

Insurance 101

Here are some Important Questions to ask your Medical Insurance Provider.

- ❖ What is your copayment or coinsurance?
- ❖ Do you have any In-Network or Out of Network Deductibles? If so, what is the overall deductible?
- ❖ Are there other deductibles for specific services (e.g. laboratory or radiology services)?
- ❖ What is not included in the out-of-pocket limit?
- ❖ Are you required to obtain a referral from your Primary Care provider for specialty services?
- ❖ Are you required to obtain prior authorization for medical services or medications?
- ❖ Are there services that your insurance plan does not cover?

Common Health Insurance terms

Monthly premium is the amount you pay per month for your health plan.

Out-of-pocket costs are the expenses you pay for your health care that aren't reimbursed by your insurance plan. Out-of-pocket costs include deductibles, coinsurance and copayments for covered services. Health Plans usually have a maximum out-of-pocket amount per year before the plan begins to pay 100 percent of the allowed amount. This limit does not include your premium, balance-billed charges, penalties or charges that your health plan doesn't cover.

Copayment is a fixed amount (for example, \$15) you're required to pay for a covered health care service, usually at the time of service. Depending on your plan, this amount will vary by the type of covered health care service.

Coinsurance is your share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is \$1,000, your coinsurance payment of 15% would be \$150. This may change if you haven't met your deductible. The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the allowed amount is \$1,000, you may have to pay the \$500 difference. (This is called balance billing.) Your plan may encourage you to use in-network providers by charging you lower deductibles, copayments and coinsurance

Annual deductible is the amount you have to pay for health care services before your health insurance plan coverage kicks in. For example, if your deductible is \$5,000, your plan won't pay anything until you've paid \$5,000 for covered health care services that are subject to the deductible. For some services, the deductible is waived, meaning that amount is fully covered and not subject to the deductible. Health Plans have different annual deductible amount for the individual (or primary member) vs. family.

Allowed amount or contracted amount is the maximum dollar amount an insurance company will pay for a given procedure or service. If a provider has a contract with an insurance company, the provider and the insurance company negotiate an allowed amount for each service or procedure. If a provider has a contract with a health insurance company, then the health insurance company considers the provider in-network and the provider will not charge more than the allowed amount (as determined by the insurance company) for a given procedure.

Usual, Customary & Reasonable (UCR) is the average charge for a given procedure or service as determined by the insurance company and typically based on the provider's local area. If a provider is out-of-network, then there is no contractual agreement on how much he or she can charge for a given procedure. To help manage costs, insurance companies will often process out-of-network claims based on UCR. If the provider's actual charge exceeds UCR, then the patient could be responsible for the difference between the UCR and actual charge amounts.

The Affordable Care Act, or ACA, is the name for the federal health care reform law first introduced in March of 2010.

Here are a few of the highlights:

1. Everyone is now required to have health insurance (and nobody can be denied coverage).
2. Plans are sold directly from health insurance companies and also through public health insurance exchanges, or marketplaces, organized by state (and the federal government).
3. Financial assistance may be available if you qualify and enroll through an exchange or marketplace.
4. There are pricing rules and limits to how premiums can vary.
5. A defined set of "essential health benefits" are always covered under the plans.

All Affordable Care Act (ACA) health plans have certain basic requirements that insurance companies must meet. No matter what plan you buy, the coverage must include a government-defined benefits package, called "essential health benefits." These include:

- ✓ Ambulatory patient services;
- ✓ Emergency services;
- ✓ Hospitalization;
- ✓ Maternity and newborn care;
- ✓ Mental health and behavioral health;
- ✓ Prescription drugs;
- ✓ Rehabilitative services and devices;
- ✓ Laboratory services;
- ✓ Preventive and wellness care;
- ✓ Chronic disease management; and
- ✓ Pediatric services (dental and vision care for children under 19, in most states).

Beyond these essential benefits, each insurance company's health plans may differ. It's important to understand the differences between the plans being offered. And remember, all ACA plans are "guaranteed issue," meaning everyone can get health insurance coverage regardless of their past or current medical conditions.

We hope that this information has been helpful. It is important that you know as much as possible about your insurance coverage. Do not hesitate to contact your insurance company about coverage and benefit guidelines. Please feel free to speak with us if there are questions or concerns about our services and your coverage.