



Health Insurance Terms You Need to Know

The health care system in the United States can be confusing. In order to get the most out of your health care benefits, you need to understand the terms used by insurance companies, the government, health plans and health care providers. This way, you can make better decisions and ultimately receive better care.

Advance Premium Tax Credit – A new tax credit provided by the Affordable Care Act to help you afford health coverage purchased through the Marketplace. Advance payments of the tax credit can be used right away to lower your monthly premium costs. If you qualify, you may choose how much advance credit to apply to your premium each month, up to a maximum amount. If your advance payments, for the year are less than the credit you are due, you'll get the difference as a refundable credit when you file your federal income tax return. If your advance payments are more than the amount of your credit, you must repay the excess with your tax return. Also called premium tax credit.

Affordable Care Act (ACA) - The comprehensive health care reform law enacted in March 2010. The Patient Protection and Affordable Care Act was signed into law on March 23, 2010.

Annual Limit - A cap on the benefits your insurance company will pay in a year while you're enrolled in a particular health insurance plan. These caps are sometimes placed on particular services, such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service. After an annual limit is reached, you must pay all associated health care costs for the rest of the year.

Benefits - The amount of money payable by an insurance company to a claimant under the insurance policy.

Claim - A request by an individual (or his or her provider) for the insurance company to pay for services obtained.

Coinurance - The money that an individual is required to pay for services after the deductible has been met. It is often a specified percentage of the charges. For example, the employee pays 20% of the charges while the health plan pays 80%.

Copayment - An arrangement where an individual pays a specified amount for various health care services and the health plan or insurance company pays the remainder. The individual must usually pay his or her share when services are rendered. Copayments are usually a set dollar amount (such as \$20 per office visit), rather than a percentage of charges.

Deductible - A set dollar amount that a person must pay before insurance coverage for medical expenses can begin. They are usually charged on an annual basis.

Denial of claim - Refusal by an insurance company to pay a submitted request for health care services obtained.

Dependent - Any individual, adult or minor whom a parent, relative or other person may choose to cover on his or her insurance plan.

Health Insurance - A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Health Insurance Marketplace (Marketplace) – A state or federal resource where individuals, families, and small businesses can shop for health insurance plans based on

costs, benefits and other important features, and enroll in coverage. Individuals who enroll in a health insurance plan through the Marketplace may be eligible for Advance Premium Tax Credits and other assistance in paying for coverage. Also known as Exchanges.

Health Reimbursement Arrangement (HRA) – Employer-funded group health plans from which employees are reimbursed tax-free for qualified medical expenses. Like health savings accounts (HSAs), unused amounts may be rolled over to be used in subsequent years. Unlike HSAs, the employer funds and owns HRA accounts. The employer sets up the HRA, determines the amount of money available in each employee's HRA for the coverage period and establishes the types of expenses the funds can be used for.

Health Savings Account (HSA) - A medical savings account available to people who are enrolled in an HSA-complaint high-deductible health plan. The account is employee-owned, and money may be contributed by both the employer and employee. If the employee leaves the company, he or she remains in control of the account. The funds contributed to the account are pre-tax, which means they aren't subject to federal income tax at the time of deposit. Funds must be used to pay for qualified medical expenses; there is a heavy tax penalty for using HSA funds for non-qualified expenses. Funds roll over year to year if you don't spend them, and can accumulate a significant balance. There is a limit to how much money can be put into an HSA every year, but no cap on how much money can be in the account.

High-deductible Health Plan (HDHP) - A plan that features higher deductibles than traditional insurance plans. HDHPs can be combined with an HSA or HRA to allow you to pay for qualified out-of-pocket medical expenses on a pre-tax basis.

In-network -Typically refers to physicians, hospitals or other health care providers who contract with an insurance plan (usually an HMO or PPO to provide services to its members. Coverage for services received from in-network providers will typically be greater than for services received from out-of-network providers, depending on the plan.

Maximum Benefits - The maximum dollar amount that an insurance company will pay for claims, either for a specific procedure or service or during a specified period of time.

Medicaid - A state-administered health insurance program for low-income families and children, pregnant women, the elderly, people with disabilities and in some states other adults. The federal government provides a portion of the funding for Medicaid and sets guidelines for the program. States also have choice in how they design their programs, so Medicaid varies state by state and may have a different name in your state.

Medically Necessary - A term used to describe the supplies and services needed to diagnose and treat a medical condition in accordance with the standards of good medical practice. Many health plans will only pay for treatment deemed medically necessary.

Open Enrollment Period - A period of time, usually but not always occurring once per year, when employees of companies and organizations may make changes to their

health insurance and other benefit options. The term also applies to the annual period in which individuals may buy health insurance plans through the Marketplace.

Out-of-network - Typically refers to physicians, hospitals or other health care providers who do not contract with an insurance plan, expenses incurred for services provided by out-of-network providers might not be covered, or coverage may be less than for in-network providers.

Out-of-pocket Maximum (OOPM) - The total amount paid each year by the member for the deductible, coinsurance, copayments and other health care expenses excluding the premium. After reaching the out-of-pocket maximum, the plan pays 100% of the allowable charges for covered services the rest of that calendar year.

Premium - The amount of money charged by an insurance company for coverage.

Prescription Insurance - Insurance that helps pay for prescription drugs and medications. Prescription insurance is often offered as part of a larger health insurance plan, though this is not always the case. Stand-alone individual prescription insurance may be available for people who are not offered prescription drug coverage or who do not have health insurance. Eligibility for specific medications and the cost of insurance varies among health plans.

Preventative Care - Any medical checkup, test, immunization, or counseling services used to prevent chronic illnesses from occurring.

Primary Care Physician (PCP) - A health care professional who is responsible for monitoring an individual's overall health care needs. Typically, a PCP serves as a gatekeeper for an individual's medical care, referring him or her to specialists and admitting him or her to hospitals when needed.

Waiting Period - A period of time in which your health plan does not provide coverage for a particular pre-existing condition.

Wellness Program - A program intended to improve and promote health and fitness, usually offered through the workplace, although insurance plans can offer them directly to their enrollees. The program allows your employer or plan to offer you premium discounts, cash rewards, gym memberships and other incentives to participate.

several providers on a single EOB form. Others prepare separate forms for each date of service and provider you see.

Typically, most EOBs include the following information:

- Name and address of the policyholder
- Name of the patient
- The group number
- The member ID number
- Claim number
- Date the claim was processed
- Date of service
- Name of the health care facility and the provider name
- Name of the procedure or service and the billing code
- Amount that was billed to the insurer by the provider
- The portion of the bill that is eligible for insurance coverage
- The reason why the non-covered portion was not covered
- The amount of charges that are subject to the patient's deductible
- The amount paid by the insurance company

The main purpose of your EOB is to help you determine if your claim has been paid, how much had been paid by your insurance company, and how much is your responsibility. Then, you will know which invoice to pay and how much.

To figure out who has been paid, match the treatment dates and providers from the invoices to the dates of service and providers listed on your EOB. Make sure your provider gives you an itemized invoice so you can effectively match your EOB to your invoices.

Keep in mind that insurance companies rarely pay 100% of a claim. You need to pay your part in applicable deductibles, coinsurance and copayments.

Below are some common reasons for partial payment of a claim by your insurance company:

- Part or the entire claim was charged to satisfy your deductible, copayment or coinsurance requirement.
- The charges for services exceed the maximum benefit available for the service.
- Your insurance policy was not in force on the date of service.
- The claim was a duplicate and had been previously paid.
- The charges exceeded the insurance company's reasonable and customary limitation.

If you receive an EOB showing that your insurance company did not pay your entire claim, first determine the reason why, and then determine if the reason is valid. If you believe there was an error, contact your health plan's member services department to ask them to review the claim.

We appreciate the opportunity to provide care to your child or children!

Questions about an ESD Pediatric Group bill or statement? Contact (513) 248-3063 during office hours or log into the secure patient portal at www.esdpeds.com 24/7.



UNDERSTANDING YOUR EXPLANATION OF BENEFITS (EOB)

After submitting a claim for medical treatment, you may receive an Explanation of Benefits (EOB) from your insurance company. The EOB is a form that insurance companies send to their members to explain what part of a claim was paid by insurance, what part was not paid, and why. It is important to understand what this statement means.

Many people find EOBs difficult to understand since they differ from one insurance company to another. Some insurance companies combine several dates of service or