UC San Diego

Insurance 101

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Agenda

Overview of Common Insurance Terms

When and Where to Access Care

Practical Application

Q&A

Broker

A broker matches their clients with a health insurance company or plan that best suits the client's needs. The broker is paid a commission by the insurance company, but represents the interests of their client rather than the insurance company. In some cases, as with Garnett-Powers & Associates, a broker can also act as a third-party administrator, handling enrollment and billing, benefit and claims questions, etc.

Insurance Carrier

The company responsible for providing you with your health insurance plan by paying your claims, maintaining provider networks, coordinating billing, and offering member assistance services.

Health Maintenance Organization (HMO)

HMO plans offer a wide range of health care services through a network of providers that contract exclusively with the HMO, or who agree to provide services to members at a pre-negotiated rate.

As a member of an HMO, you will need to choose a primary care physician ("PCP") who will act as your healthcare “gatekeeper” providing most of your health care and referring you to HMO specialists as needed.

Some HMO plans require that you fulfill a deductible before services are covered, while others only require you to make a copayment when services are rendered.

Health care services obtained outside of the HMO network are typically not covered, though there may be exceptions in the case of a life-threatening emergency.

Preferred Provider Organization (PPO)

With a PPO plan, like the name implies, it’s recommended you get your medical care from doctors or hospitals in the insurance company's network of preferred providers if you want your claims paid at the highest level.

You will likely not be required to coordinate your care through a single primary care physician, as you would with an HMO, but you will want to make sure that the health care providers you visit participate in the PPO network.

Services rendered by out-of-network providers may still be covered, but will likely be paid at a lower level.

Open Enrollment

An annual period of time where you are allowed to make alterations to your coverage that you are not permitted to make throughout the rest of the year, such as changing your plan(s), enrolling dependents, or enrolling yourself if you previously waived.

Primary Care Physician (PCP)

A primary care physician usually serves as a patient's main healthcare provider, especially under an HMO plan. The PCP serves as a first point of contact for healthcare and may refer a patient to specialists for additional services.

In-Network Provider

A healthcare professional, hospital or pharmacy that has a contractual relationship with your health insurance company.

This contractual relationship typically establishes allowable charges for specific services. In return for entering into this kind of relationship with an insurance company, a healthcare provider typically gains patients, and a primary care physician may receive a capitation fee for each patient assigned to his or her care.

An ***Out-of-Network provider*** is a healthcare professional, hospital, or pharmacy that **is not** part of your health plan's network of preferred (In-Network) providers. You will generally pay more for services received from out-of-network providers, in part because you may be responsible for out-of-pocket costs that are considered above the “reasonable and customary” fees.

Copayment

A flat charge that your health insurance plan may require you to pay for a specific medical service or supply, also referred to as a "copay." For example, your health insurance plan may require a $20 copayment for an office visit or brand-name prescription drug, after which the insurance company pays the remainder of the charges.

Coinsurance

The amount that you are required to pay for covered medical services after you've satisfied any copayment or deductible required by your health insurance plan. Coinsurance is typically a percentage of the charge for a service rendered by a healthcare provider. For example, if your insurance company covers 80% of the allowable charge for a specific service, you may be required to cover the remaining 20% as coinsurance.

Deductible

A specific dollar amount that your health insurance company may require that you pay out-of-pocket each year before your health insurance plan begins to make payments for claims. Not all health insurance plans require a deductible.

Out-of-Pocket Maximum

Out-of-pocket maximums apply to all medical plans. This is the maximum amount you will pay for health care costs in a calendar year. Once you have reached the out-of-pocket maximum, the plan will fully cover most eligible medical expenses for the rest of the plan year.

Lifetime Maximum

The maximum dollar amount that a health insurance company agrees to pay on behalf of a member for covered services during the course of his or her lifetime.

Pre-existing Conditions

An illness or injury that was diagnosed and/or treated prior to the effective date of your coverage. Some health insurance plans will exclude coverage for pre-existing conditions.

Claim

A request by a plan member, or a plan member's health care provider, for the insurance company to pay for medical services.

NOTE: If you pay out of pocket and need to be reimbursed, please contact your administrator for a claim form.

Medical Evacuation & Repatriation Insurance

This coverage, required of all J-Visa holders, is for arranging and paying for emergency evacuation to the nearest adequate medical facility, and the repatriation of mortal remains.

COBRA
(Consolidated Omnibus Reconciliation Act)

Federal legislation allowing an employee or an employee's dependents to maintain group health insurance coverage through an employer's health insurance plan, at the individual's expense, for up to 18 months after the loss of employment.

HMO Plan Example

HMO	
Core Benefits	In-Network
Deductible	None
OOP – Single/Family	$1,500 / $3,000
Office Visit	$20 / $30 Copay
Inpatient Hospital	$250 Copay per admission
Outpatient Surgery	$100 Copay per visit
Emergency Room	$75 Copay (waived if admitted)
RX	$10 / $15 / $30

PPO Plan Example

PPO		
Core Benefits	In-Network	Out-of-Network
Deductible (Individual/Family)	$300 / $900	$800 / $2,400
OOP – Single/Family	$2,500 / $7,500	$3,000 / $9,000
Office Visit	$30 / $40 Copay	40%
E-Visit*	$30 Copay	40%
Inpatient Hospital	20%	40%
Outpatient Surgery	20%	40%
Emergency Room	$150 Copay (waived if admitted)	
RX	$20 / $30 / $50	$20 / $30 / $50 (+40%)

When and Where to Access Care

Type of Provider	Scenario	Type of Illness or Injury
Primary Care Physician (PCP) (Common under HMO plan)	Annual wellness exams, or moderate pain you need diagnosed	General checkup, moderate pain of unknown origin, etc.
Specialist (Requires referral from PCP under HMO)	Experiencing pain specific to a particular region of the body (i.e. muscular, gastrointestinal, ocular, bone/joint, skin, ears/nose/throat, etc.)	Ulcers, rash, digestive problems, vision problems, elevated levels, etc.
Hospital	Having an inpatient or outpatient procedure performed, in a critical state	Delivering a baby, major/minor surgery, recovery, monitoring, etc.
Walk-in Clinic	Treatment of unscheduled, non-emergency illnesses/injuries and certain immunizations	Vaccination, mild cold/flu, minor cuts/abrasions, etc.
Urgent Care (Alternative to ER)	Treatment of most non-life threatening emergencies	Broken bones (not multiple fractures), minor wounds (not bleeding profusely), mild fever, flu, acute sinusitis, etc.
Emergency Room (ER)	Treatment of all life/limb-threatening emergencies	Severe head trauma, multiple/compound fractures, heavy bleeding, elevated fever, severe burns, seizures, poison, etc.