Presents

Common Health Insurance Terms for the Real World
Translating Insurance Into English

We understand there are countless terms in the health insurance industry, which can get overwhelming very quickly. So, in an effort to offer you a quick education on the matter, we have compiled a list of common health insurance terms and given you the real-world translation for quick reference.

We hope you enjoy brushing up on your insurance vocabulary, because you never know when all of this might come in handy!

Plan Types:

- **HMO: Health Maintenance Organization**

An HMO health plan is designed to lower costs by partnering with a medical group that will help manage the patient's care.

- **Medical Group**

This is the group of doctors that you have access to under your HMO plan. This group is what the phrase Health Maintenance Organization (HMO) truly refers to.

Medical groups are made up of both primary care doctors and specialists (dermatologist, cardiologist, OBGYN, etc.) You must choose a primary care doctor within the medical group, and. In order to access services that are beyond your primary care doctor, you will need a referral.

When you choose an HMO medical group, you can only use their doctors and facilities, however you can change medical groups throughout the year if you desire. Medical groups typically employ multiple doctors for each specialty, so you can change your doctor within the medical group.

Primary Care Doctor:

This is the doctor that you see for all minor health issues and initial consultations. If your primary care doctor can solve the problem, they will address it on their own. If your situation requires a specific expertise, you will be referred to a specialist.

With HMO plans, you must always see your primary care doctor first, for any new health issues. However, if you have an existing issue that is currently being treated by a specialist, you do not need a referral from your primary care doctor for ongoing treatment.

- **PPO: Preferred Provider Organization**

PPO health plans allow the member to seek medical care from any provider without a referral. The member can make appointments directly with specialists without having to see a primary care doctor.

Members can see any providers that have a contract with their PPO plan (aka Preferred Providers), and they can also go to an Out of Network provider is not contracted. However, there is far less coverage by the insurance company for Out of Network providers, and therefore the member's costs increase drastically.

- **EPO: Exclusive Provider Organization**

Has the same design as a PPO plan, but there is no coverage for Out of Network services. If a member receives services from any medical provider that is not contracted with their plan, they must pay 100% of the costs. By excluding the out of network providers, EPO plans force the patient to only use providers that are contracted with your insurance company.

- **HSA: Health Savings Account**

Consists of two parts: HSA compatible health plan, and Health Savings Account.

The HSA health plan is a PPO plan that has a large deductible ($3,000), and gives little-to-no access to other benefits before meeting that deductible. The HSA account is a savings account that allows members to use the money accrued for their healthcare needs using pre-tax dollars, which reduces income taxes.

The basic strategy behind the HSA is to take the savings that you receive by purchasing a high deductible plan and put that money in the HSA account. It will then accrue interest, and you can use funds from this account to offset the costs of your medical care.

- **HRA: Health Reimbursement Account**

The HRA health plan is a high deductible PPO plan ($3,000 deductible) that has lower premiums, The HRA account is designed to accrue the money that is saved versus purchasing a lower deductible PPO plan.

What differentiates an HRA from an HSA, is the account belongs to the employer rather than the member. So, the premium savings that each member receives from the high deductible plan is designed to go directly back to the company's bottom line.

The basic strategy behind an HRA is creating a high-level benefit plan for low costs. The employer can use a third-party administrator to customize their plan, which typically means lowering the deductible and improving the plan benefits for the members. This creates a better PPO plan for the members, while maintaining the low premiums of a high deductible PPO plan.

There can be significant risk that is associated with customizing the plan though, as the company is responsible for paying all claims before the plan's original deductible ($3,000.) In a year where the company's population is at average or lower levels in terms of claims, they will save money. If there is a year with high claims activity, then the company would end up paying more than they would have with a traditional PPO plan. With an HRA it's all about playing the averages and having a long-term mentality, as over time the company is likely to profit.

Part II: Benefit Terminology

- **Out of Pocket Maximum**

This is the maximum amount of money that a member will ever have to pay for their medical expenses in a calendar year. As the member pays for services throughout the year, these costs go towards the member's out of pocket maximum. Once you reach this dollar amount ($5,000), the insurance company will pay for 100% of any additional medical costs for the rest of the year.

It's the safety net that protects members from going broke in the event that they have serious medical costs.

For example:

If you were to be hit by a bus while walking down the street, your total medical bills from the hospital stay and follow up treatment would likely reach $20,000 or more. But you would only pay the out of pocket max of $5,000 and the insurance company would pay the additional $15,000. Also, nearly all other covered services would be free for the rest of the year, even if they were not related to the accident.

- **Out of Network**

Refers to any medical provider that does not have a formal written service contract with the insurance company. This means that the insurance company has no real control over the cost of this provider's services, because they have no formal agreement on pricing. Because these providers are far more expensive for the insurance company to work with, the level of coverage that a member will receive is drastically reduced or eliminated entirely. Most PPO plans have Out of Network coverage, but HMO and EPO plans are purposely designed without this level of coverage.

The biggest misconception about out of network coverage is that the member simply pays the percentage that is indicated in the "Out of Network" category of your PPO plan. The truth is that this is the tip of the iceberg.

The provider charges price that they deem appropriate (example: $300 for a doctor's visit), but the insurance company also calculates what they believe to be a reasonable price for this service ($175.) The 50% coverage that a member typically receives is based on the insurance company's price, not the provider's price. So, in our example the insurance company would only pay 50% of $175 = $87.50.

The key here is that the member is responsible for not only the remaining 50%, but also the difference between the two prices for that service. In our example that means the member pays (50% of $175) + ($300-$175) = $212.50. **The member's actual payment for this service is 70% of the doctor's price vs the 50% that is presented.**

The difference in cost for the same doctor's visit with an in-network physician is remarkable, all because the fees have already been negotiated and agreed upon.

- **Negotiated Fee**

Price that a medical provider has agreed to charge the member, based on the contract that the provider has negotiated with the insurance company. This is the amount displayed in the “Allowed Amount” column on the statements that a member receives from the insurance company after a medical procedure (Explanation of Benefits.)

Your plan benefits will be applied to this negotiated fee, so in most cases the member will pay less than this amount.

Example: Knee Surgery

Negotiated Fee = $800
Plan Benefit for Surgery = Insurance pays 80%, Member pays 20%
Member’s Cost = $160 (20% of $800)

If a member has not met their deductible, then they will not have access to their plan discounts (co-pays and co-insurance) but they still receive the negotiated fee pricing. While they must pay 100% of the negotiated fee, this price is typically lower than the price would be without insurance.

- **Co-Pay**

A flat fee that a member pays for a given medical service. A co-pay makes the member’s cost predictable, as variation in the provider’s pricing does not change what the member actually pays. I lovingly nick name co-pays “the no think benefit”, because you don’t have to think about the price that the provider charges, you already know what your portion is going to be before the bill comes.

Example:

Dr. Smith = $150 for an office visit
Dr. Jones = $250 for an office visit
Office Visit Co-Pay on member’s plan = $30.
Member pays $30 per visit for Dr. Smith or Dr. Jones, even though the providers charge different amounts.

- **Co-insurance**

The portion of charges that the member is responsible for, in regards to a specific medical service. The charges are distributed by percentage, with the insurance company paying one portion (example: 80%) and the member paying the remainder (example: 20%.)

This is the exact opposite of a co-pay, because the member's price is heavily influenced by the medical provider's original charge. Regardless of what the charges are, the member will still have to pay their percentage (example: 20%.)

A member may pay a drastically different amount for the exact same procedure, if one provider charges more than another.

Example: 1 Day Hospital Visit

Hospital A = $2,000
Hospital B = $1,000
Co-Insurance on member's plan = 20%

Member pays $400 with Hospital A (20% of $2,000), and $200 with Hospital B (20% of $1,000.)

With co-insurance, you must do your research and choose less expensive providers in order to save money.

- **Preferred Medication**

This category is mostly composed of generic drugs, but it can also include brand name drugs that are on the lower end of the cost scale. Because these drugs cost less for the insurance company, they also pass some of the savings down to the member. This means members who choose to use preferred drugs will have lower costs, with an average savings of 30-70% compared to Non-Preferred drugs. Example: $15 co-pay for preferred, $30 co-pay for non-preferred.

A common misconception regarding generic drugs is that they are a lower quality option compared to brand name drugs. The Food and Drug Administration (FDA) requires that brand name drugs and their generic counterparts must be identical in many ways, including: active ingredients, strength, dosage, and rate of absorption.

- **Non-Preferred Medication**

These are drugs that are of a higher cost to the insurance company, and therefore not the drug that they prefer the member to take. Because of the higher cost, the member pays a higher co-pay than the preferred equivalent (Example: $30 co-pay vs $15 co-pay for preferred drug.) While this category is mostly made up of brand name drugs, the more expensive generic drugs may also fall into non-preferred status. The specific classifications will vary by insurance company.

The reason that these non-preferred drugs are more expensive is because pharmaceutical companies invest money into research, development and marketing of these new medications. We've all seen the TV spots for Lipitor or the magazine ads for Viagra, right? In order to gain a return on that investment, drug companies charge insurance companies more for these medications, and a portion of that expense is passed down to the member.

- **Non-Formulary Medication**

These are medications that are so expensive and/or so rare that the insurance company does not include them on their drug list. Most of the time this means that the insurance company will limit the amount that they pay, giving the member a much higher co-pay. These drugs often require prior authorization from your doctor, to make sure the member isn't voluntarily choosing the most expensive drug option.

In certain cases, a non-formulary drug is not covered by your health insurance plan at all and therefore you will have to pay the entire cost.

- **Prescription Medication Deductible**

This is a deductible that is specifically enforced for any non-preferred or non-formulary drugs ($250 deductible.) If a member's plan has this deductible, this means that the member cannot access the discounted price (co-pay) until they have paid this deductible. The deductible does not apply to preferred drugs, so the member could use a generic drug and gain access to that discounted price right away.

The purpose of this deductible is to help steer the member away from using expensive non-preferred drugs, and instead choose the cheaper alternative. If the member still chooses to use non-preferred

drugs, they will pay the higher price (negotiated fee) for that medication until the deductible is met. After that, the member will pay the lower priced (co-pay) for the rest of the calendar year.

It's important to know, that while the negotiated fee is a higher price than the co-pay, it is typically still a lower price than what the member would receive by paying without insurance.

Example of Non-Preferred Medication Deductible:

Deductible = $250
For Drug A: Negotiated Fee = $50, Non-Preferred Co-Pay = $30

Price for 1st-5th fills of medication = $50
Deductible is met after 5th fill ($50 X 5 = $250)
6th fill and beyond = $30. This lasts till the end of the calendar year.

- **Specialty Medications**

These are drugs used to treat chronic conditions that require a high level of care. Examples include various types of cancer, rheumatoid arthritis and multiple sclerosis (MS.)

Specialty drugs often require special handling and are taken either by injection or infusion. These drugs are extremely expensive, usually costing thousands of dollars per fill. Because of this high cost, a member will typically have to pay co-insurance (30%) instead of the smaller co-pays associated with other drugs. The insurance company also put a limit on the amount they will pay. (Example: Max payment of $250 per fill.)

- **Prior Authorization**

Medications that require your doctor and the insurance company to give you written authorization before you can begin using this drug. If your drug needs authorization, you will be notified by your insurance company or your pharmacist, and your doctor will need to submit paperwork for approval.

Medications that require prior authorization usually have one of the following characteristics: dangerous side effects, can be harmful when combined with other drugs, are often misused or abused, or expensive drugs that are prescribed even though a less expensive option is available.

- Pediatric Dental and Vision Benefits
- Preventive Care
- Advanced Radiology
- Durable Medical Equipment

- Explanation of Benefits (EOB)
- Qualifying Event
- Waiting Period/ Probationary Period
- Evidence of Coverage (EOC)

- Dental
- Voluntary Plan
- Benefit Maximum
- Preventative
- Basic
- Major
- Benefit Waiting Period

***Note:** All health plans have their own specific limitations and exclusions on the services that will be covered, and the levels of coverage.*

For more Information about this document contact United Agencies Insurance at (800) 800-5880 for assistance. Or visit our website at www.ua-insurance.com for more helpful info.