UNDERSTANDING YOUR HEALTH INSURANCE

INSURANCE TERMS

COINSURANCE

The portion (usually a percentage) that a participant is required to pay for medical care after the deductible has been paid.

COPAYMENT

A flat fee that is paid with every doctor visit; the fee varies according to type of doctor (primary care versus specialist) and also place of service.

COVERED SERVICES

Those services that the plan agrees to pay for; most plans do not pay for all services.

CUSTOMARY FEE

The fee that the insurance plan feels is "typical" for a service or procedure. If the out-of-net-work doctor/hospital charge is more than this amount, you will be required to pay the difference.

DEDUCTIBLE

The amount of money you pay each year before your insurance policy starts paying.

FLEXIBLE SPENDING ACCOUNT (FSA)

A method to pay medical expenses with pre-tax dollars.

MEDICAL SAVINGS PLAN (MSP)

One type of tax-advantaged personal savings or investment account in which you set aside some money to pay for routine, out-of-pocket medical expenses and to build us savings for future medical costs. Consult with your benefits department to check on this option.

PREMIUM

The amount you pay each month in exchange for your insurance coverage; plans with more benefits have higher monthly premiums.

Since the cost of medical care is ultimately the patient's responsibility, insurance issues deserve early consideration. Call your insurance carrier or our office if you have specific questions about specialist care coverage.

For further information, go to www.COPEDS.com

HEALTH FOR LIFE

Understanding how health insurance works and what type of plan may be best for you can be a complicated process. The differences among the various plans are not as clear-cut as they once were. In general, services covered by your insurance carrier can vary depending upon the "up front" versus "down stream" costs and risk levels that you, your employer, and your insurance company have agreed to accept. Having an understanding of the various plans will help you: 1- get the most out of your current coverage, and 2- select the plan that is "best" for you the next time you have a choice.

AN INDEMNITY PLAN

This is the traditional type of insurance that allows you to select your doctor or hospital. You pay a monthly premium and then a percentage of the bill.

HEALTH MAINTENANCE ORGANIZATION (HMO)

HMO coverage means you must choose a doctor (or hospital) from the insurance plan's list. The doctors and hospitals on this list have a contract with your insurance company to provide your care.

PREFERRED PROVIDER ORGANIZATION (PPO)

A PPO has a network of doctors and hospitals that they provide for your use at a lower cost to you. Your costs are higher if you use doctors outside of the network. There are usually more doctors and hospitals to choose from in a PPO than in a HMO.

COPEDS NETWORKS

COPEDS has contractual arrangements with most major insurance plans and some smaller plans of central Ohio. Call the office or check our web site (www.copeds.com) for an up-to-date listing. For out-of-network patients, your insurance may pay for a portion of our services, and in some cases, may allow "in network" benefits for a few visits. Otherwise, we request 50% payment at time of service.

CHOOSING A PLAN

Choosing a health insurance plan is like making any other major purchase: you choose the plan that best meets your needs and your budget. For most of us, this means deciding which plan is worth the cost. For example, plans that allow you the most choices in doctors and hospitals also tend to cost you more. Plans that help to manage your care usually cost less, but give you less choice. But cost isn't the only thing to consider when selecting health insurance; you also need to consider what services are covered.

QUESTIONS TO CONSIDER

- Are my current doctors/hospitals on the plan?
- If I use a doctor or hospital outside of the plan, how much more will I have to pay?
- How do I arrange to see a specialist if needed?
- What deductibles & co-payments are required?
- How are coverage decisions made, i.e. how is "medically necessary" treatment determined?
- Does the plan cover medical supplies, weight- loss programs, home care, one-on-one counseling, and other services I may need?
- To what extent does the plan cover care for chronic illnesses that my family may need?

- What procedures require preauthorization?
- Does the lower premium of Plan "A" (over Plans "B" and "C") save enough to allow out-of-network care if needed or preferred?

PLANNING GRID

	Plan A	Plan B	Plan C
Premium/mo	_____	_____	_____
Deductible	_____	_____	_____
Copayment/office	_____	_____	_____
Copayment/hospital	_____	_____	_____
Copayment/medication	_____	_____	_____
Out-of-pocket	_____	_____	_____
TOTAL:	_____	_____	_____

DISSATISFACTION WITH YOUR HEALTH INSURANCE

Let your benefits department know if you are uncomfortable with the care you are receiving under your insurance plan. Poor health care can result in poor performance on the job, lost work days, and lost productivity, not to mention higher insurance costs if you develop problems.

PREPARE TO PAY OUT-OF-POCKET

No health insurance will cover every expense. For example, people with diabetes almost always have to pay out-of-pocket for diabetes education as this is a service most insurance plans do not cover. If possible, plan to set aside some money for out-of-pocket expenses to augment the care covered by your insurance. After all, you would spend $500-$1000 a year on tune-ups and other things over and above your warranty to keep your car in good running order--why not do the same thing for your body? Flexible spending accounts and medical savings plans may be options for you.

REFERRAL TO A SPECIALIST

Many insurance companies require referrals for specialist care (even if the specialist is in the network) in order for the office visit to be covered. The referral is not the same as pre-certification or pre-authorization for care. The referral must come from your primary care doctor and include the words "consultation with labs and x-rays."

HELP US HELP YOU

- If Dr. Zipf has a contract with your insurance, be prepared to pay your copay or coinsurance at each office visit.
- Provide us with complete information at each office visit, especially any insurance change.
- If you change insurance, check your plan's most recent provider directory to verify that Dr. Zipf is a provider.
- Check with your insurance to see if a referral (for consultation with labs and x-rays) is required prior to your specialist office visit.