



Understanding Insurance Companies

What does my plan cover?

Insurance companies play a significant role in health care finances. Today, most health care insurance companies contract with providers to develop health networks. While there are many types of plans, common types are HMOs (Health Maintenance Organizations), and PPOs (Preferred Provider Networks).

Your insurance may be through a self-insured company with a TPA (Third Party Administrator). You may also utilize a government payer like Medicare/Medicaid. You may have a TPA who administers a government plan as well.

Finally, you may have indemnity insurance. These "plans" contract with providers and often receive fee discounts in exchange for participation in their network. Regardless of what type of network or plan you have, you should understand some key elements of each plan.

Is my service provider in my network?

Who is in your network? If a physician is in your network, you may be eligible for full benefits. If you choose to work with an out-of-network physician or service, your benefits may be reduced or refused.

If a medical service is out-of-network, you may have a Point of Services Option. Your plan may allow you to see out of network providers, however you may need approval and/or pay a premium above your usual premium.

Does my plan have exclusions?

Some insurance companies carve out procedures and/or testing and exclude them from coverage. Common terms are "experimental" or "not medically necessary." Each plan is different, and while one plan may identify a procedure or test as experimental, another may include it as part of their coverage. Before moving forward with any procedure or test, it is important to identify that it is covered.

What is pre-certification?

Pre-certification of benefits is an important insurance step. Prior to procedures/testing, your insurance may or may not require a pre-certification of that procedure. Prior to any procedure or test, it is important to pre-certify with your insurance company in order to determine if it is a covered benefit and at what level it will be covered. However, all insurance companies maintain the right to deny coverage. **Pre-certification is not a guarantee of benefits.**

What are co-payments?

"Co-pays" are a fixed amount paid by the patient at the time of service. Typical co-payments are for office visits, prescriptions, or hospitalizations.

Has my deductible been met?

Your deductible is the portion of health care that must be paid by the patient before insurance coverage applies. What is your deductible? How close are you to meeting it?

What is co-insurance?

Co-insurance is the percentage of allowable charges on your medical bill that you are obligated to pay. For example, if you have 80/20 co-insurance, you will be expected to pay 20% of allowable charges. If a bill is for \$1,000 under an 80/20 agreement, you will pay \$200.

What is maximum out-of-pocket expense?

Often insurance coverage includes a maximum annual out-of-pocket amount. Once you reach that amount, typically 100% of charges are covered. Each plan varies, so it is important to check with your insurance company.

How much will I actually be charged?

"Allowable charges" is a contractual agreement between the health care provider and an insurance company. On your Explanation of Benefits or EOB, you may see the term "allowable charges." This is the contractually agreed-to charge after discounts. In this case, your co-insurance will be based on allowable charges, not the actual charge.