Know Your Insurance Benefits

At BlueSleep, we understand how confusing your health insurance might seem to you and we always strive for clarity.

Once you have registered online with us, our offices will check your insurance benefits to ascertain what services you are covered for before we provide them.

By pre-registering with us online, you will save time and effort so you won't be burdened with paperwork when you come to your first appointment at our office.

In this section, you will find a glossary of the most common insurance terms and explanations.

Benefit Year
A year of benefits coverage under an individual health insurance plan. The benefit year for plans bought inside or outside the Health Insurance Marketplace begins January 1 of each year and ends December 31 of the same year. Your coverage ends December 31 even if your coverage started after January 1. Any changes to benefits or rates to a health insurance plan are made at the beginning of the calendar year.

Coinsurance
Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. For example, if the health insurance or plan’s allowed amount for an office visit is $100 and you’ve met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

Copayment
A fixed amount (for example, $15) you pay for a covered health care service, usually when you get the service. The amount can vary by the type of covered health care service.

Deductible
The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1,000, your plan won’t pay anything until you’ve met your $1,000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

Health Insurance Marketplace
A resource where individuals, families, and small businesses can: learn about their health coverage options; compare health insurance plans based on costs, benefits, and other important features; choose a plan; and enroll in coverage.

The Marketplace also provides information on programs that help people with low to moderate income and resources pay for coverage. This includes ways to save on the monthly premiums and out-of-pocket costs of coverage available through the Marketplace, and information about other programs, including Medicaid and the Children's Health Insurance Program (CHIP). The Marketplace encourages competition among private health plans, and is accessible through websites, call centers, and in-person assistance. In some states, the Marketplace is run by the state. In others it is run by the federal government.

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 choices in how they design their program, so Medicaid varies state by state and may have a different name in your state.

Medicare
A Federal health insurance program for people who are age 65 or older and for certain younger people with disabilities. It also covers people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).

Medicare Advantage (Medicare Part C)
A type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If you're enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan and aren't paid for under Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.

Medicare Part D
A program that helps pay for prescription drugs for people with Medicare who join a plan that includes Medicare prescription drug coverage. There are two ways to get Medicare prescription drug coverage: through a Medicare Prescription Drug Plan or a Medicare Advantage Plan that includes drug coverage. These plans are offered by insurance companies and other private companies approved by Medicare.

Network
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Out-of-Network Coinsurance

The percentage (for example, 40%) you pay of the allowed amount for covered health care services to providers who don't contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

Out-of-Network Copayment

A fixed amount (for example, $30) you pay for covered health care services from providers who don't contract with your health insurance or plan. Out-of-network copayments usually are more than in-network copayments.

Out-of-Pocket Costs

Your expenses for medical care that aren't reimbursed by insurance. Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services plus all costs for services that aren't covered.

Out-of-pocket maximum/limit

The most you pay during a policy period (usually one year) before your health insurance or plan starts to pay 100% for covered essential health benefits. This limit must include deductibles, coinsurance, copayments, or similar charges and any other expenditure required of an individual which is a qualified medical expense for the essential health benefits. This limit does not have to count premiums, balance billing amounts for non-network providers and other out-of-network cost-sharing, or spending for non-essential health benefits. The maximum out-of-pocket cost limit for any individual Marketplace plan for 2015 can be no more than $6,600 for an individual plan and $13,200 for a family plan.

Prior Authorization

Approval from a health plan that may be required before you get a service or fill a prescription in order for the service or prescription to be covered by your plan.

Preauthorization

A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn’t a promise your health insurance or plan will cover the cost.

Glossary source: www.healthcare.gov/glossary