Insurance Terminology

You might have already heard some of the insurance terminology; like deductibles, co-insurance, co-pays, etc, but you might not be certain of their meanings. Below is a basic overview of **The differences between insurance policies… and some of the insurance terminology.**

Many plans have a **deductible;** which must be paid yearly**.** The deductible is the amount you pay for medical services before your health insurance starts paying. It is a **cost sharing** expense. For example, if your plan has a deductible of $1500, that means the first $1500 of your medical costs come out of your pocket, before your insurance will start paying for your medical expenses.

Cost Sharing is determined by your insurance company and it is the share of costs covered by your insurance that you pay out of your own pocket.

After you meet your deductible, your insurance company will cover your healthcare expenses. Your insurance might also have a **coinsurance**, besides a deductible. Its value is usually a percentage that you will be responsible for. For example, your insurance may pay 80% of your health care costs after you surpass the deductible, and you pay the leftover 20%. That 20% could be your share of the healthcare cost… which is known as your coinsurance, or what is considered to be the patient responsibility portion of the charges.

You might also have to pay a **copay** each time you visit a healthcare provider.

A copay is a flat fee you pay for medical service as part of a cost-sharing relationship between you and your insurance company. Copays will differ, depending on the health services you are receiving. For example, a copay for a specialty provider and the emergency room will be two different amounts.

Deductibles, **coinsurance**, and **copays** are all examples of **cost sharing**. Copay and coinsurance are similar, but **coinsurance is a percentage of costs**, as opposed to **copay**, which **is a fixed dollar amount**.

HMO vs PPO

A **Health Maintenance Organization Plan (HMO)** plan provides comprehensive coverage at a low out-of-pocket cost. **You must** have a primary care physician (PCP) and go to **that** doctor when you're sick. With all HMO plans, **you have to** get **referral**s to see any other provider, otherwise services will not be covered by your insurance company.

A referral is a special kind of pre-approval that individual health plan members—primarily those with HMOs and **Point-of-Service plan (POS)** plans—must obtain from their primary care physician before seeing a specialist or another doctor within the same network.

A Point-of-Service plan (POS) is a type of managed care plan that is a hybrid of HMO and PPO plans. Like an HMO, participants must have a PCP.

Participating Provider Options (PPO) plan allow you lots of freedom in choosing your doctor. Unlike HMOs, many PPOs will let you see **out-of-network** doctors, you just may have to pay a higher portion of the cost than you would with an in-network doctor. They also might not require referrals from your PCP to see other providers.

Out of network simply means that the doctor or facility providing your care **does not** have a contract **with your health insurance company** and more than likely your healthcare costs will not be covered.

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In-network means that your provider has a contracted with your health insurance company and your services should be covered.

Original Medicare vs Medicare Advantage Plans

Original Medicare includes Part A (inpatient/hospital coverage) and Part B (outpatient/medical coverage). You will receive a red, white, and blue card to show to your providers when receiving care.

If you have a Medicare Advantage Plan, **you will not use** the red, white, and blue card when you go to the doctor or hospital, as you cannot have both. **Instead**, you will use the membership card your Medicare Advantage plan sends you to get health services covered. Plans must provide the same benefits offered by Original Medicare, but they may apply different rules, costs, and restrictions. They also may offer certain benefits that Medicare does not cover.

Secondary Insurance is a supplement to a primary policy already held by the insured party. It may also be present when two spouses have coverage through different employers and they are dependents on each other's policies.

Commercial insurance plans are any kind of insurance that is not paid for by the government. Medicaid, Medicare and veteran's benefits are paid for by the government and therefore are not commercial insurance. Commercial insurance is also called **private insurance**.

Pre-Authorization

When an insurance company has a pre-authorization requirement, it means that the insurance company will not pay for a service unless the provider gets permission to provide the service before the services are rendered. Pre-Authorizations can oftentimes be granted retroactively, but not always… for example, a patient or hospital may have a 24-hour window to notify an insurance company after receiving emergency care.

Pre-Certification

Many insurance plans have a pre-certification requirement which means that the insurance plan must review the medical necessity of a proposed service and provide a certification number before a claim will be paid.

For any questions or concerns, please contact us at (520)387-5651.