



## ***Bayside Medical Group, Inc.***

### **Understanding Your High Deductible Health Plan (HDHP)**

The cost of health insurance has skyrocketed. How can you decrease the cost of health insurance? One way (which we do not recommend, by the way) is to buy a policy with a “high deductible.” A lower monthly premium can be very attractive. Sometimes a HDHP is the only option available. But it can be hard to understand what a HDHP really means. We get so many calls about HDHP’s from patients who are unclear about them that we are writing this fact sheet to explain the HDHP plans.

#### **What is a deductible?**

Having a deductible simply means that each year you are responsible for paying all the cost of your medical bills up to a certain point. So, for example, if you have a \$2,000 deductible for yourself, your health insurance pays nothing to your doctor or the hospital or the laboratory until you yourself have paid the first \$2,000 of medical bills for that year. There is sometimes a family plan, so that if your family pays a total of \$3,000, say, then that counts as your deductible, and the insurance kicks in with your very first bill, since the family has already been hit with high bills.

#### **How does it work?**

Say you make a visit to our office. We will then send a bill to your insurance company for our services. The insurance company will then respond to our bill, and if you have not yet met the deductible for the year, they will tell us that we need to collect payment directly from you. Each plan is different. In some plans, your deductible and your annual out-of-pocket maximum are the same amount; once you pay that amount, you owe nothing more for covered services. In other plans, once you have met your deductible, you may still be responsible for a co-pay and/or coinsurance. Also, in all cases, insurance will not pay for services that are “covered benefits” under the specific terms of your plan, and any payments you make for “uncovered benefits” do not count toward meeting the deductible.

Even if you have not yet met your deductible, because you have this insurance, you will automatically receive a discount on our charges. For instance, say our full charges are \$80 for the visit, but the discounted price is \$65. You will owe us only \$65.

## **How do you hear about what you owe?**

When the insurance company responds to our bill and we know what you owe, we will send you our bill. This is the amount you need to pay. Depending on the insurance company, you may be able to pay these expenses using a debit card or special check from your Health Savings Account (HSA) . More commonly, however, you need to simply send us a check or call us and put it on your credit card.

## **Screening and Preventive Services**

There is an important exception to meeting the deductible before insurance kicks in with some HDHP's. Many HDHP's give you a break on so-called well visits – well child visits, annual check ups, etc. Many of the HDHP's ignore the deductible for well visits and pay their share of the visit, as though you had already met the deductible. You will still owe something, copay and/or coinsurance, but not the whole thing. Again, we will hear about this when we send the bill to the insurance company.

So, that's the outline of the HDHP. Each plan has different details, so it may not be so simple as it appears here.

You can find out more about the particulars of your own health plan by looking at the provisions that the insurance company sent you. We also stand ready to help. Just call our Business Office at 925-587-2505, and ask for help in understanding your plan. We know it isn't easy, and we regret our health system is so complicated. We can only hope that it gets simpler and less expensive. We are hoping.

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## **GLOSSARY**

**Deductible** - the amount of money you must spend each year before insurance kicks in.

**Co-payment** - a flat fee you need to pay at each visit. With an HMO, you would typically owe the co-pay and nothing more. With a POS or PPO, you may owe both a co-pay and coinsurance.

**Co-insurance** - a percentage of the fee for a service that you pay. For instance, your policy may say that if you go to an in-network provider, they will pay 80% and you will pay 20%. Usually the policy will call for you to pay a higher percentage of the bill for an out-of-network provider.

Your co-payment is always applied to your bill before your coinsurance. (See example at the end of this glossary.)

**Allowable amount (or allowable charge)** - For each service the insurance company has determined a maximum charge that a provider will be paid. For instance, you might be charged \$100 for a service, but the allowable amount for that service might be \$80. The total the practice will get paid for this service is \$80, part paid by the patient and part by the insurance company.

**Out-of-pocket maximum** - the total maximum amount of money you can pay each year. This consists of the deductible plus coinsurance. After you pay this total, the insurance pays 100 percent of any further charges. Note that with some plans, co-pays may still be required, even after reaching the annual out-of-pocket maximum. Most plans have different maximums depending on whether you choose in-network or out-of-network providers.

**Uncovered services** - services that insurance will not cover and you will need to pay for completely yourself. This is very specific for each policy. Example: most policies will not pay for procedures they judge to be "cosmetic." Another example: some policies say they will only pay for one physical exam per year after age 3 or 4; if you have two physical exams during that year, one visit would be called "uncovered."

**Covered Services** (sometimes called **Plan Benefits**) - the services that your plan will pay for. Insurance plans can differ from each other in what they cover, and they can change what these services are from one year to another.

**In-Network** - Your insurance company will identify a network of physicians, hospitals, labs, pharmacies, and other health service providers with whom they have negotiated special discounted rates for medical services. Generally, your costs will be lower if you use in-network services - there are often different deductibles, out-of-pocket maximums, co-pays and coinsurance rates for in-network and out-of-network services.

**Example** - Assume that you have met your annual *deductible* requirement. The charge for a comprehensive office visit may be \$175.00. The *allowable amount* with your insurance company might be \$100. You may be required to pay a \$20 *co-payment* for the office visit. You may then be responsible for 20% *coinsurance* of the remaining \$80.00, or \$16.00. In this example, you will have paid \$36.00 (co-payment plus coinsurance) and your insurance company will have paid \$64.00, or a total paid of \$100, which is the allowable amount, for a service with a charge of \$175.00.

The world of health insurance is complicated. For any questions, please call our Business Office, 925-587-2505.