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Health Insurance FAQs

IN-NETWORK VS. OUT OF NETWORK

Most major insurances have both in-network and out of network benefits. In-network refers to seeing physicians that your insurance carrier prefers you to see, and that are "participating" or "in-network" providers with their plan. Out of network benefits means that the physician you are seeing may not necessarily belong to the insurance carriers' network. However, the insurance company is still willing to pay for part of your services (dependent upon deductibles, copays, coinsurances and out of pocket costs). **Your out-of-pocket costs will be higher when using out-of-network providers if you don't have out-of-network benefits**.

When patients have health insurance, their cost of care is split with the insurance company based on the plan they selected. Higher premiums equal low deductibles. Lower premiums equal high deductibles.

Copays: These are a fixed amount (e.g., $15, $25, $40) you pay to health care providers for a covered health care service. The amount can vary by the type of covered service. Copayments are generally lower for services delivered by primary care doctors and higher for services delivered by specialists. Remember that copayments for in-network providers are typically lower than copayments for out-of-network providers. **If your plan has a deductible, that must be satisfied before your claims process with a copay only responsibility.**

Deductible: A deductible is the amount you must pay out of pocket for health care services before the health insurance plans begin to pay. Premiums don't count toward the deductible. For example, if a deductible is $1,000, the plan won't pay anything until the consumer has paid $1,000 for covered health care services. The deductible may not apply to all services. **The deductible will always be lower than the out-of-pocket maximum.**

Coinsurance: Coinsurance is your share of the cost of a covered health care service calculated as a percentage (e.g., 20%, 30%, 40%) of the amount allowed by the health plan for that service. You pay coinsurance plus any deductibles you owe. For example, if a health insurance plan's allowed amount for an office visit is $100 and you have met the deductible, you pay a coinsurance of 20%, or $20. The health insurance plan pays the remaining 80%, or $80.

Out-of-Pocket Costs: Out-of-pocket costs are expenses for medical care that aren't reimbursed by insurance. Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services. You pay out-of-pocket costs
in addition to your monthly premiums. The amount paid is limited by an out-of-pocket maximum. After the out-of-pocket maximum is reached, the insurance company must pay for all covered benefits without imposing out-of-pocket costs. Only deductible and copays contribute to out-of-pocket maximum limits.

TYPES OF PLANS

HMO: A Health Maintenance Organization (HMO) is a type of health insurance plan that usually limits coverage to care from in-network doctors who work for or contract with the HMO. HMO plans usually require you to get a referral from your primary care doctor to visit a specialist, and they generally won't cover out-of-network care except in an emergency.

PPO: A PPO (Preferred Provider Organization) is a type of health plan that contracts with health care providers like hospitals and doctors to create a network of participating providers. You pay less if you use providers that belong to the plan's network (e.g., in-network providers). You can visit doctors, hospitals, and providers outside of the network (e.g., out-of-network providers) at an additional cost. Referrals aren't needed to visit specialists. In exchange for greater access to providers, premiums are generally higher in a PPO than in an HMO.

POS: A POS (Point of Service) plan is a type of plan in which you pay less if you use doctors, hospitals, and other health care providers that belong to the plan's network. With this type of plan, you may go to out of-network providers at a higher cost. Unlike PPO plans, POS plans generally require you to get a referral from their primary care doctor to visit a specialist.

HDHP: A High Deductible Health Plan (HDHP) is a type of health plan that features higher deductibles than traditional insurance plans in exchange for lower monthly premiums. HDHPs can be combined with a health savings account (HSA) or a flexible spending account (FSA). HSAs and FSAs let you pay for qualified out-of-pocket medical expenses on a pretax basis. The money that's contributed to an HSA or an FSA isn't subject to federal income tax at the time of deposit but must be used to pay for qualified medical expenses. You use the money in the HSA to help meet the deductible before the HDHP begins to pay for services. Funds contributed to an HSA roll over year to year if a consumer doesn't spend them, but FSA funds don't carry over from year to year. In other words, any FSA funds that consumers don't spend by the end of the plan year can't be used for expenses in the next year.

EXPLANATION OF BENEFITS (EOB) VS HEALTH INSURANCE BILL

When you visit a doctor, your insurance company will likely send you an EOB after they have received the claim. This EOB will outline the charges on the claim, how much they plan on paying or not paying and how much you may or may not have as a balance with the office. THIS IS NOT A BILL. If you see that you may owe money from this EOB, keep an eye on your mail/statements as a bill should be soon to follow.

COORDINATION OF BENEFITS

When a person is covered by two health plans, coordination of benefits is the process the insurance companies use to decide which plan will pay first for covered medical services or prescription drugs and what the second plan will pay after the first plan has paid. Coordination of Benefits is required once a year. Insurance companies coordinate benefits for several reasons:

- **To avoid paying twice for the same covered service.**
- **To determine which plan is primary and which plan is secondary (if applicable)**
- **To help keep the cost of health and prescription drug costs affordable.**

Coordination of Benefits (COB) can be updated in 3 ways. One option is to contact the Member Services number on your insurance card. In addition, you may also receive a notice via mail asking you to provide information regarding additional health insurance. Please do not disregard this mailer as claims will be denied until the information is confirmed. The third way is to update COB online with your insurance company.

PRIMARY VS SECONDARY INSURANCE

Primary insurance pays your initial medical bills, where as secondary insurance will pay for copays, deductibles, coinsurance and any other costs the primary plan does not cover. The order of Primary and Secondary is determined by whose birthday comes first in the year (Month and Day Only). The other plan automatically becomes Secondary.

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