Understanding Your Insurance Coverage

KEEP FOR YOUR RECORDS

While PartnerMD can't provide you with specifics on your benefit plan and coverage, we want to assist you in better understanding benefit plans as a whole. Understanding how your health insurance plan works is a vital component of being prepared for care, especially because coverage and benefits tend to change on an annual basis.

Below are important terms to understand and questions to ask your insurance representative.

Where do I obtain information about my health plan?

Each subscriber receives a policy handbook upon signing up for his or her insurance. You can also look for the toll free number listed on the back of your insurance card that will direct you to a benefits specialist. Covered benefits vary from policy to policy so it is important that you know your policy.

What does my plan cover?

Typically plans cover:

- Emergency services
- Hospitalization
- Laboratory tests
- Maternity and newborn care
- Mental health and substance-abuse treatment
- Outpatient care (doctors and other services you receive outside of a hospital)
- Prescription drugs
- Preventive services (such as immunizations and mammograms) and management of chronic diseases such as diabetes
- Rehabilitation services

Each plan's coverage is different, so you'll need to speak with your company's HR department or the carrier's benefits specialist for specifics.

What are deductibles, co-payments, coinsurance and out-of-pocket limits?

- A **deductible** is a set dollar amount that is required annually to be paid by the insured. The insurance will not pay any of your claims until this amount is paid by the patient. The medical provider must collect in full and is not allowed to adjust off any portion of this payment.
- **Co-payments** are set dollar amounts that you are required to pay according to your insurance policy at each office visit. There could be varying co-payment amounts based on the services (for example, allergy injections, labs and therapeutic injections).
- **Coinsurance** is the portion of medical expenses that you are responsible for after the deductible is met and the insurance company has paid its portion. For example, your policy may read 80/20, which means that your insurance will pay 80 percent of the claim and you will be responsible for the remaining 20 percent. Your policy manual will provide you with this information.

- **Out-of-pocket** limits are the most cost-sharing you will ever have to pay in a year. It is the total of your deductible, copays and coinsurance (but does not include your premiums). Once you hit this limit, the insurance company will pick up 100 percent of your costs for the remainder of the year. Most people never pay enough cost-sharing to hit the out-of-pocket limit but it can happen if you require a lot of costly treatment. Plans with higher premiums generally have lower out-of-pocket limits.

What does in-network and out-of-network mean?

- **In-network** refers to physicians and medical establishments that deliver patient services covered under the insurance plan. Insurance companies typically have negotiated lower rates with in-network providers.
- **Out-of-network** refers to physicians and medical establishments not covered under your insurance plan. Services from out-of-network providers are usually more expensive than those rendered by in-network providers. This is because out-of-network providers have not negotiated lower rates with your insurer.

How can I find out if something is a covered service?

You can review your covered benefits in your policy handbook, contact your customer service representative or speak with your HR department if you are currently employed. Additionally, you can review the Explanation of Benefits document that your insurance carrier sends you after you have received medical services. This will explain your charges and how it was reviewed and paid according to your policy by your insurance carrier. Any dollar amounts that you owe will match the statement you receive from the medical provider, as the medical provider obtains their information from the insurance carrier.

Every health care insurance policy differs even if the policy is under the same carrier, so knowing your policy can help avoid issues and frustration.

Our goal is to help you become more knowledgeable about health care plans and help minimize your out-of-pocket expense.

For medical billing issues or questions, please call (844) 618-5050. For all other questions, please contact your practice manager.