Demystifying Insurances:

Some common terms:

- **Allowed amount** – The maximum dollar amount an insurance company will pay for a given procedure or service. If a provider has a contract with an insurance company, the provider and the insurance company negotiate an allowed amount for each service or procedure. If a provider has a contract with a health insurance company, then the health insurance company considers the provider in-network and will not charge more than the allowed amount for a given procedure.
- **Benefits** – Expenses that your health insurance policy contribute towards.
- **Claim** – A formal request to an insurance company for their reimbursement of a patient's medical benefits.
- **Co-Insurance** – The percentage of covered expenses the patient share with their insurance company
- **Co-pay or Co-payment** – The dollar amount a patient must legally pay toward the cost of a benefit.
- **Deductible** – The dollar amount of eligible expenses you must pay during each policy year before benefits are payable by the insurance company.
- **Exclusions** – Medical and other expenses that your health insurance policy does not cover
- **Health care provider** – Any person or entity that provides health care services. A provider could be a doctor, a physician's assistant, a counselor, a licensed nurse practitioner, a hospital, or a physical therapist, just to name a few. Health care providers are usually licensed by the state in which they practice medicine.
- **HIPAA** – HIPAA stands for the Health Insurance Portability and Accountability Act of 1996, a U.S. federal law. HIPAA protects patients' rights regarding #personal health information (PHI).
- **In-network** – A provider or health care facility that is part of a health insurance plan's network. In general, insured individuals pay less money out-of-pocket when they see in-network providers.
- **Medical record** – Legal documentation of your visit to a health care provider, the treatment you received and your payment for services.
- **Network** – A group of doctors, hospitals, and other providers with whom a health insurance company contracts to provide discounted services to insured individuals.
- **Out-of-network** – Describes a provider or health care facility which is not part of a health plan's network. In general insured individuals usually pay more money out-of-pocket when they see out-of-network providers.

- **PHI** – PHI stands for protected health information, or any confidential information that identifies you. PHI may be oral or recorded in any form or medium a health care provider, health plan, public health authority, employer, life insurer, school, university, or health care clearinghouse creates that relates to past, present or future payment for the provision of health care to an individual.
- **Premium** – Money you pay your insurance company in exchange for insurance benefits
- **Provider** – Any person or entity that provides health care services. A provider could be a doctor, a counselor, a hospital, or a physical therapist, just to name a few. Providers are usually licensed by the state in which they practice medicine.
- **Underwriter** – A company that guarantees financial support for a health insurance policy.
- **What is a premium** - Premiums are regular payments by the patient to the insurance company to keep the health care plan active. It is often taken out of a paycheck.
- **What is a copay** - Copays are flat fees for certain visits.
- **What is a deductible** - A deductible is the amount you pay out-of-pocket for covered services before your health plan kicks in.
- **What is coinsurance** - Coinsurance is the percentage of the bill you pay after you meet your deductible. Can be in addition to copays.
- **What is U&C** - The Usual and Customary fee for your services. AKA the retail price of an exam or test.
- **What is HSA** - A Healthcare Spending Account is offered or provided to people with high-deductible health plans ($1400 or over) for medical-related expenses to offset the cost of the deductible. Money is taken out of the paycheck pre-tax. Funds roll over from year to year.
- **What is FSA** - A Flexible Spending Account is an option for those that do not qualify for an HSA. Money is taken out of the paycheck pre-tax but you must "use it or lose it" at the end of the calendar year.
- **What is an OOP Max** - Out of Pocket Max aka Spend Limit is a maximum amount that a patient will have to pay in a contract year before the insurance covers all expenses in full at 100% of the contracted rate.

In-Network PPO (IN)

- The provider is contracted to provide services at a certain fee schedule and the patient cannot be charged the difference between the doctor's fee (aka U&C or UCR) and the contracted rate. The patient is responsible for their Co-Payment, Co-Insurance, and/or Deductible, up to the contracted rate. The insurance is billed and pays the doctor their portion minus the patient responsibility.

Out of Network (OON)

- The provider has not agreed to accept the fee schedule and can bill the patient for any balance above and beyond what the insurance covers, if any.

Non-Participating (Non-Par)

- The doctor will not bill this insurance and the patient pays upfront.

Difference Between Co-Insurance and Deductible

If a health insurance company says a covered benefit “applies to deductible and co-insurance,” the patient must pay the amount of your deductible. Their deductible is a declining balance. They must pay the amount of their deductible before their insurance company begins to reimburse them for medical expenses.

After they have paid their deductible, then they only need to pay co-insurance, or a portion of their medical expenses. Their health insurance company will pay the rest. Under most health insurance plans, there is a limit to the amount of co-insurance a patient has to pay. This is known as an “out-of-pocket maximum.” In general, patients pay their deductible and co-insurance directly to the doctor’s office, not to the insurance company.

Co-Pays or Co-Payments

Patients pay a co-pay (or co-payment) at the doctor’s office. A co-payment is a fixed amount of money that they pay when the doctor delivers (or renders) services to you. Co-pays DO NOT count toward the deductible or co-insurance. Depending on the insurance policy and on the kind of doctor, the amount of the co-pay may not always be the same. For example, a patient might pay a $20 co-pay to see a Family Practitioner, but pay a $50 co-pay to see a specialist, such as an Optometrist. In general, if the doctor’s title has “ist” at the end, the doctor is a specialist and not a primary care doctor.

Types of Insurance

Health Maintenance Organization - HMO

- For an HMO, the PCP, is considered the “gate keeper” to prevent unnecessary specialist visits and treat common issues at a lower monthly premium.
- The patient has network only with NO OUT OF NETWORK benefits whatsoever. If the physician is not contracted as part of the HMO In-Network panel, then the patient must be made aware and sign a financial agreement stating they understand that the physician is OUT OF NETWORK and insurance will not pay anything towards services provided.

Preferred Provider Organization - PPO

- No referrals from PCP required. Prior authorizations may be required for certain procedures or services above a certain dollar amount. Providers can participate at the In-Network level,

the Out of Network level, or be non-Participating. A PCP is not required. PPO plans typically have higher monthly premiums to the patient.

Exclusive Provider Organization - EPO

- Like HMOs, EPOs cover only in-network care, but networks are generally larger than for HMOs. They may or may not require referrals from a primary care physician. Costs to the patient are higher than HMOs, but lower than PPOs. Not very common in eyecare.

Point of Service - POS

- Requires a referral from Primary Care Provider (PCP) before seeing a specialist. But for slightly higher patient-costs than an HMO, this plan covers out-of-network doctors, though you'll pay more for OON than for IN doctors. This is an important difference if the patient is managing a condition and one or more of their doctors are not IN.

	Low deductible	Low premiums	Referrals required	Claim forms	Out-of-network (OON) coverage
HMO	✓	✓	✓		
POS	✓	✓	✓	For OON providers	✓
PPO	Some plans			For OON providers	✓
EPO		✓	Some plans		
HDHP		✓		For OON providers	Some plans

Vision insurance — **a type of supplemental health plan —** may help **offset expenses** related to eye care, such as vision corrective wear, annual eye examinations, corrective eye surgery, contact lens exams and more.

The cost of vision insurance depends on various factors, but monthly premiums can range from $10-$30 per person. Policies that charge higher monthly premiums come with reduced costs for care. The catch is that all policies have some coinsurance costs, copays, and limits on coverage.

What are the typical benefits included in vision insurance?

- Retinal Screenings
- Eye Exam
- Frame and Ophthalmic Lens Benefits
- Contact Lens Exam
- Contact Lens Material Benefits
- Medically Necessary Contact Lens Exams and Materials
- Diabetic Eye Exams
- Additional Eyewear Benefits

Most Popular Commercial Vision Plans:

- Vision Service Plan (VSP)
- Eyemed Vision Plan
- Spectera/Optum Health Vision Plan
- Versant (formerly Davis Vision)
- Avesis