Some insurance terms to know and understand

Office Visit Copay:

- What you pay upfront at the reception of doctor's office when you present your IHC Short Term Medical insurance card. Please make sure the doctor's office accepts it and bills to insurance company.

Deductible:

- **Individual**: The selected deductible maximum is the covered person must pay an amount before coinsurance benefit begins. The deductible applies per covered person, per covered period. To be risk averse, select the least deductible amount on your plan choices, though the premium will be higher.
- **Family**: When three covered persons in a family each satisfy their deductible, the deductibles for any remaining covered family members are considered satisfied for the remainder of the coverage period.

Coinsurance:

It is the defined percentage of expense that you share with insurance company after deductible defined has been met. Typically, the sharing of this percentage is denoted at 80/20, 70/30 etc. This means, insurance will share 80% of expense and you will pay 20% of expense after having met defined deductible for the plan.

Out-of-Pocket Maximum:

- This is the defined amount of a plan, the maximum amount that you will pay for the year. This amount equals deductible plus sharing your coinsurance percentage amount of covered expenses with the insurance company.
- The out-of-pocket maximum amount is specific to expenses applied to the coinsurance percentage. It does not include covered expenses applied to the deductible, precertification penalty amounts, or expenses not covered under the policy.
- Once the deductible and Out-of-Pocket maximum amount has been satisfied, additional covered expenses within the coverage period are paid to by insurance at 100 percent, not to exceed the covered period maximum benefit amount. Benefits specific maximums may also aply.

Pre-existing condition limitation

- A pre-existing condition is defined as any medical condition or sickness for which medical advice, care, diagnosis, treatment, consultation or medication was recommended or received from a doctor within five years** immediately preceding the covered persons' effective date of coverage; or symptoms within the five years** immediately prior to the coverage that would cause a reasonable person to seek diagnosis, care or treatment will not be a covered benefit.
- Consultation means evaluation, diagnosis, or medical advice was given with or without the necessity of a personal examination or visit.
- ** 12 months in VA; 24 months in FL.

Precertification

- Precertification is required prior to each inpatient confinement for injury or illness and outpatient.
- Emergency inpatient confinements must be pre-certified within 48 hours following the admission, or as soon as reasonably possible.

- Precertification may also be conducted for a continued stay review for an ongoing inpatient confinement.
- Benefits are not paid for days of inpatient confinement, which extend beyond the number of days deemed medically necessary.
- Failure to complete precertification will result in a benefit reduction of 50 percent, which would have otherwise been paid unless the covered person is incapacitated and unable to contact the administrator.
- Precertification is not a guarantee of benefits. The servicer must be notified and approval obtained.

Exclusions

- A list of incidents, conditions, or charges that are not covered in policy benefits.
- Partial list may be viewed in brochure put out; the full list may be seen in the policy documents.

Usual, Customary and Reasonable Charges (UCR)

- The term has different meaning and interpretation depending on who uses it. For healthcare providers, it is the bill they float to the insurance company for services provided to the patient and seek reimbursement of charges.
- The insurance companies enter into negotiated contract rates with the healthcare providers and bring them in its network of Preferred Providers Organization (PPO). Providers need traffic coming in even at lower negotiated contract rates, irrespective of what they bill as their Usual, Customary and Reasonable rates of service to the insurance company. This is also termed as In-Network providers. They accept low percentage payment of bills they float and are still happy to get business from insurance carrying patients. It is '*take it or leave it situation'*, and the providers do not leave it. In parlance of insurance, it is euphemistically called 'adjustments' or 'patient's saving'. The insurance company holds out to its policy holders that they get service at highly discounted billing rate, thus the blessing of competitive contract rates (PPO) is passed on to insurance policy holders.
- For Out-of-Network providers, the acceptance of price of service will be much higher than that of negotiated contracted rates with PPO providers, but not near their inflated billing as their deserved cost of service. Often, insurance rates of out-of-network too are set in stone by insurance company to placate the providers and the patients to serve each other. If the provider is emphatic for higher cost of service, the balance of bill, after 'adjustments' will be floated to the patient, which in insurance parlance it's called 'balance billing'.
- The insurance company often recrafts its definition of UCR to pay charges based on its contract rate in that geographical area.
- Be aware of thy bills, for they belong to the patient! Supplemental Medical Insurance comes to help here to avoid financial shocks.
- What happens when one does not carry the protective shield of an active medical insurance card? He or she shalt be served with the provider's bills with ferocity of Usual, Customary and Reasonable charges, all red in tooth and claw. And when pressure and persuasion fails, the bills will eventually be pursued by collection agency when providers sell their debts for pennies on a dollar.