These terms below are some of the most commonly-used terms seen when reviewing health insurance information, and are given to provide additional understanding of these concepts.

If your child receives Early Intervention (EI) services, you are never directly responsible for any related out-of-pocket expenses.

Types of Health Insurance

Each year, fewer New Yorkers are covered under fee-for-service health insurance plans, in which insured individuals go to a doctor of their choosing and then submit their own health insurance claims. Today, many New Yorkers receive benefits under one of the following arrangements:

Health Maintenance Organization (HMO).

An HMO is a form of managed care in which you pay a monthly premium in exchange for coverage. The monthly premium is the same, regardless of how many services you use in a month. Services are provided through a restricted network of providers, also called in-network providers. Enrollment in an HMO requires the selection of a primary care physician (pediatrician/family doctor) who may refer your child to specialists for health services. HMOs may also offer a Point of Service (POS) option which allows more flexibility when choosing a physician. The POS option is generally more expensive and may require higher copayments or coinsurance and deductibles.*

Individual/Family Plans.

Another option for families is to buy their own health insurance instead of enrolling in a health plan offered through an employer. There are many plan designs to choose from with varying deductibles, copayments and coinsurance amounts. The Affordable Care Act (ACA) has made it easier to compare and purchase health insurance plans. Individuals wishing to purchase plans in New York may visit www.nystateofhealth.ny.gov to determine if they are eligible to purchase plans through the New York State Exchange and view the plan options.* Plans sold on the NYS Exchange may include HMO, PPO, EPO, Medicaid, and Child Health Plus plans.

Preferred Provider Organization (PPO).

A PPO is a network of doctors and hospitals that have agreed to accept a discounted payment in exchange for direct reimbursement from an insurance company or third party administrator. This network of providers is offered through a health plan either on a group or individual basis. Typically there are deductibles and co-insurance amounts as part of the benefit plan design.

Services can be provided by non-contracted providers; however, a higher copayment and deductible amount is usually associated with out-of-network services.*

High Deductible Health Plan (HDHP). A health insurance policy that requires you to meet a deductible amount before the insurance policy begins to pay for most services. The monthly cost for a HDHP is typically less than that of a PPO plan due to the higher deductible. Health Savings Accounts (HSAs) are used in conjunction with a qualified High Deductible Health Plan (HDHP). Families can put money into the HSA on a pre-tax basis, and unlike a Flexible Spending Account (FSA), any unused money rolls over from year to year. Employers may offer the choice of a PPO plan and a HDHP plan and the overall cost differences can be significant.*

Exclusive Provider Organization (EPO). A type of managed care coverage in which you pay a monthly premium in exchange for services. The monthly premium is the same, regardless of how many services you use in a month. All of your coverage must be obtained in-network. With an EPO, you do not need a referral from your primary care physician to see a specialist. Out-of-Network care is not covered.

Fully Insured Plans versus Self-insured Plans Administrative Services Only (ASOs)/Third Party Administrators (TPAs): Understanding the difference!

There are two ways an employer can structure a group health plan.

The first option is a Fully-Insured plan that uses the **insurance company's money** to pay claims. Employees typically contribute toward the premium regardless of which type of plan they have.

The second is a Self-Funded/Self-Insured plan. These plans use the **employer's money** to pay medical claims. Employers will contract with an administrator, which may be an insurance company-- often referred to as an ASO or a TPA- to process and pay claims with the employer's money.

Copayment/Coinsurance/Deductible

Copayment. A copayment (or copay) is a fixed-dollar amount that is paid each time you receive services and procedures. Copayments are commonly required for doctor's visits, occupational therapy, physical therapy, speech therapy, and prescriptions.

Think of copayment as a "Fixed Fee", in that you will only be responsible for a pre-determined dollar amount, regardless of the amount of the charges. So, if the insurance lists a copay as $25, you will be responsible for only the $25, regardless of the total bill – it could be $30 or $3,000, or even greater.

When your child receives services under the EI program, the State will pay the copayment for you.

Coinsurance. Coinsurance is a percentage of the total bill that is paid for services and procedures. You are responsible for paying a pre-determined percentage based on the plan. Coinsurance is commonly in effect for Out-Of-Network procedures, as part of a PPO plan.

Think of co-insurance as "cost sharing" with the insurance company. For example, if your plan lists a procedure as an 80/20 coinsurance, this means you are responsible for 20% of the total bill. So, if the bill is $100, the insurance is responsible for $80 (80%), and you pay $20 (20%).

When your child receives services under the EI program, the State will pay the coinsurance for you.

Deductible. A deductible is a fixed amount of money during the benefit period – usually one (1) year - that needs to be paid before the insurance plan makes payments for covered services. Typical insurance plans have deductibles ranging from $1,500 to $5,000, but can also be outside this range, depending on the insurance plan.

For example, if your deductible is $2,000, and your medical bill is $2,500, you must pay $2,000 before your insurance plan will provide any benefits such as coinsurance. So, let's use the 80/20 example above for coinsurance. This means that if you paid the $2,000 deductible, that leaves a balance of $500. Out of the $500, insurance pays 80%, or $400; and under the EI program, the State would pay $20%, or $100.

** Remember that based on New York State law, Early Intervention (EI) services will be provided at no cost to the parent so EI services will never be denied because the deductible has not been met. Also, the State and municipality will pay for any copayment or coinsurance required under the plan.*

Common Insurance and Early Intervention Terms

Applied Behavior Analysis (ABA). The process of systematically applying interventions based upon the principles of learning theory to improve socially significant behaviors to a meaningful degree. ABA is most often used to help children with Autism.

Affordable Care Act (ACA). A federal statute signed into law by President Barack Obama on March 23, 2010. It was designed to improve access to high quality health care at a reduced cost by expanding the number of people eligible for government programs and private health insurance benefits.

Autism Spectrum Disorder (ASD). The term used to refer to the wide range of Autism symptoms that impair a child's ability to communicate and interact with others.

Administrative Services Only (ASO). A group health self-insurance program for large employers. The employer assumes responsibility for all risk and purchases only administrative services from the insurer.

Assistive Technology Devices (ATD). The term used when referring to assistive, adaptive, and rehabilitative devices for people with disabilities. These devices are billed as durable medical equipment (DME). Examples of ATD include adaptive eating utensils, walkers, and electronic communication devices.

Certificate of Creditable Coverage. The document an insurance company gives a member when their insurance coverage ends. The certificate includes information about when the coverage started and ended, and information about Health Insurance Portability and Accountability Act (HIPAA) rights. This certificate is evidence of previous insurance coverage.

Certificate of Insurance. The document or documents a member of a group health insurance plan receives that provides a summary of general terms regarding their coverage, eligibility, and benefits. The certificate of coverage is a different document from the insurance policy itself.

Child Health Plus (CHP). A health insurance plan for individuals who are under age 19 and live in New York State. These individuals' parent(s) earn too much income to qualify for Medicaid but not enough to pay for private health insurance. Parents can apply for CHP Coverage through the New York State of Health Marketplace. For more information, click here.

Coinsurance. Coinsurance is a percentage of the total bill that is paid for services and procedures. You are responsible for paying a pre-determined percentage based on the plan. Coinsurance is commonly in effect for Out-Of-Network procedures, as part of a PPO plan. For additional information, see "Coinsurance" above.

Copayment. A copayment (or copay) is a fixed-dollar amount that is paid each time for certain services and procedures. For additional information, see "Copayment" above.

Deductible. A deductible is a fixed amount of money during the benefit period – usually one (1) year - that needs to be paid before the insurance plan makes payments for covered services. For additional information, see "Deductible" above.

Direct/Indirect Cost.

Direct Cost. A cost that can be traced directly to or identified with a service or equipment provided; for example the actual cost paid to the EI provider including the copayment/coinsurance. These costs may be paid by the health insurance plan, or the State and county.

Indirect Cost. An expense that is difficult to predict. For EI services paid for under a health insurance plan that is not subject to protections under New York State law, an indirect cost would be the cost for children to receive services outside the EI program. To learn more about whether consenting to bill could save or cost you money later, click here.

Durable Medical Equipment (DME). Any equipment that provides therapeutic benefits to a patient because of certain medical conditions or illnesses.

Early Intervention (EI). A system of coordinated services that promotes age-appropriate growth and development for children age 0-3 years with developmental delay and/or disabilities, as well as support for their families.

Early Intervention Official (EIO). The EIO is appointed by the chief elected official of your municipality/county and administers the local Early Intervention Program. They can provide information about the program or explain how to refer a child.

New York State Early Intervention Program (NYS EI or EI program). The New York State Early Intervention (EI) program is part of the national EI program for infants and toddlers with developmental delays and/or disabilities and their families. First created by Congress in 1986 under the Individuals with Disabilities Education Act (IDEA), the EI is administered by the New York State Department of Health through the Bureau of Early Intervention (BEI). In New York State, the EI Program was established in Article 25 of the Public Health Law and has been in effect since July 1, 1993.

Effective Date. The date that your insurance coverage begins.

Essential Health Benefits (EHB). A specific set of health care service categories that must be covered by certain health care plans as outlined by the Affordable Care Act (ACA).

Exclusive Provider Organization (EPO). A type of managed care coverage in which you pay a monthly premium in exchange for services. For additional information, see "Exclusive Provider Organization (EPO)" above.

Explanation of Benefits (EOB). The insurance company's written summary of a claim. The EOB shows what the provider billed, what the insurance company paid, and the remaining amount still owed. It also includes an explanation of any denial or reduction in benefits paid. This is a very important document for your Provider. If you receive an EOB from your child's health insurance, please keep it in your records- your Provider may ask you for a copy of this document.

External Appeal. A request made to the New York State Department of Financial Services when an insurance company denies health care services. Both consumers and Providers have the right to an external appeal. External appeals are reviewed by an independent external appeal agent with medical experts that will either overturn (in whole or in part) or uphold the insurance company's denial.

Flexible Spending Account (FSA). A special account you put money into that you use to pay for certain out-of-pocket health care costs. You don't have to pay taxes on this money. This means you'll save an amount equal to the taxes you would have paid on the money you set aside. Remember: You should never provide account information regarding your FSA to the Service Coordinator.

Health Maintenance Organization (HMO). An HMO is a form of managed care in which services are provided through a restricted network of providers. For additional information, see "Health Maintenance Organization (HMO)" above.

Health Plan. See "Insurance Company" below.

Health Reimbursement Account (HRA). Employer-funded group health plans from which employees are reimbursed tax-free for qualified medical expenses up to a fixed dollar amount per year. Unused amounts may be rolled over to be used in subsequent years. The employer pays for and owns the account. Health Reimbursement Accounts are sometimes called Health Reimbursement Arrangements. Remember: You should never provide account information regarding your HRA to the Service Coordinator.

Health Savings Account (HSA). A medical savings account available to taxpayers who are enrolled in a High Deductible Health Plan. The funds contributed to the account aren't subject to federal income tax at the time of deposit. For more information, visit the U.S. Department of the Treasury website by clicking here.

Funds must be used to pay for certain medical expenses. Like HRAs, funds roll over year to year if you don't spend them. Remember: You should never provide account information regarding your HSA to the Service Coordinator.

High Deductible Health Plan (HDHP). The monthly cost for a HDHP is typically less than that of a PPO plan due to the higher deductible. HSAs are used in conjunction with a qualified High Deductible Health Plan (HDHP). For additional information, see "High Deductible Health Plan (HDHP)" above.

Individual/Family Plans. Families may buy their own health insurance instead of enrolling in a health plan offered through an employer. Plans sold on the NYS Exchange (www.nystateofhealth.ny.gov) may include HMO, PPO, Medicaid, and Child Health Plus plans. For additional information, see "Individual/Family Plans" above.

Individualized Education Program (IEP). A legal document that outlines a child's learning needs, the services their school will provide, and how progress will be measured.

Individualized Family Service Plan (IFSP). A written plan that includes the details of all the Early Intervention services your child and family will participate in- including when, where, and how often these services will be delivered as well as the goals of these services. This document may also include services your child and family needs that are not part of or paid for by the Early Intervention Program.

Insurance Company. The company that collects premiums and provides insurance coverage in return. An insurance company may be an HMO, commercial insurer or other entity.

Out-of-Pocket (OOP) Expense. The dollar amount health insurance plans do not pay and the insured person is responsible for.

Out-of-State (OOS) Plan. A health insurance plan issued and regulated by a state other than the State of New York.

Policy. A contract between the policyholder and the insurance company that provides the complete terms regarding coverage, eligibility and benefits. The policy includes any associated documents such as riders and endorsements that have been made a part of the policy.

Preferred Provider Organization (PPO). A PPO is a network of doctors and hospitals that have agreed to accept a discounted payment in exchange for direct reimbursement from an insurance company or third party administrator. This network of providers is offered through a health plan either on a group or individual basis. For additional information, see "Preferred Provider Organization (PPO)" above.

Primary Care Physician (PCP). The physician who provides first contact with a patient as well as continued care for various medical conditions without limit to the cause, organ system, or diagnosis. The PCP will provide a patient with a referral to a specialist when necessary.

Prior Authorization (Pre-Authorization). A decision by your health insurance that a service, treatment plan, prescription drug, or durable medical equipment is medically necessary. This must be obtained prior to receiving the service, plan, drug, or equipment.

Provider. Health care professionals or facilities that provide health care services. Providers include physicians, hospitals, health care practitioners, labs, clinics, pharmacies or other facilities or practitioners.

In- Network. A group of doctors, hospitals, and other health care providers contracted to provide services to insurance companies' customers for less than their usual fees. Provider networks can cover a large geographic market or a wide range of health care services. Insured individuals typically pay less for using a network provider.

Out-of-Network (OON) Provider. The term used to describe a healthcare provider who is not listed on a health plan's list of contracted providers.

Qualified Medical Expenses. Health care costs that can be paid for on a tax-free basis with a health savings account and that may qualify for other preferential tax treatment. The federal government defines what qualifies as a qualified medical expense. For more information, please visit the Internal Revenue Service's Web site by clicking here.

Schedule of Benefits. A document provided by the insurance company that lists the benefits covered by the policy and any deductible, copayments, and coinsurance.

Service Coordinator (SC). Under the New York State Early Intervention program, the SC assists children with disabilities and their families in accessing the services they require. Initial Service Coordinators assist with referrals, setting up evaluations, and completing the Individualized Family Service Plan (IFSP) if needed. On-Going Service Coordinators ensure children receiving Early Intervention services are able to obtain these services and will review and update the IFSP every six (6) months.

State Fiscal Agent (SFA). An organization that acts on behalf of another party and performs various financial duties. As the SFA for the New York State Department of Health Bureau of Early Intervention, Public Consulting Group (PCG) works with the Bureau of Early Intervention and Early Intervention Providers to complete the billing and claiming process.

Summary Plan Description (SPD). The main document health insurance plans use to explain the insured's rights and obligations.

Utilization Review. The insurance company's process of reviewing whether a health care service is medically necessary using clinical review criteria. Utilization review may take place before, during or

after the services are rendered. It must be conducted by an appropriate administrative personnel or health care professionals and overseen by a licensed physician.