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 INF2F's 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 on January 1.

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

Copayment is a set dollar amount that an insured person must pay for specific healthcare services. Copays are another form of cost sharing. Insurance plans may require copays for visits to the doctor, urgent care, and emergency room. Additionally, many plans will have copays required 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 for sure.

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

Network Providers (sometimes called "in network" providers) are providers that have a contract with your insurance plan. Examples include specific hospitals, pharmacies, physicians, etc. Insurance coverage and benefits may be limited to network providers. Providers that are not contracted with your plan are sometimes called "out of network." In general, you pay less for medical care provided "in network" than "out of network".

Out-of-Pocket Limit/Maximum is the maximum amount of money that the insured person must pay during a policy period (typically one year) before the cost of covered health care services is paid in full (or at 100%) by the insurance. Out-of-pocket maximums usually include the copayments and deductibles that have been paid, but do not include premium payments.

Coverage Limits restrict or limit 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 for them. To view a sample illustrated EOB, visit Reading Your Explanation of Benefits (Note: This document is for Medicaid patients, but it contains all of the basic information needed for all insured people to better understand their own EOB statements.)

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

Tips for Using Your Insurance Plan

Get a copy of your plan for your own records and refer to it as needed for any questions you have. Know the basics of your own plan, such as your deductible, co-pay, and/or co-insurance amounts. Knowing this can help you 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 testing or 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, you should dial 911or 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 insurance 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 INF2F's 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 insurance 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 insurance plan to determine how to access mental health services and in-network providers. If you need help exploring your options, see INF2F's Mental Health Services Fact Sheet. If you are experiencing a mental health emergency, you should call 911 or visit your nearest emergency room.

Vision and Dental: Your insurance may include vision and/or dental coverage. Some employers offer these as add-on options, and the employee may pay all or part of the premiums. Review your insurance policy to determine if it offers vision or dental benefits. For other funding options for dental care, see INF2F's Dental Care Fact Sheet. For additional funding sources for vision care, contact Indiana Family to Family at 1-844-323-4636.

Appeals: If your plan denies payment for medical services that you believe should be 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.

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

Programs and systems change often. It is important to ensure that you are using the most current information. This fact sheet was updated April 2024. Please check https://www.inf2f.org/fact-sheets.html for the most recent edition.

This fact sheet was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $89,140 with 87% percent financed with non-governmental sources. The contents are those of INF2F and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.