Common Insurance Questions

by: Adrianne Crawford

When patients call to make their first appointment, often times their first question is, "Will my insurance cover this?". Here are some common insurance definitions that will help you understand your policy.

Deductible

The deductible refers to the amount of money that the insured would need to pay before any benefits from the health insurance policy can be used. This is usually a yearly amount so when the policy starts again, usually after a year, the deductible would be in effect again. Some services, like primary doctor visits and annual exams, may be available without meeting the deductible first. Radiology, surgery, physical therapy, and labwork usually goes toward the deductible. Sometimes, there are separate individual deductible amounts and total family deductible amounts.

Co-insurance

This is the amount that would need to be paid by the insured before the insurance pays, this is usually after the deductible has been met. Co-insurance is usually a percentage of the contracted amount. Example: You have a 80/20% plan. The billed amount for an X-ray is $690. The contracted rate is $445. You are responsible for a 20% co-insurance, so your bill would be $89.

Co-payments

This is another term used for coinsurance. The only difference is if you have a copay amount, this is usually a set amount instead of a percentage. Sometime you will have a different set amount copay for a Primary Care Physicain, Specialist Physician, and ER visit.

Out-of-Pocket

This is the cost one would pay out of their own pocket. An out of pocket expense can refer to how much the co-payment, coinsurance, or deductible is. Also, when the term annual out-of-pocket maximum is used, that is referring to how much the insured would have to pay for the whole year out of their pocket, excluding premiums before the insurance would cover at 100%.

Coordination of Benefits

If the insured has available two or more sources that would cover payment for certain conditions, such being under a spouse's insurance plan along with their own, the insurance company would not pay double benefits. In this case the health insurance company would coordinate benefits to make sure each plan pays a portion of the service.

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