

Insurance Basics: Understanding & Using Your Plan

Managing a medical condition can be challenging. Know how to use your insurance plan so that you are prepared when you need care. This fact sheet covers basic insurance terms and tips to make your plan work for you.

Insurance terms

There are many different types of insurance plans, each with different functions. To learn more, see the [Private Insurance Fact Sheet](#). The terms below are common to most plans.

Premium is the cost of an insurance plan. Typically, premiums are paid monthly.

Deductible is the amount that must be spent by the policyholder on covered health care services before insurance coverage begins. Deductibles typically start over at the beginning of each coverage year, usually January 1.

Coinsurance is a form of cost sharing once the insured person has met the deductible. This means the insurer will cover a certain percentage of the costs of services and the insured will pay the remaining percentage. So, if a doctor charges \$100 for service, and the insured person's coinsurance is 30%, the insured pays \$30 while insurance pays \$70.

Copayment is a set dollar amount that an insured individual must pay for stipulated health care services. Copays are another form of cost sharing. Insurance plans may designate copays for visits to the doctor, urgent care, and emergency room. Additionally, many plans will have copays established for hospital stays, prescription drug benefits, and other services. Some insurance plans will use both copayment and coinsurance cost-sharing methods. Note: Copayments and/or co-insurance may not count toward deductible, so check your plan to know.

Provider is a person or business that provides health care services to consumers.

Network Providers or providers "in network" are those with whom your insurance plan has contracted. Examples include specific hospitals, pharmacies, physicians, etc. As such, insurance coverage and benefits are limited to network providers. Providers that are not contracted with your plan are "out of network." In general, you pay less for medical care provided by an "in network" provider than an "out of network" one.

Out-of-Pocket Limit/Maximum is the most money the insured must pay during a policy period (typically one year) before the cost of covered health care services is paid in full by the insurer. Out-of-pocket maximums usually include copayments and deductibles but do not include premium payments.

Coverage Limits restrict the number of certain covered services. For example, your plan may only cover 20 sessions of speech therapy per year.

Explanation of Benefits or "EOB" is a statement from an insurance company that provides an overview of any medical charges and how much you and your plan will pay. To view a sample illustrated EOB, visit [Reading Your Explanation of Benefits](#) (Note: This document is for Medicaid patients, but contains all of the essential components for you to better understand your own EOB.)

For more information about these programs and services, contact Indiana Family to Family at 1-844-323-4636 or visit inf2f.org.

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Tips for Using Your Insurance Plan

Get a copy of your plan for your records and refer to it as needed. Know the basics of your plan, like your deductible and co-pay and/or co-insurance amounts, so that you can be prepared to cover your costs of care.

Primary Care: With many plans you must choose a Primary Care Physician (PCP). This is your main doctor who provides non-emergency care, such as well visits or screenings, acute care when you have a minor illness or infection, or when you have a health problem that requires a diagnosis/treatment. Your PCP can do an examination, order tests, and/or make a referral to a medical specialist. You will then need to determine which physicians in that specialty area are “in network” for your plan and make an appointment.

Emergency Room Services: When you are facing a life-threatening emergency, dial 911 or go to the nearest emergency room.

Prescriptions: After an examination, your PCP or medical specialist may write a prescription for medication to be filled at a pharmacy. Review your plan to determine pharmacy options and coverage information, including co-pays. Some plans have a separate deductible for prescription medications. To explore other funding options, see the [Prescription Drugs Fact Sheet](#).

Pre-Authorization or Pre-Certification: Some services, such as surgical procedures, therapy/rehabilitation services, hospitalizations, medical equipment, etc., require pre-authorization (PA) or pre-certification from your insurance company before they are covered. Review your plan and work closely with your provider’s billing office to manage your coverage. If you need additional assistance or have questions regarding this process, call Indiana Family to Family at 1-844-323-4636.

Mental Health Services: Review your plan to determine how to access mental health services and in-network providers. If you need help exploring your options, see the [Mental Health Services Fact Sheet](#). If you are experiencing a mental health emergency, call 911, or visit your nearest emergency room.

Vision and Dental: Your insurance may include vision and dental coverage. Some employers offer these as add-on options, and the employee may pay all or part of the premiums. Review your policy to determine if it offers vision or dental benefits. For other funding options for dental, see the [Dental Care Fact Sheet](#). For additional funding sources for vision, contact Indiana Family to Family at 1-844-323-4636.

Appeals: If your plan denies payment for medical services that you believe are covered, you may file an appeal with your insurance company. If you are unable to resolve the problem with your insurance company and need further assistance, contact the U.S. Department of Labor (for self-funded plans) at 1-312-353-0900 (Northern Indiana) and 1-859-578-4680 (Southern Indiana) or call the Indiana Department of Insurance (for fully insured plans) at 1-800- 622-4461. If you are not certain what plan type you have, contact your employer’s benefits administrator or call the number on the back of your insurance card for more information.

If you require further assistance to use your plan, secure insurance coverage, or find other funding options, contact Indiana Family to Family at 1-844-323-4636.

Programs and systems change often. It is important to ensure that you are using the most current information. This fact sheet was updated May 2022. Please check <https://www.inf2f.org/fact-sheets.html> for the most recent edition.

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