BAYLOR Medical Center at Garland

Common Health Insurance Terms

The following is a list of common insurance terms that you may hear or be asked about. Pages 2-5 of this document offers detailed definitions of these terms. Not sure if Baylor Medical Center at Garland accepts your insurance plan? Click here for a list of insurances accepted at Baylor Garland.

Top 5 Insurance Terms

- Co-pay
- Coinsurance
- Deductible
- Network benefits
- Out of Pocket / Stop Loss

Other Insurance Terms

- Dependent
- EOB – Explanation of Benefits
- EPO
- Group Health Insurance
- HIPAA – Health Insurance Portability and Accountability Act of 1996
- HMO
- Insured
- Major Medical Policy
- Managed Care
- Maximum Lifetime Benefit
- Medicaid
- Medicare
- Outpatient
- PCP – Primary Care Provider
- PPO
- Pre-Authorization / Pre-Certification / Prior Authorization / Prior Notification
- Pre-Certification Number
- Pre-Determination
- Provider
- Referral
- Subscriber / Policy Holder

Deductible
A fixed dollar amount that must be met by the insured person before the insurance company starts sharing expenses and pays its portion. Often, insurance plans are based on yearly deductible amounts and must be met on an annual basis. Unless otherwise noted, deductibles are on a calendar year basis. Plans may have both per individual and family deductibles. For example, an individual may have a $200 deductible whereas a family may have a $400 deductible. Call your insurance company for the most up-to-date information regarding your deductible.

Co-pay
A set amount the insured person is expected to pay at that time of service for a specific type of visit. This information may be located on your insurance care and may have varying amounts according to service types, for example, Physician Office Visit $20, Specialist Office Visit $30, Emergency Room Visit $100. Co-pays may or may not be in addition to any Deductibles or Coinsurance established by your insurance plan.

Coinsurance
A percentage of covered expenses shared by the insured person and the insurance company, after the deductible has been satisfied. For example, if you have an 80/20 plan, after meeting your deductible, your insurance plan pays 80% of the covered medical expenses and you will be responsible for the remaining 20%.

Out of Pocket / Stop Loss
The dollar amount paid, through Deductibles and Coinsurances, by the insured's own savings before their plan pays 100% of eligible medical expenses for the balance of the plan year.

Network Benefits
Hospitals, physicians and other healthcare providers within the approved network of participating providers for an insurance company, to provide services for their customers

- Generally, In-Network providers have negotiated a discount to insurance company customers for less than their usual fees. If a health plan uses a preferred provider network, insured individuals typically pay less for using a network provider.
- Out-of-Network providers are not part of the insurance plan's network of contracted providers. Customers usually pay more when using an out-of-network provided, if their plan uses a network, since services at out-of network providers are at a lower rate by the insurance plan and at a higher rate by you.

Dependent
A person or persons relying on the policy holder for support may include the spouse and/or unmarried children (whether natural, adopted or step) of an insured.

EOB – Explanation of Benefits
This is a notice you receive from your insurance company after your claim for healthcare services has been processed. It explains the amounts billed, paid, denied, discounted, uncovered, and the amount owed by the patient. The EOB may also communicate information needed by the insured in order to process the claim

EPO
Exclusive Provider Organization (EPO) A more restrictive type of PPO and may have a smaller network than PPO, with no coverage for non-emergent care received from non-network providers.

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

HIPAA – Health Insurance Portability and Accountability Act of 1996
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) 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 health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, providers, payers (or plans), and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care.

HMO
Health Maintenance Organization (HMO) An insurance plan that has contracted with providers to provide healthcare services at a discounted rate. These services will require prior pre-certification, authorization, and/or referrals. . A primary physician within the HMO handles referrals. Many HMO plans have set co-pays for certain services.

Insured
A person covered by an insurance policy.

Major Medical Policy
A type of health insurance policy that provides benefits for most medical expenses, usually subject to deductibles, co-insurance, and a high maximum benefit.

Managed Care
A broad and constantly changing array of health plans, which attempt to manage the cost and quality of care. Ideally, managed care brings about a comprehensive health care system where patients receive the care they need - including preventive care - when they need it, and in the most cost-efficient manner possible. The three most common "managed" health insurance plan choices are: Health Maintenance Organization (HMO), Point-of-Service (POS) and Preferred Provider Organization (PPO). Another option is what is commonly called traditional, indemnity or fee-for-service insurance.

Maximum Lifetime Benefit
The maximum amount a health plan will pay in benefits to an insured individual during that individual's lifetime.

Medicaid
A state administered, federal and state-funded insurance plan for low-income families who have limited or no insurance

Medicare
Medicare is the federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).

The different parts of Medicare help cover specific services:

- **Medicare** Part A **(**Hospital **Insurance)** Part A covers inpatient hospital stays
- **Medicare** Part B (Medical **Insurance)** Part B covers certain doctors' services, outpatient hospital care
- **Medicare** Part C **(Medicare** Advantage Plans**)** A type of Medicare health plan offered by a *private company* that *contracts with Medicare* to provide you with all your Part A and Part B benefits. *If you're enrolled* in a Medicare Advantage Plan, Medicare services are *covered through* the *plan* and *aren't paid* for *under Original* Medicare.
- **Medicare** Part D **(**prescription **drug coverage)**

See the Medicare website, at http://www.medicare.gov/ for a more detailed breakdown.

How Medicare Works

Original Medicare is coverage managed by the federal government. Generally, there's a cost for each service.

A **Medicare Advantage Plan** is a ***type*** of **Medicare** health **plan** offered by a ***private company*** that **contracts** with Medicare to provide you with all your Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. **If you're enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan and aren't paid for under Original Medicare.**

Not sure what kind of coverage you have?
1. Check your red, white, and blue Medicare card.

2. Check all other insurance cards that you use. Call the phone number on the cards to get more information about the coverage.
3. Check your Medicare health or drug plan enrollment at mymedicare.gov.
4. Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

12 things to know about Medicare Advantage Plans

1. You're still in the Medicare Program.
2. You still have Medicare rights and protections.
3. You still get complete Part A and Part B coverage through the plan.
4. You can only join a plan at certain times during the year. In most cases, you're enrolled in a plan for a year.
5. You can join a Medicare Advantage Plan even if you have a pre-existing condition, except for End-Stage Renal Disease (ESRD).
6. You can check with the plan before you get a service to find out if it's covered and what your costs may be.
7. You must follow plan rules, like getting a referral to see a specialist to avoid higher costs if your plan requires it. The specialist you're referred to must also be in the plan's network. Check with the plan.
8. If you go to a doctor, other health care provider, facility, or supplier that doesn't belong to the plan, your services may not be covered, or your costs could be higher. In most cases, this applies to Medicare Advantage HMOs and PPOs.
9. If you join a clinical research study, some costs may be covered by your plan. Call your plan for more information.
10. Medicare Advantage Plans can't charge more than Original Medicare for certain services like chemotherapy, dialysis, and skilled nursing facility care.
11. Medicare Advantage Plans have an annual cap on how much you pay for Part A and Part B services during the year. This annual maximum out-of-pocket amount can be different between Medicare Advantage Plans. You should consider this when you choose a plan.
12. If the plan decides to stop participating in Medicare, you'll have to join another Medicare health plan or return to Original Medicare.

Outpatient

Health care services on an outpatient basis, such as surgery or diagnostic testing, 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 health care facilities where procedures are performed.

PCP – Primary Care Provider

These specialized physicians provide a full range of healthcare services to individuals and generally coordinate and "manage" the care of their patients. Family medicine physicians, general internal medicine physicians and pediatricians are recognized by managed health plans as primary care physicians. Some HMOs recognize obstetrician/gynecologists as primary care physicians.

PPO

Preferred Provider Organization (PPO): Insurance Plan with fewer restrictions in accessing providers than with other plans. You can pick any doctor, hospital or service you want. If the provider is "preferred" by the plan (in-network), you pay a lower a co-payment and co-insurance, depending on your plan design. If you choose a doctor or hospital that is "out-of-network," then you will have higher co-payments and co-insurance. You may also be billed for any amount charged that the plan does not consider "reasonable." In other words, you may opt to use a PPO provider and receive maximum reimbursement and benefits, or seek medical care from a non-PPO provider and receive reduced reimbursement and benefits.
Typically, PPO plans do not require referrals for Specialist office visits, however they still may require pre-certification for outpatient diagnostic testing. It is best to check with your individual insurance provider.

Pre-Authorization / Pre-Certification / Prior Authorization / Prior Notification

Authorization given by a health plan for a member to obtain services from a healthcare provider for the hospitalization or medical treatment has been approved before services are provided. Authorization for a specific medical procedure before it is done is commonly required for hospital services.
It can also include stipulation that the insured obtains permission for admission to the hospital for non-emergency care or an institution for care. It is required for payment by most U.S. managed care organizations. It is a cost containment measure that provides full payment of health benefits only if the hospitalization or medical treatment has been approved in advance

Pre-Certification Number

The Pre-Certification Number is a number obtained from your insurance company by doctors and hospitals and will represent the agreement by the insurance plan that the service has been approved. This is not a guarantee of payment.

Pre-Determination

A requirement for prior approval from a health insurer before it will pay for a proposed treatment

Provider

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

Referral

Approval or consent by a primary care doctor for a patient to see a certain specialist or receive certain services

Subscriber / Policy Holder

Person responsible for payment of premiums, or person whose employment is the bases of eligibility for a health plan membership. / This is the person who holds ownership of an insurance policy.