

Say What?!?

An Introduction to Health Insurance-Speak

This document defines some of the common terms you'll run into as you navigate the complicated landscape of health insurance.

Networks. Insurance companies negotiate rates with specific providers and facilities, which are considered **preferred** or **in-network**. If you choose to go to a provider who is **not** in your network you may be required to pay a higher percentage of cost, higher co-pay, or the entire cost. A list of network providers can be found online for most insurance companies, but when you call to make an appointment with a medical provider, verify that the provider works with your insurance.



- **Health Maintenance Organizations: HMO's** are insurance plans that require you to choose a Primary Care Physician (PCP). You'll have to see your PCP first and will always have to get a referral from your PCP in order to see any Specialist. There is a network of providers that you must see to receive coverage.
- **Preferred Provider Organization: PPO's** are insurance plans that have network of providers that you can see for reduced fees negotiated by the insurance company. Participants are not required to use a network provider, but you may be responsible for more of the cost if you go outside of the network. PPO's do not require referrals to see Specialists.



Co-Payment (co-pay). Your co-pay is the specified amount you must pay for office visits, prescriptions and other services. Co-pays are often higher for Specialist medical providers, or for out-of-network, diagnostic, surgical, and emergency services. Co-pays do not apply toward your deductible.

Deductible. The amount of money you must pay out-of-pocket **before** your insurance will cover expenses. The deductible is paid directly to the medical provider, not to the insurance company. Some plans require a deductible to be met:

- before *any* services are covered
- *only* for specific procedures
- when services are *out-of-network*

Coinsurance. The portion you must pay towards the total cost of covered expenses. For example, if your plan pays 80% and you pay 20% of costs, the 20% you pay is called *coinsurance*. There is usually a maximum coinsurance you pay per calendar year. Coinsurance is usually *in addition* to any co-payments and deductibles.

Co-Payments are flat dollar amounts (i.e., my co-pay for my Primary Care Physician is \$40, while my co-pay for a Specialist is \$50); Coinsurance is defined as a percentage of the charges rendered.

Pre-authorization & Pre-certification. Approval by your insurance company for a specific procedure or service **prior** to the date of service. ***Even for covered procedures, insurance may deny payment if authorization was not made prior to the date of service.*** Staff at your doctor's office can assist with referrals, pre-authorizations and pre-certifications.



Exclusions: Insurance plans do not cover everything. Each plan will have a list of exclusions for things not covered. Make sure that you look over these exclusions so that you won't be surprised to learn that a service or procedure won't be covered. Also, always contact your insurance company before having any major procedure done to make sure that it is not excluded.

Preventative and Diagnostic services

Your insurance may classify laboratory work, x-ray, MRI, and other services as either preventative (routine) or diagnostic. Preventative services typically have different co-pay and/or deductible requirements than diagnostic services. Diagnostics usually cost more.

- **“Unexpected” co-pays:** In some instances, what begins as *preventative* care such as a colonoscopy, may become *diagnostic* care if a polyp is found and removed during the procedure. There is no way to make this determination before the procedure is performed.
- **“Additional” co-pays:** For some diagnostic testing, such as MRIs, CT scans, and Ultrasounds, a co-pay is required for each body part that is examined. Even if they are examined at the same time, they are considered by insurance companies as two exams and require two co-pays.

Formulary. Insurance companies will often only cover certain prescription drugs. A Formulary is the list of prescription drugs covered by a specific health insurance plan.

Is this covered?



Depending on the specifics of your insurance plan, there isn't always an easy answer to this question.

Just because a service is provided in your doctor's office does not mean that it will be covered by the co-pay. For instance, let's say you were long-boarding and you fell and scraped up your knees. You went to the doctor to get the wound cleaned and the doctor removed a rock that had been pushed into the skin. You would be responsible for the co-pay for the doctor's office visit, and the rock removal might be classified as a surgical procedure, which would have its own associated fee. Also, as noted above, co-payments are sometimes difficult to predict, since insurance companies treat preventive and diagnostic services differently, even for the same procedure. If you are having a preventive procedure (like a pap smear) performed, ask your doctor whether the procedure could be re-classified as a diagnostic procedure down the road.

Some services are covered **only** after a deductible has been met, **only** with network providers, or **only** if you pay a higher percentage of the cost.



Co-pays for prescription drugs and immunizations vary depending on the drug and how it is classified. Some may require higher co-pays or cost more until a deductible is met, including:

- Prescription drugs that are not “formulary.”
- Prescription drugs for which there is not a generic available.
- Immunizations
- Specialty and injectable medications

If you are planning any type of specialty or surgical procedure, verify coverage with your insurance provider **prior** to the date of service.

- Verify whether or not you need to go to a specific facility (in network).
- Find out if your insurance covers only part or all of the procedure.
- Ask how follow-up or after-care is covered.
- Preauthorization or pre-certification is often required.

Contact your insurance provider directly to find out if services, medications or procedures are covered.

