Insurance Glossary

Note: This glossary is not intended to be all-inclusive or exhaustive. It is intended to give the reader a very basic idea of the most common types of medical insurance plans and insurance terminology that exists, especially as it pertains to the coverage of autism spectrum disorders.

Types of Insurance Plans

HMO (Health Maintenance Organization) – This type of insurance is generally much more affordable, however, there are more restrictions than a PPO plan. The network of available healthcare providers may be smaller and you will need to select a primary physician. However, there are usually no deductibles. Co-payments for HMO plans are also usually lower than PPO co-payments.

HSA (Health Savings Account) – This type of plan was introduced in January of 2004. Basically, you set up a "savings account" and this account is used in conjunction with an HSA insurance plan to pay for your medical costs. Contributions to your HSA savings plan are made at pre-tax and you may invest these funds however you like. Unused funds in your account are tax-free and may accrue interest year-to-year.

Indemnity Plan – An indemnity plan will allow you much more freedom in healthcare choices. This freedom does come with some drawbacks, however, and will normally require you to pay a deductible. It may also require you to initially pay for healthcare visits and submit your claim for re-payment from the insurance company yourself (which is usually taken care of by the healthcare provider directly). With this type of plan, you will not need to have a primary care physician.

POS (Point of Service) – This type of health insurance is a hybrid between a PPO and an HMO. You still need to have a primary care physician, but you will have access to more healthcare options in your network. As with an HMO, there are normally no deductibles, and co-payments are usually lower.

PPO (Preferred Provider Organization) – This type of insurance will normally require you to visit doctors within a certain network in order to receive insurance coverage. This type of plan will normally have a deductible and may include a co-payment for doctor visits and/or co-insurance. Typically, PPO plans require a higher co-insurance for out-of-network healthcare providers.

Self-Insured Policy – A self-insured group health plan (or a "self-funded" plan) is one in which the employer assumes the financial risk for providing healthcare benefits to its employees. Practically speaking, self-insured employers pay for each out of pocket claim as they are incurred instead of paying a fixed premium to an insurance carrier, which is known as a fully insured plan. Typically, a self-insured employer will set up a special trust fund to earmark money (corporate and employee contributions) to pay incurred claims. This money may even be professionally managed by a large insurance carrier (e.g. Blue Cross Blue Shield) which would provide the employee with an insurance card. This does not mean, however, that you are in any way covered by that insurance carrier. *Note: Self-insured plans are*

exempt from covering ABA services for autism in Illinois. They may still cover it, but are not compelled to by law.

General Terminology

Co-insurance – Co-insurance is a portion of your medical expenses that your plan requires you to pay. This is separate from, and in addition to, your deductible and any co-payments you may be required to provide. This amount can range anywhere from 10% to 80% depending on your health insurance provider and your specific plan. For example, your doctor performs a procedure that costs $500. Your policy states that you are required to pay a 10% co-insurance payment. This means that you would need to provide $50 and the insurance company will provide $450 (less any co-payments required of you) assuming you have met your deductible. Some plans require a higher co-insurance when an out-of-network provider is used.

Co-payment – A co-payment is a charge that you owe to your medical provider at the time of services which is not covered by your insurance (i.e. you pay the co-payment and the insurance company pays the rest). The amount of the co-payment will be agreed upon between you and your insurance company before you purchase your plan. Co-payments can range anywhere from $15 to $50 depending on your insurance policy. Your insurance company may require you to provide this co-payment for doctor visits or for prescription medication.

CPT Code – The Current Procedural Terminology Code is an accepted method of coding developed by the American Medical Association in connection with the Health Care Financing Administration Common Procedure Coding System to describe a medical service by use of a numeric code. For example, the three primary codes we use for our services are 96150 – Assessment, 96155 – Consultation, and 96152 – Therapy. These may be useful to you when speaking with your insurance provider about our services.

Deductible – A health insurance deductible is a set dollar amount agreed upon between you and your insurance provider where any medical expenses incurred by you before the total amount of the deductible has been met will be your responsibility. Once you have met your deductible, further costs will then be covered by your insurance provider. For example, if your deductible is $250 and your first doctor's visit is $245, you will be responsible for this entire amount. However, your next visit will be covered by your insurance company—after you have paid the remaining $5 and any co-insurance or co-payments you are responsible for. Deductibles are typically renewed annually, meaning once the year is over you will be responsible for paying the $250 again.

Discounts – A predetermined reduction of charges that the healthcare provider and the insurance company work out in advance. Discounts are sometimes a requirement for a healthcare provider becoming part of an insurance company's network.

Exclusions – Products or services for which the insurance policy will not cover or pay. In order to keep insurance premiums low, some policies will exclude certain conditions (e.g. pregnancy).

Explanation of Benefits (EOB)/Explanation of Medicare Benefits (EOMB) – A notice that is sent to the client after the healthcare provider files a claim. This notice explains what the provider billed for, the approved amount, how much was paid, and what, if anything, the client owes.

Group Policy – An insurance plan that provides healthcare coverage to a select group of people. Group health insurance plans are one of the major benefits offered by many employers. These plans are generally uniform in nature, offering the same benefits to all employees or members of the group.

ICD-9 Code – International Classification of Diseases, 9th revision. It is a standardized classification of diseases, injuries, and causes of death, by etiology and anatomic localization and codified into a 5 or 6 digit number, which allows clinicians, statisticians, politicians, health planners, and others to speak a common language. The ICD-9 code for autism is 299.00.

In-network Provider – This term refers to a doctor or healthcare practitioner that has contracted with an insurance company. Since they have contracted with the insurance company, visits to these providers will be covered by that health insurance company. You will usually receive a list of all of the in-network providers in your area from your health insurance company.

Medicaid – This is a joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state. *Note: Medicaid is exempt from covering ABA services for autism in Illinois.*

Medicare – The federal health insurance program for people 65 years of age or older and certain younger people with disabilities. Medicare is not involved in covering ABA services.

National Provider Identifier (NPI) – This is a unique number assigned to various providers. This number is needed when sending a claim to third party payers.

Out-of-network Provider – This term refers to a healthcare provider who has not contracted with your health insurance company. Visits to out-of-network providers will cost more, depending on your plan, and may not even be covered at all by your insurance company.

Provider Contract – A contract which spells out the agreement between the insurance company and the healthcare provider. The contract states covered ICD-9 and CPT codes, UCR, plan discounts, as well as the conditions under which the provider must provide services. Billing and payment deadlines are also part of the contract (e.g. the provider must submit insurance claims within 60 days of the service date).

UCR Rate (Usual, Customary, and Reasonable) – A predetermined rate that the insurance company is willing to pay for services. If the doctor or healthcare service provider bills more than this rate, it will not be covered by the insurance company.