



Health Insurance

CHAPTER

22

Having the diagnosis of a chronic condition, like a primary immunodeficiency, can be financially taxing. If diagnostic services are limited and therapy is not administered on a regular basis, the cost of complications and subsequent hospitalizations is burdensome.

Health Insurance for Primary Immunodeficiency

Having the diagnosis of a chronic condition, like a primary immunodeficiency, can be financially taxing. If diagnostic services are limited and therapy is not administered on a regular basis, the cost of complications and subsequent hospitalizations is burdensome.

Most individuals with primary immunodeficiency rely on private third party payers to assist them with these expenses. Unfortunately, people are often frustrated when faced with the overwhelming task of paperwork, phone calls and other issues simply to justify the use of a diagnostic procedure or therapy prescribed by their physician.

Looking for health insurance and understanding the maze of issues involved can be an overwhelming process that often leads to feelings of isolation and helplessness. While not designed to solve each and every health insurance problem, this chapter will provide you with some of the information to prepare you to be your own best advocate.

Most of the information is practical. First, there is a description of the various payers, what they cover and whom they serve. Next, there is

information about what to look for when changing insurance coverage, a very important issue when a chronic condition is involved. The Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA is then reviewed. It is one of the most important federal laws enacted within the past decade regarding protection for you and your family's health insurance coverage when faced with life events. Other features that you should have a general working knowledge of are explained, such as COBRA, a name for extended benefits.

Other hands-on information follows with how to prepare yourself to face your insurer confidently with questions about your coverage. And last, but not least, as in every profession these days, health insurance has its own "language." There is a glossary of insurance terms so that you will feel confidently "bilingual."

When it comes to your health coverage, never hesitate to ask lots of questions and search for as many resources as possible. Your well-being and that of your family relies on it.

Who Are the "Payer Players"?

To best prepare for working with your health insurer, you must understand who the various "payer players" are in the scheme of things.

Group Health Insurance

Group health insurance coverage is a policy that is purchased by an employer and is offered to eligible employees of the company (and often to the employees' family members) as a benefit of working for that company. The majority of Americans have group health insurance coverage through their employer or the employer of a family member. Many people don't realize that health insurance is issued differently for different types of employers, and that, because insurance is regulated at the state level of government, the laws regarding health insurance offered by the different types of employers can vary significantly from state to state. Millions of Americans work for small employers, which for health insurance purposes are generally those with 50 employees or less. Millions of other Americans get their health

insurance coverage through large employers. Generally, those are business with more than 50 employees. The laws about how coverage can be issued to large groups are different than those for small groups, and premium rates are also determined differently. Federal law mandates that no matter what pre-existing health conditions small employer group members may have, no small employer or an individual employee can be turned down by an insurance company for group coverage. This requirement is known in the insurance industry as "guaranteed issue."

COBRA

Most people who are able to continue their group health insurance benefits are eligible to do so according to federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). However, COBRA does not apply to all employers; so many states have developed other continuation-of-coverage options for people who are not covered by COBRA. Also, many

Who Are the “Payer Players”? continued

people leaving group insurance to buy individual health insurance privately have portability benefits required by another federal law.

You are responsible for paying the premium, which is usually kept at 102% of what your employer was paying on your behalf. (The 2% is for administrative fees). For job termination or a reduction in hours, COBRA's duration is normally 18 months. In the case of a divorce, separation or death of a spouse, COBRA may be available for up to 36 months. In the case of a dependent child ceasing to be a dependent child under the parent's employer plan, may be entitled up to 36 months. If you are deemed disabled by Social Security within 60 days of your termination of employment or reduction in hours of employment, you are able to extend the COBRA continuation period from 18 months to 29 months. This extension is granted under the HIPAA federal legislation discussed earlier. The extended period of time offered is designed to protect you until you become eligible for Medicare, since there is a 29 month waiting period before you can receive Medicare benefits.

When these situations, known as “qualifying events” occur, it is your responsibility, as the employee, to notify the human resources department of your employer (that person or group responsible for medical insurance) within 60 days or you lose the option.

For further information on COBRA coverage and your rights under COBRA law, you should contact the human resource department or the benefits manager within your organization or call your local Department of Labor.

Individual Health Insurance

Individual health insurance is coverage that a person buys independently. It can be for an individual, a parent and dependent children, or a family. The majority of Americans get their health insurance coverage through an employer or through a government program, but five percent of the population purchases private health coverage on an individual basis. Each state separately regulates how individual policies may be marketed and sold.

Individual health insurance is very different than group health insurance, which is the type of insurance that is offered through an employer. Since laws mandating what types of services must be included in individual policies are often

different than those dictating what must be included in group policies, benefits are generally less extensive than what most people would receive through coverage they have through work. Individual consumers may be surprised to learn that some benefits that may be considered “standard” in a group policy, may not be included in an individual plan.

Individual health insurance companies are much more limited than group insurance companies in their ability to spread risk, so the laws concerning individual health insurance are different in most states. This means that applicants for individual insurance will need to complete a medical questionnaire when applying for benefits and, unlike a group insurance policy, in most states a company can decide not to cover people with very serious medical conditions (e.g., primary immunodeficiency), deeming them “uninsurable.”

The Uninsurable

In most states you can be turned down for individual coverage if you have a very serious medical condition (e.g., primary immunodeficiency). Most states have developed some way to provide uninsurable people with access to individual health insurance coverage. Thirty-three states provide coverage to medically uninsurable people through high-risk pools. Twelve states use other means of providing uninsurable people with access to individual coverage (e.g., requiring that all individual health insurance companies issue individual policies regardless of health status, coverage through a designated health insurance company of last resort, etc.) There are five states that still have no means of providing individual health insurance access to people with catastrophic medical conditions. To find out what your state's options are for medically uninsurable individuals, check with your local Insurance Commissioner's Office.

High Risk Pools

At the time of the writing of this handbook, thirty-three states provide coverage to medically uninsurable people through high-risk pools. High-risk pools are private, self-funded health insurance plans organized by states to serve high-risk individuals who meet enrollment criteria and do not have access to group insurance. In most states, they are independent entities governed by their own boards and administrators, but in other states, they function as part of the

Who Are the “Payer Players”? continued

state’s department of insurance. You generally have a choice of health plan options and will receive enrollment cards and other information just like any other health plan. High-risk pools normally contract with a health insurance carrier or third-party administrator to administer paperwork and claims, so your enrollment card and other paperwork may not even appear to be produced by the high-risk pool. Once enrolled, you use your benefits just like any other consumer of private insurance coverage.

Coverage options are very similar to traditional individual health insurance offerings. It is generally a comprehensive major medical plan with a range of deductible options. The most common risk-pool option is a PPO plan, but many states also offer indemnity coverage and some states have HMO and/or HSA options available to consumers. Risk pool health insurance is more expensive than traditional individual insurance.

Medicare

Medicare is a federal health insurance program which provides coverage for people over the age of 65, blind, disabled individuals, and people with permanent kidney failure or end-stage renal disease. The Medicare program is administered by the Centers for Medicare and Medicaid Services (CMS) and pays only for medical services and procedures that have been determined as “reasonable and necessary.” Medicare is divided into three parts—Parts A, B, and D.

Part A covers inpatient hospital services and certain follow-up care. This includes the cost of lab tests, x-rays, nursing services, meals, semi-private rooms, medical supplies, medications, necessary appliances, and operating and recovery rooms.

Part B covers physician’s services and other medical expenses. Medicare Part B will cover both the IVIG product and administration when provided in a physician’s office or in the hospital outpatient setting. The coverage determination for IVIG is reviewed by each Medicare regional carrier through their medical policy department. Each carrier will issue their own local coverage determination (LCD), which outlines the specific coverage guidelines for the use of IVIG therapy. Since January 1, 2004, the Medicare Part B program only allows coverage in the home setting. It is important to note that the home coverage provision is **ONLY** for primary immunodeficiencies, and the coverage and reimbursement is only intended for the IVIG drug

itself. Ancillary charges that may accompany the IVIG infusion are not covered under this provision. Beneficiaries must pay a monthly premium and a small deductible each year for all approved services covered under Part B.

Part D The new Medicare Prescription Coverage program (Medicare Part D) went into effect on January 1, 2006. Anyone who has Medicare coverage can choose the new prescription coverage benefit. The new prescription benefit coverage was passed by Congress to give Medicare beneficiaries more options for prescription drug coverage that had never before been covered under the Medicare program. As it relates to coverage of IVIG, the new Medicare Part D program **DOES NOT** cover IVIG in the home setting for those who have a primary immunodeficiency. However, Medicare Part D may cover IVIG in the home for other disease states. CMS administers the Part D program through contracts with commercial and private payers referred to as Medicare Prescription Drug Plans (PDPs). To learn more about the new prescription drug coverage go to www.medicare.gov, or call 1-800-MEDICARE.

For most of these services, Medicare pays 80% of the bill and the beneficiary pays the 20% coinsurance. You must first have Part A before receiving Part B. If you apply for Social Security disability, you will receive Medicare benefits after being on disability for two years.

In many states, people covered under Medicare have the option of choosing between managed care and fee-for-service plans.

Individuals may also consider purchasing a Medigap (supplemental insurance) policy. Medigap policies help pay some of the health care costs that your original Medicare plan will not cover. For instance, there are 12 different standardized Medigap policies (Plans A through L). Some of these plans will help pay for the 20% coinsurance under the Medicare Part B program. To learn more about the various plans and coverage guidelines go to www.medicare.gov/medigap, or call 1-800-MEDICARE.

Medicaid

Medicaid is a welfare program sponsored by both the federal and state governments, which is administered by the individual states. Coverage varies from state to state although each of the state programs adheres to certain federal guidelines.

Who Are the “Payer Players”? continued

Medicaid enrollment criteria also varies from state to state, but coverage is usually available only to those who are not eligible for any other type of health insurance and meet poverty guidelines. Each state has a predetermined income level that an individual or family must meet to qualify for Medicaid benefits. The local office of the State Department of Social Services is responsible for reviewing applications and managing eligibility requirements. Some states require Medicaid beneficiaries to join managed care plans.

Medicaid programs may require prior authorization for certain forms of treatment or prescription drugs. This means that your physician must contact Medicaid to obtain approval for reimbursement of the treatment before you receive it.

State Assistance Programs

Your state may have a special assistance program for particular chronic conditions. Most of these programs are funded by state and local budgets and are designed to meet the needs of adults and/or children who are not eligible for any other medical coverage.

They may also serve as a secondary or supplemental coverage to Medicaid. The level of coverage available will change according to such variables as state needs and available funding. These programs may be identified under such names as Children with Special Health Care Needs, Crippled Children’s Services, or Children’s Medical Services.

Coverage for children with primary immunodeficiencies may be severely restricted or not available at all. It is best to check with your local sources of information for eligibility information before considering this as a coverage option. SSI, or Supplemental Security Income, makes monthly payments to aged, disabled, and blind people with limited income and resources.

Disabled children, as well as adults, may qualify for SSI payments. Eligibility and benefits vary by state, but more information can be obtained by contacting your local Social Security Office listed in the White Pages of the phone book.

State Children’s Health Insurance Program (SCHIP)

As part of the Balanced Budget Act of 1997, Title XXI (or SCHIP) of the Social Security Act was passed in late 1997. The State Children’s Health Insurance Program gives grants to states to provide health insurance coverage to uninsured children up to 200% of the federal poverty level (FPL). States may provide this coverage by expanding Medicaid or by expanding and creating a separate state children’s health insurance program. The program’s primary purpose is to help children in working families with incomes too high to qualify for Medicaid but too low to afford private family coverage. Although benefits vary from state to state, children generally are eligible for regular check-ups, immunizations, eyeglasses, doctor visits, prescription drug coverage, and hospital care. Based on income levels, states can impose premiums, deductibles, or fees for some services. Since coverage and benefits do vary, it is important that families investigate the options available in their respective state. For more information regarding eligibility and coverage, call 1-877-Kids-NOW (1-877-543-7669).

The ABC’s of Health Plans

Most health insurance companies offer several types of programs with many variations in deductibles, copayments and covered services. Review the details of any specific plan very carefully before purchasing to ensure it will meet you and your family’s specific needs. Below is a description of the different types of plans offered through insurance companies, starting with the most restrictive, least expensive plan.

HMO is a Health Maintenance Organization. As a member of an HMO, you select a primary care physician from a list of doctors in that HMO’s network. Your primary care physician will be the first medical provider you call or see for a medical condition. He or she will make any needed referrals to a medical specialist. Typically, these specialists will be part of the HMO network. If you obtain care without your primary care physician’s referral or obtain care from a non-network member, you will be responsible for paying the entire bill (with exceptions for emergency care). Normally HMOs have a copayment for the visit or service. This is the most restrictive type of plan.

Who Are the “Payer Players”? continued

POS is a Point-of-Service Plan. It is a type of managed care plan that is an HMO with an out-of-network option. You can decide whether to go to a network provider and pay a flat dollar or to an out-of-network provider and pay a deductible and/or a coinsurance charge.

PPO is a Preferred Provider Organization. As a member of a PPO, you can use the doctors and hospitals within the PPO network or go outside of the network for care. You do not need a referral to see a specialist. If you obtain care from a medical provider outside of the PPO network, you will pay more for the service. For example, a PPO might pay 90 percent of the cost for a visit with an in-network doctor but only 70 percent of the cost for a visit to a non-network doctor. You will typically pay a copayment for each office visit. You will usually be responsible for paying an annual deductible.

Indemnity plan is commonly known as a fee for service or traditional plan. If you select an Indemnity plan you have the freedom to visit any medical provider. You do not need referrals or authorizations; however, some plans may require you to precertify for certain procedures. Most indemnity plans require you to pay a deductible. After you have paid your deductible, indemnity policies typically pay a percentage of “usual and customary” charges for covered services; often the insurance company pays 80% and you pay 20%. Most plans have an annual out of pocket maximum and once you’ve reached this they will pay 100% of all “usual and customary” charges for covered services. Many health insurance companies have moved away from indemnity plans. This is the least restrictive, therefore the most expensive type of health plan.

Health Insurance Portability And Accountability Act of 1996 (HIPAA)

Probably one of the most important and encompassing federal laws affecting the health insurance industry was the passage of HIPAA. We all are susceptible to a variety of events in life, which may affect health insurance coverage. Situations such as the onset of a chronic illness or disabling disease, changing jobs or a business closing can have adverse consequences when locating or attempting to keep your health insurance coverage. HIPAA protects health insurance coverage for workers’ families when

they change or lose their jobs. Due to the fact that the HIPAA law is very complex and contains many more provisions than indicated in this writing, we recommend that you contact your employer’s benefits administrator or your State Insurance Commissioners office for further information on how HIPAA can affect you or your family.

Key Provisions

Group Health Insurance—Employees can credit time spent under their previous employer’s plan satisfying a preexisting exclusion towards the new employer’s plan, as long as they do not have more than a 63 day break between coverage.

Moving from Group Health to an Individual Health Plan—If you are no longer eligible for Group coverage, you are able to obtain coverage with an Individual health plan, which includes HMO’s if:

- You have an aggregate 18 months or more of previous coverage under a group health, government or church plan.
- You have had no lapse in coverage longer than 63 days.
- You are not eligible under another group plan, Medicare or Medicaid.
- You do not have any other health insurance coverage.
- You have elected and exhausted any eligible COBRA coverage.
- You were not terminated from your most recent prior coverage due to non-payment of premiums or fraud.

Be aware that your state law may provide for greater protection than HIPAA, but not less than the minimum requirement mandated by the HIPAA law.

Comparing Plans

It is important to consider specific issues when deciding on a health insurance policy. You should compare: the cost of premium, coinsurance, copayments, deductibles, lifetime maximums, and the prescription coverage.

Your lifetime maximum (LTM) will differ according to your health coverage plan. Most LTMs will range from \$250,000 to \$1 million. Once you have exhausted your LTM, you no longer have health coverage, so it is wise to keep a running total of the major expenses that affect it such as

Who Are the “Payer Players”? continued

hospitalizations, surgeries, annual cost of drug therapy, etc. Also, know the difference between elective and required procedures and plan accordingly, as these costs most likely will go against your lifetime maximum.

Ask such questions as: How are chronic conditions like primary immunodeficiency covered within the plan? What about referrals to specialists? What are the procedures? Do they have restrictions on prescription drugs?

Words to the Wise

It cannot be emphasized enough that it is critical for you to be your own best advocate when dealing with your health plan. First, read your policy and then ask your personnel department, the Immune Deficiency Foundation (IDF), and any other resource you can find, lots of questions. Try to keep current information concerning the new rules affecting your policy.

Review your medical bills to check for mistakes; billing errors occur more often than you might think. Keep important information such as your policy number, your ID number, insurer's address and phone number, and doctor's address and phone number in one place to refer to whenever you communicate with your insurer. If there's a possibility you might reach your lifetime maximum, please explore the alternatives before your maximum runs out.

Many employers offer open enrollment once a year when you may change your coverage to another plan offered by your employer. Ask your employer if and when an open enrollment period is offered. If you have difficulty getting benefits through your employer, consider coverage through associations, schools, professional groups, farm groups, or local chambers of commerce. You may qualify for individual or group benefits. Document each time

you contact your insurer. Get the full name and title of each person you talk with whenever you contact your insurer. This information will be important if you experience difficulties with your coverage and need to document your situation in writing.

If your problem becomes more complicated, don't panic. You, and/or your physician, may appeal to the medical director of the insurance company and may need to work with the provider to submit additional justification of your claim. Often, in the case of primary immunodeficiencies, insurers need to be educated as to what the condition is and what the approved forms of treatment are. Most of the manufacturers of intravenous immune globulin (IVIG) offer reimbursement support services for their products and should be an excellent source of information.

The IDF can refer you to these sources. There may come a time when an insurance company terminates your policy. If it does so for any other reason than bankruptcy, they are required by state and federal law to find you new coverage. Enforcing this law is up to the State Insurance Commissioner. You should contact them especially if you feel your cancellation is due to a pre-existing condition. Arbitrary cancellation is illegal.

Conclusion

You could spend a major portion of every waking day working on insurance issues for yourself or your family. Some of you are fortunate enough to never experience problems. Others of you are in an endless search for insurance coverage or

adequate reimbursement. Never hesitate to seek assistance from resources. There is no such thing as a stupid question when it comes to you or your family's well being.

Glossary of Insurance Terms

ACCESS: Right to enter or use healthcare services.

ANCILLARY SERVICES: Healthcare services conducted by providers other than physicians and surgeons. These will usually include such services as physical therapy and home healthcare.

ANNUAL BENEFIT CAP: Maximum amount paid for specific medical services or total medical services.

ASSIGNMENT OF BENEFITS: A written authorization by the patient/insured to make payment to the provider of services (hospital, physician, home care company, etc.) directly.

BALANCE BILLING: The practice of participating providers (such as doctors, hospital, or other medical practitioner) billing the insured for the difference of the billed amount minus the contracted rate. Many plans prohibit the use of balance billing and may use sanctions against providers who balance the bill.

BASIC BENEFITS: Refers to the portion of the insurance policy which generally provides coverage for inpatient services: room and board, surgery, drug therapy, physician services, etc.

BENEFICIARY: The person entitled to receive benefits under a plan, including the covered employee and his or her dependents.

CASE MANAGEMENT: Planned approach to manage service or treatment to an individual with a serious medical problem. Its dual goal is to contain costs and promote more effective intervention to meet patient needs. This is often referred to as large case management.

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

(CMS): A branch of the federal government's health and human services that govern the Medicare and Medicaid programs.

CHARGE-BASED: Reimbursement based upon billed fees for physician's services.

CLAIM FORM: Requests for payment are submitted to insurers on claim forms. Claim forms include spaces for showing the patient's name and address, diagnosis, documentation of medical necessity and kinds of services received.

COBRA: Consolidated Omnibus Budget Reconciliation Act (COBRA) provides continuation of group health coverage that otherwise might be terminated. It was passed by Congress in 1986. COBRA provides certain former employees, retirees, spouses, former spouses, and dependent children the right to temporary continuation of health coverage at group rates. This coverage, however, is only available when coverage is lost due to certain specific events.

CODING: Several coding systems are used to describe patients and the services they receive in the healthcare system. These are used on medical records and billing forms.

COINSURANCE: An agreement between the insured and the insurance company where payment is shared for all claims by the policy. A typical arrangement is 80%/20% up to \$5,000. The insurance company pays 80% of the first \$5,000 and the insured pays 20%. Usually after 80% of \$5,000, the insurance company then pays 100% of covered expenses during the remainder of the calendar year up to any limits of the policy.

COORDINATION OF BENEFITS (COB): A contractual provision to prevent an insured from receiving benefits under more than one health insurance plan so that the insured's benefits from all sources do not exceed allowable medical expenses or eliminate appropriate patient incentives to contain cost.

COPAYMENT: A flat fee paid at the time a medical service is received. It does not accumulate towards a plan's deductible or out-of-pocket maximum.

COST-BASED: Reimbursement methodology typically used to pay institutions on the basis of accounting cost audits. The books of the provider are examined in an effort to avoid paying profits and unallowed items.

COVERAGE: The products and services your health plan is willing to pay for.

DEDUCTIBLE: A flat amount that the patient is automatically responsible for paying before the insurance plan begins to pay benefits.

EFFECTIVE DATE: The date that coverage begins for the insured.

ELIGIBLE EXPENSE(S): The portion of the medical care provider's services that are covered for payment under the terms of the health plan or insurance contract.

ELIGIBILITY: The screening method used by an insurance company or government program to determine whether the patient qualifies for benefits.

EXCLUSIONS: Illnesses, injuries, devices, procedures, or conditions for which the policy will not pay.

EXPLANATION OF BENEFITS (EOB): A document sent to an insured when the plan or insurance company handles a claim. The document explains how reimbursement was made, or why the claim was not paid, and if any additional information is needed. The appeals procedure should be outlined to advise the insured of his/her rights if there is dissatisfaction with the decision.

FEE-FOR-SERVICE: Payment for services based on each visit or service rendered. Under this arrangement plans or insurers have not established contracted or capitated rates of payments with providers prior to the insured claim occurrence.

FEE SCHEDULE: Maximum dollar or unit allowances for health services that apply under a specific contract.

INSURED/POLICYHOLDER: The person for whom the insurance policy is registered under.

LIFETIME MAXIMUM: The maximum amount that the insurance company will pay for medical expenses. This amount may be listed as the maximum amount for each illness or condition. Or it may be listed as total costs paid from a portion of a policy; e.g. inpatient expenses vs. outpatient.

MAJOR MEDICAL: Refers to the portion of the insurance policy which usually provides coverage for outpatient services: doctor's office visit, outpatient pharmacy services, home therapy, etc.

MEDICAL NECESSITY: In order to be financed by an insurer, a service must be medically necessary.

OPEN ENROLLMENT: A time period when a person can obtain insurance coverage or change insurance carriers without penalty for a pre-existing condition. This opportunity may be available from some employers on an annual basis.

OUT-OF-NETWORK: Medical services obtained by managed care plan members from unaffiliated or non-contracted healthcare providers. In many plans, such care will not be reimbursed unless previous authorization is obtained.

OUT-OF-POCKET EXPENSES: Those medical expenses that an insured must pay that are not covered under the group contract.

OUT-OF-POCKET MAXIMUM: The maximum amount that an insured is required to pay under a plan or insurance contract.

PARTICIPATING PROVIDER: A provider who has agreed to contract with a managed care program to provide eligible services to covered persons.

PRE-AUTHORIZATION: Previous approval required for referral to a specialist or non-emergency healthcare services.

PRE-CERTIFICATION: Utilization management program that requires the individual or provider to notify the insurer before hospitalization or surgical procedure. Notification allows the insurer to authorize payment and to recommend alternate courses of action.

PRE-EXISTING CONDITION: A condition or diagnosis which existed (or for which treatment was received) before coverage began under a current plan or insurance contract, and for which benefits are not available or are limited.

PREMIUM: The payment a subscriber must pay in order to maintain medical benefits.

PRIMARY CARE PHYSICIAN (PCP): The network physician designated by an employee (and each of his or her dependents) to serve as that employee's entry into the healthcare system. The PCP often is reimbursed through a different mechanism (such as capitation) than are other network providers. This physician sometimes is referred to as the "gatekeeper."

PRIMARY COVERAGE: The insurance plan that is required to pay benefits first based on state and federal insurance regulations.

QUALITY ASSURANCE: Set of activities that measures the characteristics of healthcare services and may include corrective measures.

REASONABLE & CUSTOMARY: The maximum amount a plan or insurance contract will consider eligible for reimbursement, based upon prevailing fees in a geographic area.

REIMBURSEMENT: The amount the plan pays for a particular product or service. Your plan may reimburse the full amount charged by your doctor, pharmacy, or hospital; or it may reimburse a percentage or set amount.

SECONDARY COVERAGE: An insurance plan that is required to pay benefits after the primary plan has paid or denied payment for medical expenses.

SUPPLEMENTARY COVERAGE: Insurance to help cover those parts of Medicare Part B that are non-reimbursable.

THIRD PARTY ADMINISTRATOR (TPA): Method by which an outside person or firm, not a party to a contract, provides specific administrative duties (including premium accounting, claims review and payment, arranges for utilization review and stop-loss coverage) for a self-funded plan. Entity may also handle payment of claims.

USUAL, CUSTOMARY, AND REASONABLE (UCR) FEES: Charges of healthcare providers that are consistent with charges from similar providers for identical or similar services in a given locale.

UTILIZATION REVIEW: The process of evaluating the appropriateness, necessity and quality at medical care for purposes of insurance coverage.

References:

National Association of Health Underwriters (NAHU): <http://www.nahu.org>

Consumer Guides for Getting and Keeping Health Insurance: <http://www.healthinsuranceinfo.net/>