

# Working with Your Insurance Provider: A Guide to Seeking Weight-loss Surgery

An insurance policy document with a magnifying glass resting on it. The document is white with a black border and the words "Insurance Policy" printed in a large, bold, serif font. A magnifying glass with a black handle and a silver ring is positioned over the document, with its lens focused on the text.

**Insurance  
Policy**



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# Introduction

Individuals affected by severe obesity rely on their insurance provider to assist them in the process of seeking access to safe and effective medical treatment. Many times they experience difficulty when working with their insurance providers, such as repeated denials of claims. In addition, the process often times seems complicated, and physically and emotionally draining. This brochure is designed to provide individuals with the knowledge needed to successfully work with their insurance provider and become an advocate for change.

Inside, you will find information discussing the effects of obesity and severe obesity, tips for working with your insurance provider, detailed information concerning the treatment options available for severe obesity and much more. In addition, we also provide sample letters to write to your insurer and employer to help you detail and express why access to care is important to you and your family.

We encourage you to consider joining with others who are affected by obesity by becoming a member of the Obesity Action Coalition (OAC). Membership information may be found by visiting our Web site at [www.ObesityAction.org](http://www.ObesityAction.org) or by calling the OAC National Office at (800) 717-3117.

### About the Obesity Action Coalition (OAC)

The OAC is a non-profit organization dedicated to helping individuals affected by obesity. As the ONLY organization focused solely on those affected, the OAC provides comprehensive educational resources and conducts a wide variety of advocacy initiatives.

The OAC is a membership organization and encourages each and every individual affected to join the cause.

*The information contained in “Working with Your Insurance Provider: A Guide to Seeking Weight-loss Surgery” is for educational purposes only and is not a substitute for medical or legal advice, a review and evaluation of your insurance policy, or a review and evaluation of applicable insurance law. The OAC recommends consultation with your legal and/or healthcare professional.*

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## Reviewing Your Insurance Policy or Employer Sponsored Medical Benefits Plan

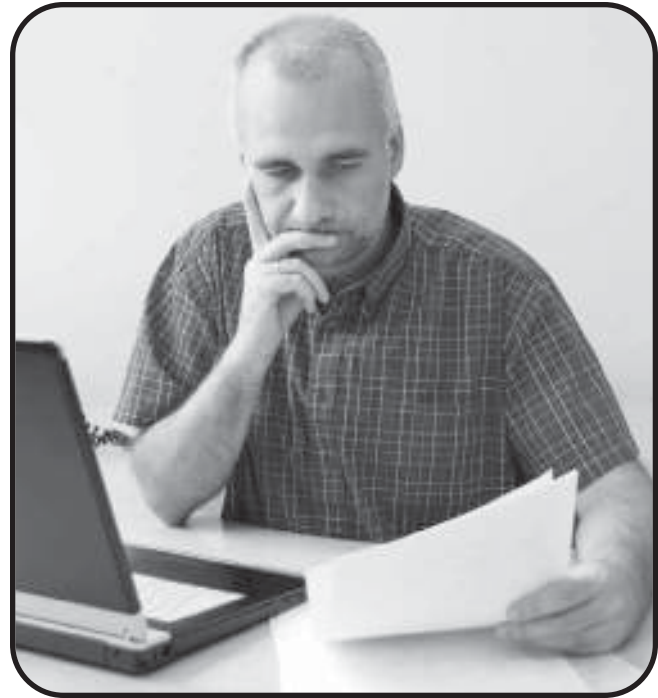
There are two ways you could be covered for medical insurance:

- You either have an insurance policy that you pay for yourself, or that is paid in full or in part by your employer (known commonly as a fully-insured policy).
- Or, you may be covered by an employer's self-insured medical benefits plan (known commonly as a self-insured policy).

If the plan is sponsored by your (or you are a dependent for a spouse's or parent's) employer, then how they pay for the plan is key to who makes the decisions on the treatment of obesity and what the appeal process is for denials.

How your employer pays for your plan also affects which documents control the coverage in the plan. If the plan is fully-insured, then the key document is the insurance policy. The insurance policy may also be called a Certificate of Coverage or Summary of Benefits. If the plan is an employer's self-insured benefit plan, then the key document is the plan document, which is usually communicated in the form of a Summary Plan Description (SPD).

Another key difference is that fully-insured policies are governed by your state insurance commission, while an employer's plan (self-insured) is governed by the Federal Government through the Employee Retirement Income Security Act (ERISA) laws and regulations. These differences may affect how you approach your insurance provider and employer in this process.



### Fully-insured

If you are covered by a fully-insured policy, you will need to begin the process by assessing your insurance policy. To do this, first you need to request the policy/contract. These documents can either be provided from your employer or insurance company. These documents are written in a legal style format and may be difficult to understand.

### Self-insured

If the plan is self-insured by an employer, you should have a copy of the plan's SPD, which will provide you with a better understanding of what the plan covers. If not, request a copy from your human resources department. (Many large employers have benefits Web sites where all of the plan documents can be found.) These documents explain your enrollment with the provider, such as whether you are enrolled in an HMO, PPO or indemnity plan.

In regards to severe obesity management exclusions, request that your insurance provider highlight the sections in your plan that discuss the exclusions and mail you a copy. If the insurance representative refuses to do this, thank them for their time, hang up and call again.

If your employer is self-insured, you may want to write them a letter explaining how this disease has affected your life. For a sample letter, please see page 11.



### Fully-insured vs. Self-insured

If the employer plan is **fully-insured**, the insurance company is ultimately responsible for the healthcare costs, and the employer typically purchases a standardized package of coverage.

If the plan is **self-insured**, the employer is ultimately responsible for the healthcare costs, and therefore can customize the plan to include and exclude specific coverage, such as bariatric surgery coverage.

# Reviewing Your Policy

## Determining if Your Policy Has an Exclusion or Inclusion

### Policy Exclusions

The first-step in reviewing your policy is to determine if your policy has an exclusion. Exclusions are medical services not covered by an individual's insurance policy.

**Example of Language for a Policy Exclusion:**

*Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including severe obesity, or for the purpose of weight reduction, regardless of the existence of co-morbid conditions.*

If your policy has an exclusion, you should contact your employer and encourage them to add the benefit. Often times exclusions are a tougher case to plead, however, many individuals have been successful in encouraging their employer to add a benefit. A sample letter is provided on page 11 to help when contacting your employer.

### Policy Inclusions

If your policy has an inclusion, this means that your policy covers bariatric surgery, under certain specifications.

**Example of Language for a Policy Inclusion:**

*The plan will cover the surgical treatment of obesity if the patient is severely obese and if the surgery is performed by a practice certified by ASMBS and/or ACS.*

If your policy covers bariatric surgery, you will want to find out the requirements and to make sure that you meet all requirements prior to you moving forward.

### Other Language to Consider

If you do not have a direct inclusion or exclusion, your policy could have some general exclusion language in one part of the plan, but specifically allow the surgery in another. Be sure to read your policy carefully to make sure you understand what is covered and what is not covered.

For instance, oftentimes policies have a section that lists "Expenses Not Covered." While this section may seem to have exclusions, it also will provide language where there is a covered benefit.

Here is some sample language for "Expenses Not Covered:"

*The medical plan does not cover the following expenses:*

- *any services or supplies not specifically listed under covered expenses*
  - *treatment or surgery for obesity, weight reduction or weight control unless the patient is severely obese and suffers from a related medical condition. Pre-treatment approval is necessary. The only procedures currently allowed are Gastric Bypass with Roux-en-Y, Gastric Sleeve and Gastric Banding.*
- Severe obesity is defined as having a Body Mass Index (BMI) of 40 or greater or a BMI of 35 or greater with related medical conditions. Related medical conditions include, but may not be limited to: arthritis, diabetes, hypertension, liver and gallbladder disease, and cardiovascular disease.*
- *treatment or surgery to reverse any procedures performed to treat obesity, weight reduction or weight control unless medically necessary*

Other language to consider is listed as "Covered Expenses."

This language directly lists what is a covered benefit and also provides more specifics about coverage specifics. Here is sample language for "Covered Expenses:"

- *treatment or surgery for obesity weight reduction or weight control if the patient is severely obese and suffers from a related medical condition. Severe obesity is defined as having a Body Mass Index (BMI) of 40 or greater or a BMI of 35 or greater with related medical conditions. Related medical conditions include, but may not be limited to: arthritis, diabetes, hypertension, liver and gallbladder disease, and cardiovascular disease. The only procedures currently allowed are Laparoscopic Adjustable Gastric Banding (LAGB), Gastric Bypass/Gastric Bypass with Roux-en-Y and Gastric Sleeve.*
- *medically necessary treatment or surgery to reverse procedures performed to treat obesity, weight reduction or weight control*



**It is important to take your time and read your policy carefully. Sometimes the wording may appear confusing or misleading. If you are having a hard time reading your policy, the best thing to do is to contact your insurance provider or benefits manager and discuss your plan in more detail.**

## What You Need When Working with Your Provider

- Insurance provider's name and phone/fax number
- Policy number or employer's plan number
- Insurance company patient representative and/or contact person
- Insurance company e-mail address
- Insurance company Web site address (Many insurance providers maintain Web sites that include member information, such as coverage of medical procedures. Sometimes providers may require you sign up to view certain areas of the Web site. This process may be confusing. If so, call your provider and ask to be walked-through the sign-up process.)

## Helpful Tips When Speaking with Your Insurance Representative

### Do

- Speak slowly and clearly.
- Ask for their name and write it down when they answer the call (request they spell it for you if you are not sure).
- Ask for a specific phone number and/or e-mail address from the representative and write it down.
- Ask for a hardcopy of your policy or employer's SPD to be mailed to you with the areas regarding obesity and morbid obesity highlighted.
- Make sure you receive anything you are promised or guaranteed with your policy in writing.
- Keep a detailed record of all your documents.
- Be persistent.

### Don't

- Do not be rude.
- Do not demand anything.
- Do not threaten anyone.
- Do not get frustrated. If you experience an unpleasant representative, simply thank them for their time, hang up, and call back.

## Reading Your Insurance Contract or Employer's Summary Plan Description

Okay, you are halfway there now! It is important to know the details of your insurance policy. Once you have determined the type of plan you have and whether or not you have an inclusion/exclusion, you should also familiarize yourself with your plan documents. This will help you when trying to work with your insurance provider contact. As always, remember to get everything in writing when speaking with them.

Here are questions that you should be able to answer when determining coverage and the type of coverage that you have:

- What are your health insurance benefits?
- What is the definition of morbid obesity according to your plan?
- If any, what coverage of morbid obesity is listed?
- What limits and/or requirements are stated in order to receive morbid obesity treatment? For example:
  - Is there a certain amount of required time you must document attempted weight-loss?
  - Does the documented time have to be consecutive?
  - Is your physician required to document your weight-loss attempts?
  - Do you need to weigh a certain amount before treatment is performed and/or initiated?
  - Is there an age requirement to receive care?
  - Must you use a specific Center of Excellence or medical provider to receive coverage?
  - Are there weight limitations preventing coverage?
- Is there a maximum dollar limit on your benefits?
- What treatment options are excluded or specifically included (*see sample on page 4*)?
- What is the co-payment for medical services?
- What testing is covered, such as nutritionist, psychologist, labs, sleep apnea study, ultrasounds, etc.?
- Does your insurer require weight-loss prior to surgery? If so, what percentage or number of pounds is required?



# The Pre-approval Process

Once you have determined the type of coverage you have and understand your policy, you will want to get pre-approved (or receive a prior authorization) for your procedure. Pre-approval is almost always required for weight-loss surgery. This is an excellent way to make sure that this procedure is covered under your contract.

Typically, your surgeon's office will submit the necessary information to your insurance provider in order to seek pre-approval. However, if they do not, you will want to seek pre-approval on your own.

When seeking pre-approval, it is best to contact your insurance provider in writing and request a determination of your coverage amount prior to your procedure (to ensure receipt of your letter, send it by certified mail and file a copy of the individual's signature who accepted it). Again, make sure to request this in writing (*see a sample letter on page 11*).

Make sure to follow-up with your insurance company. If you have not received anything within a week of speaking with them, call back and confirm your materials have been received.

## Insurance Provider and Reviewing Claims

Your insurance provider very carefully reviews your claim and looks for two main things:

1. Which procedure/benefit are you trying to access
2. Reason why you are accessing this benefit (if available based on your policy restrictions/exclusions)

The procedure/benefit you are trying to access will be coded using a CPT code. These codes originate from the American Medical Association and allow physicians to record the treatments provided to allow for processing of your claim.

The "reason" for the treatment will be represented by an ICD-9 code. This tells the insurance company your doctor's diagnosis and why treatment is needed. These are the codes and processes used to determine whether or not a claim will be covered under your policy.



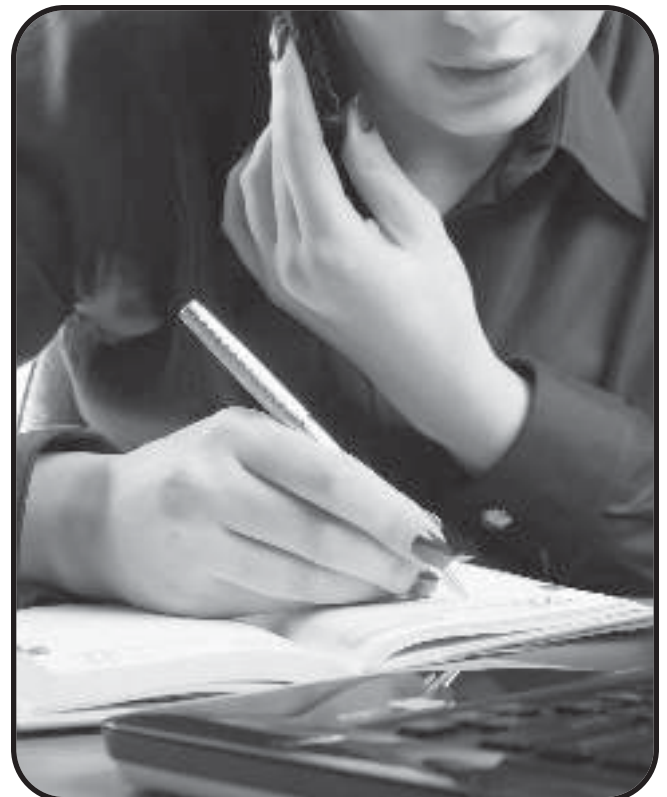
### Difference Between CPT Codes and ICD-9 Codes

**CPT Code:** This code indicates the procedure/benefit you are trying to access. These codes allow physicians to record the treatments provided to allow for processing of your claim.

**ICD-9 Code:** This code indicates the "reason" for the treatment. These codes tell the insurance company your physician's diagnosis and why treatment is needed. These codes also determine whether or not a claim will be covered under your policy.

If the codes were incorrect, obtain the correct codes and a letter from your doctor, and resubmit your claim. An incorrect coding error could impact your claim and deny reimbursement.

The chart on page 7 lists samples of CPT and ICD-9 codes.



## Sample CPT and ICD-9 Codes

Please note that the below codes are provided as an example. Codes often change, so check with your surgeon's office for the most current codes.

### CPT Codes

<b>Procedure</b>	<b>CPT Code</b>
Laparoscopic Gastric Bypass . . . . .	43644
Open Gastric Bypass . . . . .	43846
Adjustable Gastric Banding System . . . . .	43770
Biliopancreatic Diversion with Duodenal Switch . . . . .	43845
Sleeve Gastrectomy . . . . .	43775

### ICD-9 Codes

<b>Diagnosis</b>	<b>ICD-9 Code</b>
Severe Obesity . . . . .	278.01
Diabetes . . . . .	250.02
Hypertension . . . . .	401.1
Cardiovascular Disease . . . . .	414.9
Sleep Apnea . . . . .	780.57
Gastroesophageal Reflux . . . . .	530.81
Degenerative DZ Wt. Bearing Joints . . . . .	715.09
Chronic Respiratory Disease . . . . .	519.9
Chronic Depression . . . . .	296.12
Chronic Venous Insufficiency . . . . .	459.81
Hyperlipidemia . . . . .	272.4
Hypercholesterolemia . . . . .	272.0
Urinary Stress Incontinence . . . . .	788.32/625.6

# Appealing a Denial

## Appealing a Denied Prior Authorization

In the event you are denied, do not become upset. This is common and often a “first response” by many insurance providers. Unfortunately, many individuals face this challenge when getting approved for weight-loss surgery. However, it is important to know that you can appeal this decision and let your voice be heard.

It is essential you understand the appeal process prior to you submitting your appeal. It is also important that you construct your appeal carefully, making sure that you provide support for each reason you were denied. Typically, your surgeon’s office will submit the necessary information to appeal your denial. If they do not, you can appeal it on your own. How you appeal your denial depends on the type of plan you have (fully-insured or self-insured).

## If You Have a Fully-insured Policy

The next step is to resubmit the authorization. For the resubmission process, you will need to know why you were denied. Do not be afraid to call your contact and ask for a detailed explanation in writing as to why you were denied.

Once you receive the explanation, read it carefully. Most times, denials are categorized as either “Not Medically Necessary,” “Experimental Procedure” or “Excluded Procedure.” If there is something in it you do not understand, call your provider and ask for a more detailed explanation. Remember, you pay for your insurance, so let them work for it. Review your billing codes and make sure the correct ones were used.

### “Not Medically Necessary” Categorization

In the event the denial was categorized as “Not Medically Necessary,” make sure the correct codes were used and then request a letter from your doctor stating the nature of the procedure. Once you have the correct codes and a letter from your doctor, resubmit (*see a sample letter on page 12*).

### “Experimental Procedure” Categorization

In the event the denial was categorized as an “Experimental Procedure,” make sure the correct codes were used and then request a letter from your doctor stating the procedure is not experimental. Once you have the correct codes and a letter from your doctor, resubmit (*see a sample letter on page 12*).

### “Excluded Procedure” Categorization

In the event the denial was categorized as an “Excluded Procedure,” once again, make sure the correct codes were used. At this point, make sure all factors of your severe obesity status have been reported, such as obesity-related conditions that affect you (heart disease, diabetes, sleep apnea, etc.). Once you have the correct codes and a letter from your doctor stating your current health condition (including all obesity-related conditions), resubmit (*see a sample letter on page 12*).

Some insurance providers are limited by the state in which they operate as to the number of appeals they can accept from patients. If you have reached the maximum number of appeals from your insurance provider, you may be eligible for an external review.

If your state offers external reviews of denials, you have the right to request a review of the HMO’s decision concerning the complaint or appeal within 365 days after receipt of the final decision letter from your insurance provider. For a definition of External Review, please see the Glossary at the end of this guide.

## If You Have an Employer’s Self-insured Medical Benefits Plan

The denial probably will occur at the predetermination stage of the process; therefore, you may not receive a formal Explanation of Benefit (EOB) form from the provider denying the authorization. In order to submit an appeal, you must receive a formal written denial, usually in the form of an EOB. This EOB should include a paragraph explaining your appeal rights and how to submit an appeal. Such as:

*If you do not agree with this determination, you may appeal it in writing to the Pension and Benefits Appeals Board within 60 days of receiving this letter. In addition, you have the right to appear personally before the Board, review pertinent documents, submit issues and arguments in writing, have a representative appear before the Board or present written issues and arguments, and present additional information to the Board.*

The denial should also give you a detailed explanation why you were denied, and what specific sections of the plan were used to make the denial.



Do not be afraid to contact the provider to request the details of your denial. Also, if you have studied your plan and feel there is a specific portion of the plan that allows for the treatment, you should ask them to review your denial with this in mind. Many times an insurance company applies the rules they have for their insured products and not the plan rules for the specific employer when making initial determinations.

The laws and regulations that allow a company to get tax advantages for providing employees with medical benefits also require the plan to implement an appeal process.

A verbal denial, such as the plan does not cover this procedure, does not meet these regulations. If you cannot get a formal denial from the provider, contact your employer's personnel or benefit department for a formal denial. At the most, the plan must respond to your claim within 60 days or they may not be in compliance with ERISA.

Once you have received the denial, you should submit your appeal paying close attention to any time limits required by the process. This may sound like a lot of work, but in the end the benefits to your health are worth it.

## Avoiding Discouragement

The process of contacting and working with your insurance provider may be a frustrating one. Do not become discouraged. By taking your time with each step and maintaining patience, you will only enhance your ability to have your treatment option covered by your insurance. Remember your rights as a policy holder. Do not be afraid to ask questions and do not forget, as we mentioned before, that you pay for your insurance, so make them work for it!



## Statistics to Include in Your Appeal Letter

These statistics briefly detail severe obesity and its affects in the United States. Feel free to use these statistics when writing your letter(s) to your insurance provider. Educate them on the affects this disease has not only on you and your quality of life, but also others.

- It is estimated that more than nine million Americans are affected by severe obesity. Severe obesity is characterized by an individual weighing more than 100 pounds over their ideal body weight, or having a body mass index (BMI) of 40 or higher.
- Approximately 75 percent of individuals affected by severe obesity have at least one obesity-related condition (diabetes, hypertension, sleep apnea, etc.) which significantly increases the risk of premature death.<sup>1</sup>
- Life expectancy for a 20 year-old male affected by severe obesity is 13 years shorter than a normal weight male of the same age.<sup>2</sup>
- Annual direct medical expenditures attributable to obesity are \$147 billion.<sup>3</sup>

1. Must A, Spadano J, Coakley EH, Field E, Colditz G, Dietz WH. *The Disease Burden Associated with Overweight and Obesity. JAMA, 1999;282:1523-1529.*

2. Fontaine KR, Redden DT, Wang C, Westfall AO, Allison DB. *Years of life lost due to obesity. JAMA. 2003 Jan 8;289(2):187-93.*

3. Finkelstein EA, Trogodon JG, Cohen JW, Dietz W. *Annual Medical Spending Attributable to Obesity: Payer - and - Service - Specifics Estimates. Health Affairs Web Exclusive, July 27, 2009.*

# Other Options to Pay for Surgery

## What Else Can You Do?

In the event your insurance will not cover the cost of your chosen treatment option, there are other options.

- **Loans** – A loan from a bank may provide you with the financial resources needed for your treatment option. Equity lines are often a popular choice to fund weight-loss surgery. Shop around and try to get the best interest rate.
- **Financing Plans** – Check with your doctor and see if financing plans are available.
- **Credit Cards** – Many times credit cards are used to pay for medical expenses. Check with your doctor to see which ones are accepted. In addition, credit cards may also offer the ability to cash advance on them (be aware of the interest rate on cash advances as they may be higher than purchasing rates).
- **Borrow Money** – There is no shame in asking a loved one or a friend for a loan.



## Other Ways You Can Advocate for Safe and Effective Treatment

The OAC offers a variety of educational and advocacy pieces to help you become an effective advocate for change. By visiting the “Advocacy & Support” section of the OAC Web site at [www.ObesityAction.org](http://www.ObesityAction.org), you will have the resources to advocate to legislators, regulators, the media, the public and your insurance provider.

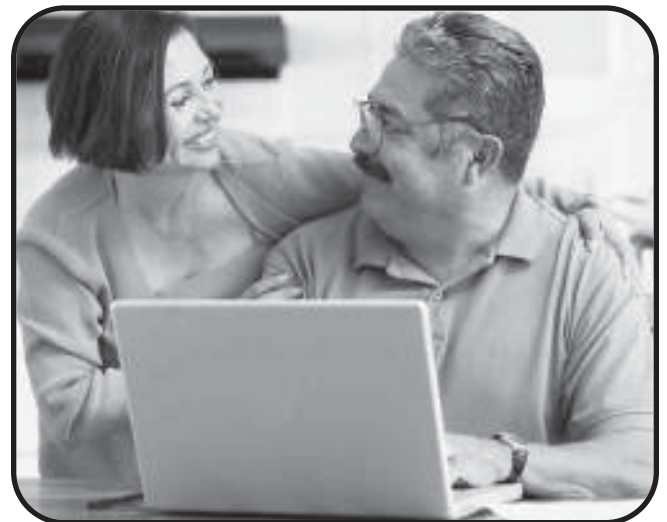
It is important to raise awareness of severe obesity to everyone you can. By doing so, you will not only improve the quality of life for yourself, but also all others affected by severe obesity.

## Legal Assistance

Often times those seeking weight-loss surgery face many obstacles. If you feel you require legal assistance, please visit the “Helpful Links” section located on the OAC Web site under the “Educational Tools” tab.

## Insurance Company Contact Information

For a list of commonly used insurance companies, visit: [www.obesityaction.org/advocacy/getting-started/insurance-providers](http://www.obesityaction.org/advocacy/getting-started/insurance-providers).



## Sample Letter to Write to Your Employer

Your Full Name  
Your Full Address  
Your City, State and Zip  
Your Phone Number with Area Code

Current Date

Benefits Manager's Name  
Employer's Title  
Employer's Address  
Employer's City, State, Zip

Dear Benefits Manager (insert name),

**In your first paragraph, mention the following points:**

1. Discuss how you recently contacted your insurance provider to inquire about weight-loss surgery and you were told it is not covered under their policy.
2. Share your personal connection with this disease. Tell the individual how severe obesity and its related conditions have affected you and your family. Elaborate on the number and cost of medications you are currently taking due to your obesity-related conditions. (Remember to remain brief. A short letter can accomplish just as much as a long one.)

**In your second paragraph, mention the following items:**

1. The affects weight-loss surgery has on severe obesity.
2. The number of people affected by severe obesity?
3. The chance of decreasing the prevalence or existence of any severe obesity-related conditions.

(For more information on the above mentioned items and to view more facts and figures to include in your letter, please visit the OAC Web site at [www.ObesityAction.org](http://www.ObesityAction.org).)

**In your last paragraph, discuss the following closing items:**

1. Request that your employer adjust their insurance policy to include weight-loss surgery or discuss with their provider the possibility of adding the procedure(s).
2. Request a timely response and thank them for their time and assistance.

Sincerely,  
Your Full Name

## Sample Letter for Pre-approval

Your Full Name  
Your Full Address  
Your City, State and Zip  
Your Phone Number with Area Code

Current Date

Insurance Provider's Name  
Insurance Provider's Address  
Insurance Provider's City, State, Zip

Dear Insurance Provider (insert name of insurance provider contact),

**In your first paragraph, mention the following points:**

1. Discuss how severe obesity affects or has affected you and your family.
2. Share your personal connection with this disease. (Remember to remain brief. A short letter can accomplish just as much as a long one.)

**In your second paragraph, mention the following items:**

1. Is the procedure I am seeking covered under my contract?
2. If yes, what are the limitations?
3. If no, are there any portions of the procedure that may be covered?
4. If the procedure is excluded, please mail me a copy of my policy with the pertaining excluded sections highlighted.

**In your last paragraph, discuss the following closing items:**

1. Request that the insurance provider write you back as soon as possible, informing you on the procedure in question.
2. Thank them for their time.

Sincerely,  
Your Full Name

# Sample Letters

## Sample Appeal Letter from Surgeon/Patient to Insurance Provider

Your Full Name

Your Full Address

Your City, State and Zip

Your Phone Number with Area Code

Current Date

Insurance Provider's Name

Insurance Provider's Address

Insurance Provider's City, State, Zip

Dear Insurance Provider (insert name of insurance provider contact),

I am appealing your decision for denying my medically needed weight-loss surgery. My height and weight are (height) (weight) and my BMI is (BMI). As statistics show and as medical doctors, you must be aware that diet and exercise help, but as a long term resolution to permanent weight-loss only 5 percent of people succeed. I am well aware of the risks with this surgery, but I believe the risks of being affected by severe obesity outweigh the risks of surgery.

I am (age)-years-old and have been overweight since I was about (age)-years-old. I have been on diets my whole life, having some success, but would always gain the weight back I lost, plus more. I will list the diets I have been on, but never kept any documentation because I could not have known at the time the insurance company would require it. Nor did I know that until this fairly new surgery even became an option for me, I would have to document weight-loss before getting the surgery.

(List all diets and weight-loss products used. If possible, include documentation.)

- Weight Watchers
- Nutri-Systems
- Schick weight-loss clinic (to the extreme of being shocked when eating bad foods)
- Quick weight-loss clinic
- Susan Powter book and diet
- Atkins
- Richard Simmons diet and exercise tapes
- Cyber Vision behavioral modification tapes
- Medically supervised diet and shots with a psychiatrist
- Cabbage soup diet
- Redux pills, under a medical doctor's care
- Overeaters Anonymous
- Slim Fast
- Hypnoses
- Xenical
- Gym
- Protein Power Book Diet

Currently, I am being monitored by my doctor, not necessarily being weighed once a month, but keeping a close eye on me. Again, I did not know it was required by my insurance for approval of the surgery.

I am not quite sure of how many years I have had (*name of insurance company*) insurance, but it has been many years for sure, much before they changed their requirement for documented medical weight-loss. I have attached some of my medical records that I feel are pertinent to weight-loss.

I have many obesity-related diseases, such as (*high blood pressure, high cholesterol, poor circulation, acid reflux, pains in my joints and now have been diagnosed with diabetes, sleep apnea and asthma*). I am on *Cardizem, Accupril, HTCZ, Synthroid, (for goiter), Zantac, Naproxen, Advair and Albuterol inhalers and soon to be on a CPU machine.*

(Discuss everything about how severe obesity affects your life. Below, please find examples.)

Being affected by severe obesity puts a strain on everything I do. I cannot walk very far without getting out of breath, I cannot tie my shoes, fit in small seats whether in airplanes, seats in an office waiting room, theater, ball park or restaurant, wherever they may be. I am embarrassed of what I look like. I lack self confidence. I am not functioning to my full potential at work. I am always tired to the point of falling asleep at my desk. It takes me twice as long to do many things. I have no energy. I want to be more active and be able to do the things normal sized people do. I do not want to die. I know this surgery will be a life saver for me. Please reconsider your decision and save my life.

Sincerely,

Your Full Name

**Actuary:** A mathematician working for a health insurance company responsible for determining what premiums the company needs to charge based in large part on claims paid versus amounts of premium generated.

**Admitting Privileges:** The right granted to a doctor to admit patients to a particular hospital.

**Advocacy:** Any activity done to help a person or group get something the person or group needs.

**Agent:** Licensed salespersons that represent one or more health insurance companies and present their products to consumers.

**Allowed Expenses:** The maximum amount a plan pays for a covered service.

**Benefits:** Medical services for which your insurance will pay.

**Brand-Name Drug:** Prescription drugs marketed with a specific brand name by the company that manufactures it, usually the company that develops and patents it. When patents expire, generic versions of many popular drugs are marketed at lower cost by other companies. Check your insurance plan to see if coverage differs between name-brand and generic.

**Broker:** Licensed insurance salesperson who obtains quotes and plans from multiple sources information for clients.

**Capitation:** A flat monthly fee that a health plan pays to a provider (doctor, hospital, lab, etc.) to take care of a patient.

**Carrier:** Insurance company or HMO offering a health plan.

**Case Management:** Case management is a system embraced by employers and insurance companies to ensure that individuals receive appropriate, reasonable healthcare services.

**Certificate of Insurance:** The printed description of the benefits and coverage provisions forming the contract between the carrier and the customer. Discloses what is covered, what is not, and dollar limits.

**Claim:** A notice to the insurance company that a person received care covered by the plan. A claim also may be a request for payment and will state so.

**COBRA:** Federal legislation that lets you, if you work for an insured employer group of 20 or more employees, continue to purchase health insurance for up to 18 months if you lose your job or your coverage is otherwise terminated.

**Co-insurance:** A term that describes a shared payment between an insurance company and an insured individual, usually described in percentages. For example, the insurance company agrees to pay 80 percent of covered charges and the individual picks up the remaining 20 percent.

**Co-payment:** The insured individual's portion of the cost, usually a flat predictable dollar amount. Under many plans, co-payments

are made at the time of the service and the health plan pays for the remainder of the fee.

**Coverage:** What the health plan does and does not pay for. Coverage includes almost everything mentioned in this booklet: benefits, deductibles, premiums, limitations, etc.

**Covered Expenses:** What the insurance company will consider paying for as defined in the contract. For example, under some plans generic prescriptions are covered expenses, while brand name prescriptions may be covered at a different reimbursement rate or not at all.

**Deductible:** A portion of the covered expenses (typically \$100, \$250 or \$500) that an insured individual must pay before benefits are paid by the insurance plan. Deductibles are standard in many indemnity and PPO policies, and are usually based on a calendar year.

**Denial of Claim:** Refusal by an insurance company to honor a request by an individual (or his or her provider) to pay for healthcare services obtained from a healthcare professional.

**Dependents:** Spouse and/or unmarried children (whether natural, adopted or step) of an insured.

**Dependent Worker:** A worker in a family in which someone else has greater personal income.

**Diagnosis:** The art or act of identifying a disease from its signs and symptoms.

**Effective Date:** The date your insurance is to actually begin. You are not covered until the policy's effective date.

**Employee Assistance Programs (EAPs):** Mental health counseling services that are sometimes offered by insurance companies or employers. Typically, individuals or employers do not have to directly pay for services provided through an employee assistance program.

**Exclusions:** Medical services that are not covered by an individual's insurance policy.

**Explanation of Benefits:** The insurance company's written explanation to a claim, showing what they paid and what the client must pay.

**External Review:** A review of a denied claim from an outside agency other than your insurance provider. To find out if your insurance provider offers an external review or provides contact information for the agency reviewing the claim, view the "Exclusions" section of your insurance policy.

**Generic Drug:** A "twin" to a "brand name drug" once the brand name company's patent has run out and other drug companies are allowed to sell a duplicate of the original.

**Group Insurance:** Coverage through an employer or other entity that covers all individuals in the group.



**Health Maintenance Organizations (HMOs):** Health Maintenance Organizations represent "pre-paid" or "capitated" insurance plans in which individuals or their employers pay a fixed monthly fee for services, instead of a separate charge for each visit or service. The monthly fees remain the same, regardless of types or levels of services provided. Services are provided by physicians who are employed by, or under contract with, the HMO. HMOs vary in design. Depending on the type of the HMO, services may be provided in a central facility or in a physician's own office (as with IPAs).

**HIPAA:** A Federal law passed in 1996 that allows persons to qualify immediately for comparable health insurance coverage when they change their employment or relationships. It also creates the authority to mandate the use of standards for the electronic exchange of healthcare data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for healthcare patients, providers, payors (or plans) and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable healthcare. Full name is "The Health Insurance Portability and Accountability Act of 1996."

**Indemnity Health Plan:** Indemnity health insurance plans are also called "fee-for-service." These are the types of plans that primarily existed before the rise of HMOs, IPAs, and PPOs. With indemnity plans, the individual pays a pre-determined percentage of the cost of healthcare services, and the insurance company (or self-insured employer) pays the other percentage. The fees for services are defined by the providers and vary from physician to physician.

**Independent Practice Associations (IPA):** IPAs are similar to HMOs, except that individuals receive care in a physician's own office, rather than in an HMO facility.

**In-network:** Providers or healthcare facilities which are part of a health plan's network of providers with which it has negotiated a discount. Insured individuals usually pay less when using an in-network provider, because those networks provide services at lower cost to the insurance companies with which they have contracts.

**Lifetime Maximum Benefit (or Maximum Lifetime Benefit):** the maximum amount a health plan will pay in benefits to an insured individual during that individual's lifetime.

**Limitations:** A limit on the amount of benefits paid out for a particular covered expense, as disclosed on the Certificate of Insurance.

**Long-Term Care Policy:** Insurance policies that cover specified services for a specified period of time. Long-term care policies (and their prices) vary significantly. Covered services often include nursing care, home healthcare services and custodial care.

**Long-term Disability Insurance:** Pays the insured individual a percentage of monthly earnings if they become disabled.

**Length of Stay (LOS):** LOS refers to the length of stay. It is a term used by insurance companies, case managers and/or employers to describe the amount of time an individual stays in a hospital or inpatient facility.

**Managed Care Plan:** A term that typically refers to an HMO, Point of Service, EPO, or PPO; any health plan with specific requirements, such as pre-authorization or second opinions, which enable the primary care physician to coordinate or manage all aspects of the patient's medical care.

**Maximum Out-of-Pocket:** The most money you can expect to pay for covered expenses. The maximum limit varies from plan to plan. Some companies count deductibles, co-insurance, or co-payments toward the limit, others do not. Once the maximum out-of-pocket has been met, many health plans pay 100 percent of certain covered expenses.

**Medigap Insurance Policies:** Medigap insurance is offered by private insurance companies, not the government. It is not the same as Medicare or Medicaid. These policies are designed to pay for some costs that Medicare will not cover.

**Multiple Employer Trust (MET):** A trust consisting of multiple small employers in the same industry, formed for the purpose of purchasing group health insurance or establishing a self-funded plan at a lower cost than would be available to each of the employers individually.

**Network:** A group of doctors, hospitals and other healthcare providers contracted to provide services to insurance company customers for less than their usual fees. Provider networks can cover a large geographic market or a wide range of healthcare services. Insured individuals typically pay less for using a network provider.

**Open Enrollment:** A specified period of time in which employees may change insurance plans and medical groups offered by their employer, without proof of insurability. Open enrollment usually occurs once a year, but check with your employer to be sure.

**Out-of-Plan (Out-of-Network):** This phrase usually refers to physicians, hospitals or other healthcare providers who are considered non-participants in an insurance plan (usually an HMO or PPO). Depending on an individual's health insurance plan, expenses incurred by services provided by out-of-plan health professionals may not be covered, or covered only in part by an individual's insurance company.

**Out-Of-Pocket Maximum:** A predetermined limited amount of money that an individual must pay out of their own savings, before an insurance company (or self-insured employer) will pay 100 percent for an individual's healthcare expenses.

**Outpatient:** A patient who receives healthcare services (such as surgery) on an outpatient basis, meaning they do not stay overnight in a hospital or inpatient facility. Many insurance companies have identified a list of tests and procedures (including surgery) that will not be covered (paid for) unless they are performed on an outpatient basis. The term outpatient is also used synonymously with ambulatory to describe healthcare facilities where procedures are performed.

**Plan Administration:** Supervising the details and routine activities of installing and running a health plan, such as answering questions, enrolling individuals, billing and collecting premiums and similar duties.

**Pre-Admission Certification:** Also called pre-certification review, or pre-admission review. Approval by a case manager or insurance company representative (usually a nurse) for a person to be admitted to a hospital or in-patient facility, granted prior to the admittance. Pre-admission certification often must be obtained by the individual. Sometimes, physicians will contact the appropriate individual. The goal of pre-admission certification is to ensure that individuals are not exposed to inappropriate healthcare services (services that are medically unnecessary).

**Pre-Admission Review:** A review of an individual's healthcare status or condition, prior to an individual being admitted to an inpatient healthcare facility, such as a hospital. Pre-admission reviews are often conducted by case managers or insurance company representatives (usually nurses) in cooperation with the individual, his or her physician or healthcare provider and hospitals.

**Pre-Admission Testing:** Medical tests that are completed prior to being admitted to a hospital or inpatient healthcare facility.

**Pre-Authorization:** An insurance plan requirement in which you or your primary care physician must notify your insurance company in advance about certain medical procedures (like outpatient surgery) in order for those procedures to be considered a covered expense.

**Pre-Existing Conditions:** A medical condition that is excluded from coverage by an insurance company, because the condition was believed to exist prior to the individual obtaining a policy from the particular insurance company.

**Preferred Provider Organizations (PPOs):** You or your employer receive discounted rates if you use doctors from a pre-selected group. If you use a physician outside the PPO plan, you must pay more for the medical care.

**Premium:** The money paid to an insurance company for coverage. Premiums are usually paid monthly and may be paid in part or in full by your employer.

**Primary Care Provider (PCP):** A healthcare professional (usually a physician) who is responsible for monitoring an individual's overall healthcare needs. Typically, a PCP serves as a "quarterback" for an individual's medical care, referring the individual to more specialized physicians for care.

**Provider:** Provider is a term used for health professionals who provide healthcare services. Sometimes, the term refers only to physicians. Often, however, the term also refers to other healthcare professionals such as hospitals, nurse practitioners, chiropractors, physical therapists and others offering specialized healthcare services.

**Reasonable and Customary Fees:** The average fee charged by a particular type of healthcare practitioner within a geographic area. The term is often used by medical plans as the amount of money they will approve for a specific test or procedure. If the fees are higher than the approved amount, the individual receiving the service is responsible for paying the difference. Sometimes, if an individual questions his or her physician about the fee, the provider will reduce the charge to the amount that the insurance company has defined as reasonable and customary.

**Rider:** A modification made to a Certificate of Insurance regarding the clauses and provisions of a policy (usually adding or excluding coverage).

**Risk:** The chance of loss, the degree of probability of loss or the amount of possible loss to the insuring company. For an individual, risk represents such probabilities as the likelihood of surgical complications, medications' side effects, exposure to infection or the chance of suffering a medical problem because of a lifestyle or other choice.

**Second Opinion:** A medical opinion provided by a second physician or medical expert, when one physician provides a diagnosis or recommends surgery to an individual.

**Second Surgical Opinion:** These are now standard benefits in many health insurance plans. It is an opinion provided by a second physician, when one physician recommends surgery to an individual.

**Short-Term Disability:** An injury or illness that keeps a person from working for a short time. The definition of short-term disability (and the time period over which coverage extends) differs among insurance companies and employers. Short-term disability is designed to protect an individual's full or partial wages during a time of injury or illness (that is not work-related) that would prohibit the individual from working.

**Short-Term Medical:** Temporary coverage for an individual for a short period of time, usually from 30 days to six months.

**Small Employer Group:** Generally means groups with less than 100 employees. The definition may vary between states.

**Specialist:** A physician who practices medicine in a specialty area. Cardiologists, orthopedists, gynecologists and surgeons are all examples of specialists. Some health plans require preauthorization from your primary care physician before you can see a specialist.

**State Mandated Benefits:** When a state passes laws requiring that health insurance plans include specific benefits.

**Stop-Loss:** The dollar amount of claims filed for eligible expenses at which point you have paid 100 percent of your out-of-pocket and insurance begins to pay 100 percent. Stop-loss is reached when an insured individual pays the deductible and reaches the out-of-pocket maximum of co-insurance.

**Triple-Option:** Insurance plans that offer three options from which an individual may choose. Usually, the three options are: traditional indemnity, an HMO and a PPO.

**Underwriter:** The company that assumes responsibility for the risk, issues insurance policies and receives premiums.

**Usual and Customary Charges:** The average cost of a specific medical procedure in your geographic area. This is the maximum amount some insurance companies will pay for certain covered expenses. Also referred to as allowed expenses, they reflect the provider's retail cost of service.

**Waiting Period:** A period of time when you are not covered by insurance for a particular illness.

# Membership Application

## OAC Membership Categories

(select one)

- Individual Membership: \$20/year
- Institutional Membership: \$500/year
- Chairman's Council Membership: \$1,000+/year

## OAC Membership Add-ons

(optional, but only accessible by OAC members)

### Add-on 1: Educational Resources

To order bulk copies of OAC resources, members can purchase educational packages. If you'd like to order resources, select one of the below packages.

- Standard Package**  
10-50 educational pieces/quarter \$50
- Deluxe Package**  
51-100 pieces/quarter \$100
- Premium Package**  
101-250 educational pieces/quarter \$150

### Add-on 2: Make a General Donation

Make a tax-deductible donation to the OAC when joining as a member. Your donation helps the OAC's educational and advocacy efforts.

- \$5
- \$10
- \$25
- \$50
- \$100
- Other \_\_\_\_\_

## Membership/Add-on Totals:

Membership Category: \$ \_\_\_\_\_

Add-on 1 (if applicable): + \$ \_\_\_\_\_

Add-on 2 (if applicable): + \$ \_\_\_\_\_

**TOTAL MEMBERSHIP PAYMENT:** \$ \_\_\_\_\_

## Contact Information

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

## Payment Information

- Check (payable to the OAC) for \$ \_\_\_\_\_.
- Credit card for my TOTAL membership fee of \$ \_\_\_\_\_.
  - Discover®
  - Visa®
  - MasterCard®
  - Amex®

Credit Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ Billing Zip Code: \_\_\_\_\_

RETURN TO:

**Mail:** OAC  
4511 North Himes Ave., Ste. 250  
Tampa, FL 33614

**Fax:** (813) 873-7838



# MEMBERSHIP



## Building a Coalition of those Affected

The OAC is the **ONLY** non-profit organization whose sole focus is helping those affected by obesity. The OAC is a great place to turn if you are looking for a way to get involved and give back to the cause of obesity.

There are a variety of ways that you can make a difference, but the first-step is to become an OAC Member. The great thing about OAC membership is that you can be as involved as you would like. Simply being a member contributes to the cause of obesity.

## Why YOU Should Become an OAC Member

Quite simply, because the voice of those affected needs to be built! The OAC not only provides valuable public education on obesity, but we also conduct a variety of advocacy efforts. With advocacy, our voice must be strong. And, membership is what gives the OAC its strong voice.

# Membership Benefits

## Benefits to Individual Membership

- Official welcome letter and membership card
- Annual subscription to the OAC's publication, *Your Weight Matters Magazine*
- Subscriptions to the *OAC Members Make a Difference* and *Obesity Action Alert* monthly e-newsletters
- "Bias Buster" Alerts, alerting specifically to issues of weight bias
- Immediate Advocacy Alerts on urgent advocacy issues and access to the OAC's expert advocacy team
- Ability to lend your voice to the cause

