Stanford HEALTH CARE

Insurance Terms and Definitions

It is important to understand the following definitions that insurance companies use when you are choosing your next insurance carrier. If you need help in evaluating the different plans you are offered, contact the Human Resource representative at your work.

PPO - Preferred Provider Organization
Having a PPO means that you can see the physician of your choice. Physicians may be "in-network" with the PPO or "out-of-network". Physicians who join a network offer their services to the insurance company at a discounted rate. If your physician is not contracted (out-of-network) with the insurance company, your PPO should still provide some coverage for your exam. The exact coverage is different for each policy and should be listed in your insurance booklet that was provided with your card. Additionally, PPO's do not require a primary care physician or any referrals.

POS - Point of Service
The patient may use the plan like an HMO or use it like a PPO and be able to choose their health care providers. With the HMO option, the patient is responsible for a co-payment. With the PPO option, the patient may have a deductible and coverage similar to a PPO.

HMO - Health Maintenance Organization
Any organization that provides delivery of health maintenance, usually through a specified medical group such as the San Jose Medical Group, Santa Clara IPA or El Camino Medical Group. A Primary Care Provider (PCP) manages all specialist referrals with the exception of Ob/Gyn services. You are required to stay within the same medical group for all of your care.

EPO - Exclusive Provider Organization
A delivery system similar to an HMO, which consists of a contracted panel of providers. The difference is that the patient may elect to see a specialist without a referral from the primary care physician. If the patient does not see an in-network physician, she does not have any coverage for any services.

Usual and Customary Charges:
A term that insurance companies use to cap the insurance companies payments. If the physician is contracted, the amount is what the insurance company will pay for a procedure or service. If the physician is out-of-network, the insurance company will pay a percentage of the "usual and customary" charge. Because a contract does not exist between the physician and the insurance company, the patient is responsible for the difference between the billed charge and the usual and customary, as well as their percentage charge. For example, if the billed charge is $100 and the insurance company thinks it should be $80 (the usual and

customary), then the insurance may only pay 80% ($64) of the $80. The patient would be responsible for their 20% ($16) in addition to the difference between the usual and customary and the billed charge ($20) for a total of $36.

Co-Insurance
A requirement under a health insurance policy where the patient is responsible for a portion or percentage of the cost of covered services. Example: The insurance company may be required to pay 80% leaving the subscriber to pay 20% as co-insurance. Usually the health insurance policy provides that the insurer reimburses a specified percentage of the covered services after deductible.

Deductible
A fixed amount that a patient contributes in payment for medical services during a specified period. Example: The insurer policy may state that the patient has a $200.00 deductible per year. The first $200.00 in services billed to the insurance company would be denied reimbursement, as the deductible is patient responsibility.

Copayment
A provision under a health insurance policy where the patient assumes a fixed amount of the costs of covered services such as a $10.00 co-payment per office visit.

Exclusions
Specific conditions not covered or services not paid for under a health insurance contract. Typical exclusions may be cosmetic or elective surgery, infertility services, or preventative care.

Medical Savings Account
Available to a self employed person or an employee in a small business with less than 50 employees - this type of account is paired with specific high deductible, comprehensive major medical insurance policies. It allows the insured to set aside pre-tax funds to use to meet the deductible and co-insurance liability. There are specific Internal Revenue Service guidelines in setting up and using this type of account. Your Human Resource Department should be able to discuss specifics of this type of account with you.

Flexible Spending Account
This type of account is set up through your employer and allows you to designate pre-tax deductions to reimburse you for qualifying medical expenses that your insurance company does not pay. There are specific Internal Revenue Service guidelines in setting up and using this type of account. Your Human Resource Department should be able to discuss specifics of this type of account with you.

Dual Insurance
Exists when you are covered by both your company and your partner’s company or if you are covered through your employment and have purchased individual coverage in addition. Generally speaking, the insurance through your employer is primary and the insurance through your partner’s employer is secondary. In order for your secondary insurance to process your claims for payment, your primary insurance has to have been billed and processed your claim first.