1. **Participant Charges**
    a. **What is the medical billing process?**

Typically, when you visit the hospital, you will be checked in and be required to fill in information such as identification and coverage details.[1] You will be charged copayment when you visit and later receive another bill for the actual treatment.[1]

After your visit, the hospital will send the list of services you received to a claims processor at your insurance company, who interprets the bill.[4] This will include not only the services, but also the name of the doctor you saw as well as your relevant medical and coverage details.[1] After this information is collected, the coder will make it into a claim.[1]

When you get your claim/bill, Be sure to check and make sure you were not charged for procedures you did not receive. You should receive a bill not of the full charge but of what you are to pay. If you receive a surprise bill, you can file a complaint.[2] Otherwise, you would pay the bill. Please note, you will also receive an EOB (Explanation of Benefits) describing your coverage, which is different from your bill.[4]

1. https://www.medicalbillingandcoding.org/billing-process/#:~:text=Once%20a%20claim%20reaches%20a,accepted%2C%20denied%2C%20or%20rejected
2. https://www.insurance.ca.gov/01-consumers/110-health/60-resources/NoSupriseBills.cfm
3. https://www.healthcare.gov/
4. https://www.anthem.com/blog/health-insurance-basics/health-insurance-claims-process/

    a. **What do you owe?**

How the insured is billed depends on the insurance company. Most insurance companies now offer an online portal where payments can be made. However, many other options are available such as pay by phone, pay automatically, and pay by bank.

With insurance, the insured is generally billed for the premiums along with deductibles, coinsurance, and copayments. A **deductible** is the amount that the insured pays e.g. if the deductible is $1000, one must pay for all procedures up to $1000.[3]

Once the deductible is met, the insured only need to pay for the **copayment** for whatever services they receive.[3]

Additionally, once the deductible is met, the insured needs to only pay their **coinsurance** percentage of the remaining charges. This means if the remaining balance is $500 and the coinsurance is 25%, the charge is only $125.[3]

Payment will continue up to the insured's **out-of-pocket maximum**, outside of premiums and non-covered charges. An **out-of-pocket maximum or limit** is the maximum amount you will

have to pay, and after you meet this limit, your insurance plan pays all remaining charges as long as it is covered by your plan.[3]

b. Cost-sharing

Not everything is covered by the insured health insurance. Many will cover a portion of the bill, so the insured will need to pay for the remaining balance. This procedure is called cost-sharing.[3]

In general, cost-sharing will include the following:

i. Deductibles
ii. Coinsurance
iii. Copayments

However, it does not include premiums and certain services that are out-of-network or non-network. Do note, the premium exception may not apply to Medicaid and CHIP depending on states.[3]

c. Premiums

Premiums are payments the insured needs to make each month. Please note, when picking a plan, lower premiums tend to indicate lower coverage. Therefore, if you are in need of more health care, consider selecting a plan with higher premiums (but with low deductibles as that means less the insured needs to pay).[3]

1. https://www.medicalbillingandcoding.org/billing-process/#:~:text=Once%20a%20claim%20reaches%20a,accepted%2C%20denied%2C%20or%20rejected
2. https://www.insurance.ca.gov/01-consumers/110-health/60-resources/NoSupriseBills.cfm
3. https://www.healthcare.gov/
4. https://www.anthem.com/blog/health-insurance-basics/health-insurance-claims-process/

5. How to Choose and Enroll in a Plan

a. What should you consider?

Many factors need to be considered when choosing a plan. The first factors to consider are the amount of coverage one needs and costs. If one requires more health care, then consider a plan with higher premiums along with a lower deductible and lower copayment. If one is looking for a cheaper plan and requires less health care, a plan with lower premiums may be ideal. However, note that lower premium plans may have higher deductibles and copayments.

Example Plans:

Health Maintenance Organization or HMO: HMOs are plans with a set network of doctors and facilities you are permitted to visit, with a primary care physician determining your treatments.[1] Referrals are needed for specialists and out-of-network is not covered, but premiums and costs

are lower.[1] **As such, a key benefit** is that compared to other plans, HMOs tend to be cheaper. This may be the best plan for you if you do not need frequent care. If you travel frequently, you may want to consider another plan as HMOs do restrict you to in-network health care providers.[1]

Preferred Provider Organization or PPO: PPOs allow you to receive out-of-network care (at a higher cost) without referrals.[1] However, there are also higher premiums and deductible.[1] **As such, a key benefit** is there is more flexibility in providers. This may be the best plan for you if you need frequent care, especially from specialists and possibly you travel frequently.[1]

Point of Service or POS: POS are similar to HMOs but out-of-network care is covered (for a higher fee) and referrals are not required.[1] As such, POS are a blend of HMOs and PPOs, but deductibles are higher in POS.[1] **As such, a key benefit** is that there is more flexibility, but at a cost. This may be the plan for you if you need out-of-network care, but you want a primary care doctor assigning treatment.[1]

Exclusive Provider Organization or EPO: EPOs limited in the doctors and facilities you can see, but unlike HMOs and POS, primary care physicians do not dictate your care (referrals not needed).[1] Note, unless an emergency, out-of-network care is not covered.[1] **As such, a key benefit** is there is flexibility in specialists. This may be the best plan for you if you do not care about the range of doctors you can see but still would like to see specialists.[1]

b. Chart comparing advantages and disadvantages?

based off (1) and (2)	HMO	PPO	POS	EPO
Cost? *non-deductibles like premiums*	Low	High	Mid	Low
Out-of-Network Coverage?	No	Yes	Yes	No
Referrals Needed?	Yes	No	No	No
Required Primary Care Physician?	Yes	No	Yes	If you want

c. How do you apply/enroll?

There are multiple ways to apply or enroll into health insurance. If possible, one can enroll with their employer for employer-sponsored health insurance. Another option is that many universities offer insurance to their students.

However, if these options are not possible, one can apply on their own via a government marketplace or directly with an insurance company. There are also brokers one can buy health insurance with as a third-party.

Usually, the time to apply is during the insurance's open enrollment period, though there are exceptions for those who experience hardship and suddenly lose coverage.

1. https://www.insurance.com/health-insurance/difference-between-ppo-hmo-hdhp-pos-epo.html#What_is_a_PPO
2. https://www.justworks.com/blog/breaking-down-difference-between-hmo-ppo