**TOPIC—Choosing Healthcare Insurance Benefits**

**OBJECTIVES—**

1) Define and describe commercial insurance and the various plans they offer.

2) Provide a glossary of common healthcare insurance terms.

**CONTENT—**

When you are hired by a healthcare provider, in most cases, you will qualify for health insurance benefits. You will be provided with an enrollment form and in some cases, will have more than one option for coverage. It is important that you make an informed decision for yourself and your family, if applicable.

Your employer contracts with an insurance carrier, e.g., Blue Cross/Blue Shield, Aetna, Cigna, etc., to provide a range of benefits and process claims. The employer pays an annual premium to the health insurance provider for a health plan that is offered to employees. Employees may pay a percentage of this premium to receive the health benefits.

Types of Plans include—

*Indemnity or Fee-for-service Plans*—Traditional insurance plans in which the individual pays a pre-determined percentage of the cost of healthcare services and the insurance company pays the other percentage. The individual can choose any provider and a typical plan may cover 80% of charges while the individual is responsible for the other 20%.

*Health Maintenance Organization (HMO)*—HMOs represent an insurance option 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 fee remains the same regardless of the services provided. They generally provide comprehensive healthcare services including some preventive care. In most instances, the insured must seek services within the HMO or there is no coverage. For example, the insured may be covered at 100% if healthcare services are provided by the HMO, but if the individual chooses to go to a provider who is not part of the HMO, there is no coverage. Open-ended HMOs, however, do allow enrolled individuals to use providers outside of the HMO and receive some coverage for services provided.

*Preferred Provider Organization (PPO)*—In a PPO, the insurance carrier contracts with physicians and hospitals to establish a network of participating providers. The providers offer discounted, pre-negotiated fees for their services and the insurance company offers incentives to their enrollees to use the PPO. For example, the insured may be covered at 90% if healthcare services are provided by the PPO, but if the individual chooses to go to a provider who is not part of the PPO, the services are covered at 70%.

There are many variations on these types of plans. It is important that you read your benefit plan provisions carefully and choose a plan which best fits your needs and/or the needs of your family. Some of the many terms you will encounter are defined below.

**Definitions of Terms Related Healthcare Insurance**

*Claim*—A request made by an individual or the provider to the insurance company for payment of healthcare services provided.

*COBRA*—Federal law that allows the employee (if you work for an insured employer group of 20 or more employees) to continue to purchase health insurance for up to 18 months if you lose your job or your coverage is otherwise terminated.

*Coinsurance*—An amount you may be required to pay as your share of the cost for services, after you pay any deductibles. Coinsurance is usually a percentage, for example, 20%.

*Copayment*—An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit or a prescription. A copayment is usually a set dollar amount. For example, you might pay $10 or $20 for a doctor's visit or prescription.

*Deductible*—The amount you must pay for healthcare or prescriptions, before your insurance carrier begins to pay.

*Explanation of Benefits*—The insurance company's explanation in writing of what they paid and what the insured must pay and why.

*HIPAA*—The Health Insurance Portability and Accountability Act allows an individual to immediately qualify for comparable health insurance coverage when they change their employment or relationships. It also requires that specific measures are taken to protect the security and the privacy of personally identifiable health care data.

*Managed Care*—A system of healthcare delivery which attempts to ensure quality and medical necessity of healthcare services while managing the cost. These systems typically offer a variety of HMO and PPO options.

*Medically Necessary*—Services or supplies that are needed for the diagnosis or treatment of your medical condition that meet accepted standards of medical practice.

*Out of Pocket Expense*—Payment for services not covered by the insurance plan, i.e., the expense is paid by the individual.

*Pre-Admission Certification*—Insurance plans may require the insured to obtain pre-admission certification prior to being admitted to the hospital. The process is used to ensure that the proposed services are medically necessary

*Premium*—The periodic payment to Medicare, an insurance company or healthcare plan for health coverage.

*Pre-existing conditions*—A medical condition which may be excluded from coverage because the individual had the condition prior to enrolling in the plan.

*Preventive Care*—Routine healthcare provided to prevent rather than treat disease. It would include an annual physical, screening mammogram, well child care, and screening colonoscopy to name a few.

*Primary Care Physician (PCP)*—Your primary care physician is the physician you see first for most health problems. He/she makes sure that you get the care you need to keep you healthy. He/she may talk with other physicians and healthcare providers about your care and refer you to them. In many plans, you must see your primary care physician before you see any other healthcare provider.

*Reasonable and Customary Fee*—The average fee charged by a specific form of practitioner, e.g., an orthopedic surgeon, for a specific service within a geographic area. An insurance company may use this fee to determine the amount of money they will approve for a certain test or procedure. The insured may be responsible for the difference.

*Referral*—A written order from your primary care physician for you to see a specialist or get certain medical services. In many managed care plans, you need to get a referral before you can get medical care from anyone except your primary care physician. If you don't get a referral first, the plan may not pay for the services.

**RESOURCES—**

www.healthinsurance.org This site provides understandable consumer information on health insurance.