INSURANCE *basics*

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Navigating healthcare plans and insurance terms can often feel overwhelming, especially if you're new to the world of coverage options and its terminology. This guide is designed to clarify common insurance terms and key concepts to help you make informed, confident healthcare decisions.

The following definitions represent common terms you might come across when learning about and using your insurance plan.

TYPES OF HEALTH INSURANCE PLANS

Managed Care Plan	A type of health insurance plan that has negotiated costs to provide services to patients at a reduced cost. Providers within that contract are considered "in-network." There are 4 types: Exclusive Provider Organization, Health Maintenance Organization, Point of Service, and Preferred Provider Organization.	
Exclusive Provider Organization (EPO)	A managed care plan where services are covered only if you use doctors, specialists, or hospitals in the plan's network (except in an emergency).	
Health Maintenance Organization (HMO)	A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care, except in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage. HMOs often provide collaborative care with various specialty doctors and focus on prevention and wellness.	
Point of Service (POS)	A type of plan where you pay less if you use doctors, hospitals, and other healthcare providers that belong to the plan's network. POS plans require you to get a referral from your primary care doctor in order to see a specialist.	
Preferred Provider Organization (PPO)	A type of health plan where you pay less if you use providers in the plan's network. You can use doctors, hospitals, and providers outside of the network without a referral for an additional cost.	
Medicare	A federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with end-stage renal disease.	
There are 4 different parts of Medicare that help cover specific medical services:	**Medicare Part A (Hospital Insurance)**	**Part A** covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home healthcare.
	Medicare Part B (Medical Insurance)	**Part B** covers certain doctors' services, outpatient care, medical supplies, and preventive services.
	Medicare Part C (Medicare Advantage)	**Part C** includes Part A, Part B, and, often, Part D "bundled" from a Medicare-approved private insurance company.
	Medicare Part D (Prescription Drug Coverage)	**Part D** helps cover the cost of prescription drugs (including many recommended shots and vaccines).
Medicaid	A joint federal and state program that is the single largest source of health coverage in the US. Mandatory groups that must be eligible for Medicaid include low-income families, qualified children and pregnant women, and individuals receiving Supplemental Security Income (SSI). Individual states have additional options for coverage and may choose to cover other groups.	

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BASIC INSURANCE TERMINOLOGY

Appeal	A request for a health insurer or plan to review a decision (approval/denial) again.
Bridge	A patient access support program sponsored by a drug manufacturer that can help eligible patients access treatment if they experience an unexpected gap, change, or loss of insurance coverage.
Commercial Insurance	Health insurance that is sold and administered by a private company rather than provided by the government.
Copay	A fixed amount a person may pay for a covered healthcare service or product, usually when they first receive the service or product. The amount can vary by the type of covered healthcare service.
Deductible	The amount you pay out-of-pocket for medical expenses each year before your insurance helps with costs. For example, if your deductible is $1,000, you are responsible for expenses up to that amount. After that, your insurance shares more of the cost, which could lower your expenses for treatments like biologic medication.
Formulary	A list of generic and brand-name prescription drugs covered by a specific health insurance plan.
Healthcare Provider	A physician (typically a medical doctor), healthcare professional, or healthcare facility that is licensed, certified, or accredited as required by state law.
Medically Necessary	Healthcare services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.
Premium	The amount that you must pay for health insurance, usually monthly, quarterly, or annually.
Pharmacy Benefit Manager (PBM)	An organization that manages prescription benefits for insurance plans.
Specialty Pharmacy	A pharmacy that manages medications that are more complex, such as biologics.

Explore **https://www.healthcare.gov/find-assistance** to learn more about insurance.

DO YOU HAVE ANY OTHER INSURANCE QUESTIONS?

Contact your **Nurse Navigator* (1-833-931-6877, 8am-8pm ET, Monday-Friday)** to learn more about coverage and financial assistance options that may be available to you.

*Nurse Navigators do not provide medical advice and will refer you to your healthcare professional for any treatment-related questions.

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