Understand Insurance Terminology

Health care today is more complicated than ever, and simply understanding your benefits can seem like a real challenge. Here are some of the terms used by plans and providers, plus what they mean for you.

Understanding What You Pay

Copay

A copay (or copayment) is the flat dollar amount that you pay for an office visit to an in-network provider or for a prescription drug. It does not count toward your deductible. Copays can be different for each plan or service.

Deductible

The deductible is the annual amount you need to pay out of your pocket for covered health expenses before your plan begins paying a percentage of your costs. It can be different depending on where you seek treatment.

For example, if your deductible is $250 and your first covered medical bill for the year is $400, you will pay all of the first $250, but only a percentage of the next $150 (and each additional bill that year). That percentage is determined by your coinsurance.

Coinsurance

Coinsurance is the percentage of the total medical bill that you must pay after you have met your deductible for the year. For example, if you have a 10% coinsurance and you receive a bill for $150 (after deductible has been met), you would only pay $15. Coinsurance is different for each plan.

Ultimately, the amount you spend on coinsurance in a given year is limited by your plan's out-of-pocket maximum.

Out-of-Pocket Maximum

Every medical plan has an annual out-of-pocket maximum for in-network services. This is the most you will pay each year in deductibles, copays and coinsurance. There is also an out-of-pocket maximum for prescription drugs for each plan, separate from its medical out-of-pocket maximum.

Other Terms

Formulary
Each prescription plan has its own list of brand name drugs, called a "formulary." Your costs for brand name drugs are lower when you choose drugs on this list. Alternately, non-formulary drugs are those that are NOT on the list.

Primary Care Physician (PCP)
A single doctor who coordinates your medical care.

Precertification
When your doctor refers you for certain procedures, your plan may require precertification or prior approval of the procedures by your insurance plan. This is to ensure you are covered for the procedure. If you are referred to a provider or facility that is in your insurance network, your provider can usually obtain precertification or prior approval on your behalf. If the provider or facility is out of-of-network, you will likely have to obtain the precertification or prior approval yourself. Precertification requirements can be different depending on your plan.

If you do not get precertification for a treatment that requires it before undergoing the treatment, you may be held responsible for payment.

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