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Understanding my insurance - what do I owe?

It is important to understand how your health insurance plan works so that you can best anticipate your financial responsibility. In some respects, health insurance can be compared to your car insurance, but there are differences so it is good to learn how your health insurance works and how much you are responsible for paying.

What is a premium?

A premium is a payment that is paid to the insurance company to participate in the plan, similar to the premium for your car insurance. It is most commonly paid monthly. Some employers may pay for all or part of your premium, and some with lower incomes may be eligible for subsidies through the government under the Affordable Care Act. The premium is a separate payment from a copay, co-insurance, or deductible.

What is a co-pay?

A co-pay is a fixed amount that is paid at the time of service. Your insurance may have pre-determined co-pays that you are required to pay if you visit the doctor, go to the emergency room or urgent care, fill prescriptions or go to the hospital. The amount of the co-pay may vary and is often printed on your insurance card. For example, the copay to see your primary care provider may be less than the co-pay to see a specialist. The co-pay for generic medicines may be less than for brand name medicines, etc. It is important to know that the co-pay can be higher for an out-of-network provider than an in-network provider. You should be prepared to pay your co-pay at the time of service.

What is an "in network provider" vs. an "out of network" provider?

Your insurance company may contract with certain doctors and hospitals. These providers are considered to be in-network. Your insurance plan may only allow you to see providers that are in-network and you would have to pay for all services provided by someone who is out-of-network.

Some insurance plans may cover some of the costs for seeing out of network providers, but your out of pocket expense is usually higher than if you see in-network providers. One exception is Emergency Care. If you have an emergency and need to go to the ER at an out-of-network hospital, services are usually covered by your health insurance.

What is a deductible?

Just as with your car insurance, a deductible is a predetermined amount for which you are fully responsible before the insurance will start to pay its share. It may take several doctor's visits, tests, or services to meet your deductible.

It is important to realize the some services may not count towards your deductible and this will vary depending on your insurance plan. These are called exclusions and limitations, and may usually be found in your health insurance policy. Co-pays often do not count toward the deductible.

The deductible applies to each year, so money paid by you in the prior year will not count toward the next year's deductible. Your deductible may also be higher for out-of-network services than for in-network services.

If you have not met your deductible, you may be required to pay for all or part of your visit/treatment at the time of service.

What is a co-insurance?

Once you have reached your deductible, your insurance will start to pay for services. Many times, however, they will only pay for a certain percentage of the services. The rest is the patient's responsibility and is called the co-insurance.

For example, the insurance may pay for 80% of the services and you will be required to pay for the remaining 20%. The co-insurance may be higher for out-of-network providers. The co-pay does not count toward the co-insurance, so this will be money owed in addition to the co-pay.

What is a formulary?

A formulary is a list of prescription drugs that are covered by a specific health insurance plan.

A formulary can contain both name-brand and generic drugs. Patients pay co-pays on formulary drugs. If a drug is not on the list, the patient will pay much more, up to the full cost of the drug. Every healthcare plan has a different list of acceptable drugs and co-pay prices called tiers.

Health insurance plans usually have a committee of practicing physicians and pharmacists who recommend drugs for the formulary based on the drug's quality, safety, and effectiveness. Most health plans will pay for medications that have been approved for sale by the U.S. Food and Drug Administration.

What is an explanation of benefits?

Most of us have seen an "explanation of benefits" or EOB, but what does it mean? After you've visited a doctor, clinic, or hospital, an EOB from the insurance administrator tells you and your provider what portion of the provider's charges are eligible for benefits under your insurance plan.

The EOB is the result of the claims process. To better understand your EOB, let's look at the steps in the claims process.

If your physician is part of a provider network, and you have an insurance plan using this network, the provider usually sends your bill to the network to have the network discount calculated. The network sends the claim to your insurance administrator.

If your provider is not in a network, the provider may send the bill to you or your insurance company. If you're sent the bill, you'll submit the claim to your insurance administrator.

Your insurance administrator reviews the claim to determine your benefits. If another insurance company is involved, the insurance companies coordinate benefits to determine which plan is responsible for the charges. Your health insurance administrator sends you and your provider an EOB, and, when appropriate, your provider also receives a check.

Your EOB may identify:

- The patient and the service provided.
- The amount charged by the provider.
- The amount of the charges that are covered and not covered under your plan.
- The amount paid to your provider.
- The amount owed by you.

Remember that the EOB is not a bill, but it explains what was covered by insurance. The provider may bill you separately for any charges you must pay.

The information provided on this handout is for general educational purposes only. It is not intended to be used as a substitute for medical advice from your healthcare provider. Any concerns or questions you have about your health or the health of your family should be discussed with your physician. Please note that medical information is constantly changing. Therefore some information may be out of date.