The Patient's Health Insurance Primer

Let's face it. Health insurance is complicated and confusing for everybody. The following is a very basic description of how health insurance works and what happens with your bill when you visit your doctor or have a procedure.

Charges. The clinic or hospital sets fees for services they perform.

Allowable Amount. Insurance companies determine the amount they will pay for healthcare services. Some payers dictate this to healthcare providers (Medicare) while some payers may negotiate a discount with healthcare providers.

Patient Cost Sharing. Depending on your insurance plan, you may have to pay some of these amounts for your health care services in addition to your monthly insurance premium.

Patient Cost Sharing Terms

- **Co-payment**. A fixed amount you pay for a covered health care service, i.e. $30 for a doctor's office visit. Your insurance company requires the healthcare provider to collect this at the time of service. This amount may be different for services at the doctor's office, hospital, or pharmacy. Check your insurance card or policy.
- **Co-insurance**. Your share of the costs of a covered health care service, calculated as a percent of the allowed amount, i.e. 20%. You pay co-insurance *plus* any deductibles you owe. For example, the allowed amount for your doctor's office visit is $100 and you have already met your deductible, so you would owe $20.
- **Deductible**. The amount you owe for health care services covered under your insurance plan before your health insurance begins to pay. For example, you have a $1,000 deductible. You will have to pay the first $1,000 of covered health services before the insurance will pay anything. After you have paid $1,000, your insurance may cover a percentage of the cost of services and you must be the co-insurance amount. Deductibles may not apply to all services, i.e. preventive services like mammography or colonoscopy, so check your policy.
- **Out of Pocket Limit**. The most you pay during a policy period (usually a year) before your health insurance plan starts paying 100% of the allowed amount. This limit never includes your premium, balance-billed charges, or health care your health insurance or plan does not cover. Some plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit.
- **Balance Billing**. When a health care provider bills you for the difference between the provider's charge and the allowed amount. A preferred provider may NOT balance bill you for covered services.
- **Preferred Provider**. A health care provider who has a contract with your health insurer or plan to provide services to you at a discount. Check with your plan for a list of preferred providers or your plan has a "tiered" network and you must pay more for certain providers than others.
- **Preauthorization (Prior Authorization)**. Your health insurance may require preauthorization for certain health care services treatment plans, prescription drugs, or durable medical equipment before you receive them, except in an emergency. The insurer will require that the health care provider demonstrate that the service is *medically necessary*. Preauthorization is not a promise that your insurance will cover the cost.
- **Medically Necessary**. Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.

We are here to help. If you have any questions please ask to talk with Kalispell Gastroenterology's financial counselor.