do not see one of those providers, your insurance may not cover it. Your insurance company can tell you which doctors are in its network and if you need a referral to see a specialist or someone outside the network. Remember, out-of-network providers may balance-bill you for amounts not covered by your insurance.

3

All my prescriptions are covered with the same co-pay.

Not necessarily. Name-brand drugs are often much more expensive than generic drugs. You may end up being charged more, or the drug may not be covered at all. Be sure to check with your insurance company.

4

I can go to any hospital for care, and my health insurance will pay for it.

Just like preferred networks for doctors, your insurance company has a network of preferred hospitals. If you go to an out-of-network hospital, not only will your cost of treatment be higher, you might also be required to pay the hospital any amount not paid by your insurance.

5

A medical provider who works at a hospital in my health plan's network is considered part of that network.

It is not that simple. Some medical providers who treat you at a hospital may not be employees of the hospital, and they bill separately for any services they provide. This is especially true for anesthesiologists. Check with your insurance company to make sure your provider is considered "in network" before you receive treatment or have a scheduled procedure.

6

My health plan covers me if I'm hurt in a car accident.

Your auto insurance will pay up to a certain amount for reasonable and necessary medical care related to the accident, depending on your policy. This is called Personal Injury Protection (PIP). In Oregon, the minimum level of coverage is $15,000 (though you can buy more). Once your PIP benefits are exhausted, your health insurance should start to pay.

7 My health plan must cover a service or treatment if my doctor says it's necessary.

Not always. Health plans may impose medical criteria to determine if a service or treatment is medically necessary. However, if you are denied, you have the right to file an appeal.

8 If I have a baby, or adopt one, I have to wait until open enrollment to add my child to my health plan.

You do not have to wait for open enrollment to add your new arrival to your health plan. Most health plans automatically provide coverage for newborns for the first 31 days, but you must enroll your baby within that time and pay any additional premiums or there will be no retroactive or ongoing coverage.

9 As soon as I'm signed up with a health insurance company, it will pay 100 percent of my health care costs.

Plans have different co-pays, deductibles, and annual out-of-pocket maximums. You generally must pay certain costs yourself until you reach your plan's deductible. Even then, you may still have cost-sharing until you reach your annual out-of-pocket maximum. After that, your insurance company will pay 100 percent of covered services. Bottom line: Depending on your plan, you could be required to pay thousands of dollars out of pocket before your medical expenses are fully covered by insurance.

10 If I live or work in Oregon, my health insurance plan is regulated by Oregon laws and the Oregon insurance commissioner.

It depends. Oregon regulates individual or family plans purchased in the state. Oregon also regulates most small employer group plans (1-50 employees under current law), although it is possible to participate in small group plan issued in another state. Larger employer group plans may not fall under state jurisdiction. Many employers choose to self-fund, which removes the plan from state regulation and places it under the jurisdiction of the U.S. Department of Labor. Oregon also regulates the rates in the individual and small employer markets.

For more information, contact the
Oregon Division of Financial Regulation
at 888-877-4894 (toll-free) or visit dfr.oregon.gov

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