Educate yourself on getting the most out of your insurance!

As a courtesy to our patients, AI3 will contact patient insurance companies for care authorization. We recommend that patients contact their insurance company to educate themselves on their insurance plans. Here are explanations of some key health insurance words that you may hear.

• **ICD 10 Code** is the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) is a system used by physicians and other healthcare providers to classify and code all diagnoses, symptoms and procedures recorded in conjunction with hospital care in the United States (why a patient is visiting the doctor). *http://searchhealthit.techtarget.com/definition/ICD-10-CM*

CPT Codes are five-character codes used by insurers to help determine the amount of reimbursement that a practitioner will receive for services provided. **CPT codes** are the United States' standard for how medical professionals document and report medical, surgical, radiology, laboratory, anesthesiology, and evaluation and management (E/M) services. All healthcare providers, payers, and facilities use CPT codes. (What is being planned / performed at the doctor's office) *http://searchhealthit.techtarget.com/definition/ICD-10-CM*

A Network is the facilities, providers, and suppliers your health insurer has contracted with to provide health care services.

> • Contact your insurance company to find out which providers are "in-network." These providers may also be called "preferred-providers" or "participating providers."
>
> • If a provider is "out-of-network" it might cost you more to see them.
>
> • Networks can change. Check with your provider each time you make an appointment, so you know how much you will have to pay.

• **A Deductible** is the amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay.

> For example, if your deductible is $1,000, your plan won't pay anything until you've met your $1,000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

• **Co-insurance** is your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

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https://www.healthcare.gov/using-marketplace-coverage/common-questions/
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• **A Copayment** or copay is an amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or prescription drug. A copayment is usually a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit, lab work, or prescription. Copayments are usually between $0 and $50 depending on your insurance plan and the type of visit or service.

• **A Premium** is the amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly, or yearly. It is not included in your deductible, your copayment, or your co-insurance. If you don't pay your premium, you could lose your coverage.

• **Out-of-pocket** maximum is the most you pay during a policy period (usually one year) before your health insurance or plan starts to pay 100% for covered essential health benefits. This limit includes deductibles, co-insurance, copayments, or similar charges and any other expenditure required of an individual for a qualified medical expense. This limit does not have to include premiums or spending for non-essential health benefits. The maximum out-of-pocket cost limit for any individual Marketplace plan for 2014 can be no more than $6,350 for an individual plan and $12,700 for a family plan.

• **Explanation of Benefits (or EOB)** is a summary of health care charges that your health plan sends you after you see a provider or get a service. It is not a bill. It is a record of the health care you or individuals covered on your policy got and how much your provider is charging your health plan. If you have to pay more for your care, your provider will send you a separate bill.

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Questions to ask your insurance provider before having a procedure

When calling your insurance company prior to treatment is highly recommended. Please have a paper and pen at hand:

1. Ask the first name and first initial of their last name of the person that you are speaking to.
2. Ask the Insurance Representative if the call is being recorded.
3. Note the date and time of the conversation as well as the geographic location of the person you are speaking to.
4. Tell them you will be seeking treatment and these are the CPT codes ICD 10 codes you are anticipating will be used :

   CPT codes:

   ICD 10 codes:

5. Inquire if any referral, authorization or pre-notification is needed to have the procedure paid for by the insurance company.
6. It is important to understand what your deductible is and the current balance. Also ask what goes towards the deductible.
7. Ask what your out-of-pocket is and the balance. Also inquire what goes against your out-of-pocket and or what brings down the balance.
8. Ask the representative given the current balances of your deductible and out-of-pocket what would it cost you to have the treatment.
9. Inquire about any co-pays and or co-insurance that you should expect to pay for treatment.
10. Next inquire if there are any specific policies that the insurance company has regarding having the treatment. For example:" Do you need a specific diagnosis or documentation in your chart in order for the insurance company to pay for treatment?"
11. Ask any other questions that you may have.
12. At the end of the call ask the representative if there is a confirmation number for the call (please write it down if there is)
13. Ask the representative to read you the notes exactly as they are in the system.
14. Keep this information until the procedure has been processed through the insurance company

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