Your Guide to Health Insurance:

What Common Words Mean

Health insurance protects you from the high costs of medical bills. With insurance, you do not need to worry about paying for medical care when you need it.

Memorial Sloan Kettering Cancer Center

Provider Networks

Some insurance plans will have a list of healthcare providers and hospitals you will choose from. This is called the provider network.

Healthcare providers in the provider network are called in-network providers. If you go to in-network providers, you will only need to pay the copayment and coinsurance out of your own pocket.

Healthcare providers who are not in your plan's provider network are called out-of-network providers. If you visit a healthcare provider out-of-network, your insurance may pay something but it will be more expensive for you.

Health Insurance Plans

There are different types of health insurance plans.

- Health Maintenance Organizations (HMOs) are plans that only let you see in-network providers. An HMO usually makes you get a referral from your primary care provider (PCP) to see a different kind of provider (called a specialist). Specialists are experts in caring for people with specific conditions, such as heart disease, brain disorders, and cancer.
- Preferred Provider Organizations (PPOs) are plans that let you see providers who are in-network or out-of-network.
- Indemnity Plans are plans where you pay some of the costs of healthcare. Your insurance pays the rest. These plans are also called fee-for-service.
- Medicaid is a free, public program for people who make below a certain amount of money.
    - Medicaid plans can be straight Medicaid (also called fee-for-service Medicaid). Or they can be a Managed Care Plan (MCP) to provide you with care at low cost.

Prescriptions

A prescription is a written or electronic order from your healthcare provider. It tells your pharmacist to provide you with specific medications. Not all drugs will be paid by your insurance plan. Check with your insurance or ask your pharmacy about which drugs are covered.

A formulary is a list of drugs that your insurance plan will pay for. These also are called preferred drugs.

You may hear drugs being described in 2 forms.

- Generic drugs have exactly the same active ingredient, dosage, directions, and strength as brand name drugs. But they do not have the name of a brand. Generic drugs are named after their active ingredient.
    - Ibuprofen is the generic name for Advil.
- Brand name drugs are the same as generic drugs. They cost more because they have the name of a brand.
    - Advil is the brand name of Ibuprofen.

What you pay for a drug depends on its level (or tier) on the formulary:

Tier 1 drugs are generic drugs, and usually the cheapest for you.

Tier 2 drugs are brand name drugs. They usually are given to you when the generic is not available.

Tier 3 drugs are not on the formulary. Your insurance plan only will pay for them if a healthcare provider says you need them.

If you think you were charged for something that your insurance plan should pay for, call your provider's office. Ask for an explanation. After speaking with them, you may still think your insurance plan should pay. If so, call the Member Services number on the back of your insurance card to file a complaint. A complaint is sometimes called an appeal or grievance. Member Services may ask you to confirm some information. This includes your name, date of birth, and the ID number on your insurance card.

There are some important words you should know that can help to better understand insurance. Here is a list of the words and their meaning.

A premium is what you pay your insurance company every month to have the insurance.

A deductible is what you must pay before your insurance plan starts to pay for healthcare services.

A copayment is what you pay on your own at every medical visit.

Coinsurance is when your insurance plan pays a part of your medical bill and you pay the other part.

An out-of-pocket maximum is the highest amount you will ever have to pay on your own for health services.

A yearly or lifetime limit is the highest amount your insurance plan will ever pay (every year or during your lifetime).

Cost-sharing is when your insurance plan does not cover the whole medical bill. You pay for the part it does not cover.

Prior authorization is when your insurance plan agrees to pay for a drug or treatment. You or your healthcare provider must call the plan to ask for prior authorization, based on your medical needs.

An explanation of benefits (EOB) is a form that tells you what your insurance plan paid for your medical visit. If you also must pay an amount, the EOB will tell you what you owe.

For questions about your NYSOH insurance plan or your health:

Please call your IHCD Navigator,

_____

(Navigator name)

at

_____

(phone number)

Memorial Sloan Kettering Cancer Center

Immigrant Health and Cancer Disparities Service
Towards Equity in Health