CHOICE
Diagnostic Imaging

UNDERSTANDING COMMON INSURANCE TERMS

Please know Choice Diagnostic Imaging is a diagnostic radiology practice and not a physician's office. Therefore, your co-insurance, co-pays and deductible differ from your typical physician office visit.

Also, advanced radiology procedures, such as MRI and CT often require pre-authorization or referral prior to your exam and can take up to 48-72 hours to complete.

HELPFUL TERMS:

Allowed Amount

sometimes known as the "allowed charge," "maximum allowable," and "usual, customary, and reasonable (UCR)" charge, this is the dollar amount considered by a health insurance company to be a reasonable charge for medical services or supplies based on the rates in your area

Copayment

A fixed amount ($20, for example) you pay for a covered health care service after you've paid your deductible.

Let's say your health insurance plan's allowable cost for a CT scan is $200. Your copayment for an advanced diagnostic radiology service is $100.00

- If you've paid your deductible: You pay $100.00, usually at the time of the visit.
- If you haven't met your deductible: You pay $200.00, the full allowable amount for the visit.

Copayments (sometimes called "copays") can vary for different services within the same plan, like drugs, visits to specialists and diagnostic radiology services.

Generally plans with lower monthly premiums have higher copayments. Plans with higher monthly premiums usually have lower copayments.

Coinsurance

The percentage of costs of a covered health care service you pay (20%, for example) after you've paid your deductible.

Let's say your health insurance plan's allowed amount for a CT scan is $200.00 and your coinsurance is 20%.

- If you've paid your deductible: You pay 20% of $200.00, or $40.00. The insurance company pays the rest.
- If you haven't met your deductible: You pay the full allowed amount, $200.00.

Example of coinsurance with high medical costs

Let's say the following amounts apply to your plan and you need a lot of treatment for a serious condition. Allowable costs are $12,000.

- Deductible: $3,000
- Coinsurance: 20%
- Out-of-pocket maximum: $6,850

You'd pay all of the first $3,000 (your deductible).

You'll pay 20% of the remaining $9,000, or $1,800 (your coinsurance).

So your total out-of-pocket costs would be $4,800 — your $3,000 deductible plus your $1,800 coinsurance.

If your total out-of-pocket costs reach $6,850, you'd pay only that amount, including your deductible and coinsurance. The insurance company would pay for all covered services for the rest of your plan year.

Generally speaking, plans with low monthly premiums have higher coinsurance, and plans with higher monthly premiums have lower coinsurance.

CPT Code

The **Current Procedural Terminology (CPT)** code set is a medical code set maintained by the American Medical Association. The CPT code set describes medical, surgical, and diagnostic services and is designed to communicate uniform information about medical services and procedures among physicians, coders, patients, accreditation organizations, and payers for administrative, financial, and analytical purposes.

Deductible

The amount you pay for covered health care services before your insurance plan starts to pay. With a $2,000 deductible, for example, you pay the first $2,000 of covered services yourself.

After you pay your deductible, you usually pay only a copayment or coinsurance for covered services. Your insurance company pays the rest.

- Many plans pay for certain services, like a checkup or disease management programs, before you've met your deductible. Check your plan details.
- All Marketplace health plans pay the full cost of certain preventive benefits even before you meet your deductible.
- Some plans have separate deductibles for certain services, like prescription drugs.
- Family plans often have both an individual deductible, which applies to each person, and a family deductible, which applies to all family members.

Generally, plans with lower monthly premiums have higher deductibles. Plans with higher monthly premiums usually have lower deductibles.

Letter of Protection

A Letter of Protection is a letter sent by the attorney of an injured party to a medical provider agreeing to pay the medical expenses owed by the patient out of any future recovery whether by settlement or by trial and judgment. It is a contractual agreement that allows the injured person to get the care they need effectively on credit with the creditor (the medical provider) agreeing to wait until the conclusion of the case to demand payment. If the attorney settles the case or obtains a judgment in the case, the attorney then has an obligation to make sure the medical provider's bill gets settled out of those funds. If there is no recovery (i.e. the injured person goes to trial and loses the case), then the injured person is still responsible for the bill and the medical provider retains the right to pursue them for the remaining balance.

Medicare

A federal health insurance program for people 65 and older and certain younger people with disabilities. It also covers people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).

Medicare isn't part of the Health Insurance Marketplace. If you have Medicare coverage you don't have to make any changes. You're considered covered under the health care law.

Medicare Replacement or Advantage Plans (Medicare Part C)

A type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If you're enrolled in a Medicare Advantage Plan, most Medicare services are covered through the plan and aren't paid for under Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.

Out-of-pocket maximum/limit

The most you have to pay for covered services in a plan year. After you spend this amount on deductibles, copayments, and coinsurance, your health plan pays 100% of the costs of covered benefits.

The out-of-pocket limit doesn't include your monthly premiums. It also doesn't include anything you spend for services your plan doesn't cover.

Example of out-of-pocket maximum with high medical costs

Let's say you need surgery with allowable costs of $20,000, and the following figures apply to your health insurance plan.

- Deductible: $1,300
- Coinsurance: 20%
- Out-of-pocket maximum: $4,400

You pay the first $1,300 of covered medical expenses (your deductible).

Your 20% coinsurance on the rest of the costs ($18,700) comes to $3,740.

So your total costs would be $5,040. That's $1,300 (your deductible) plus $3,740 (coinsurance).

But your out-of-pocket maximum is $4,400. Your insurance company pays all covered costs above $4,400 — for this surgery and any covered care you get for the rest of the plan year.

Generally, plans with lower monthly premiums have higher out-of-pocket limits. Plans with higher premiums usually have lower out-of-pocket maximums.

Personal Injury Protection for Auto Insurance (PIP)

Florida is one of ten states that have personal injury protection (no fault) auto insurance. The intention was to provide injured drivers up to $10,000 in immediate medical coverage in lieu of establishing fault through the court system. The goal was to reduce payment delay for injured drivers, as well as limit the utilization of the court system. In Florida, PIP coverage is required to be purchased by all owners of motor vehicles registered in this state. PIP coverage makes the individual responsible for their own injuries in an accident regardless of fault.

Preauthorization

A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Prescription

An instruction written by a medical practitioner that allows a patient to be provided a medicine, treatment, or diagnostic test.

Referral

A referral is different than a pre-authorization, and is a specific pre-approval that individual health plan members--primarily those with HMO's—must obtain from their chosen primary care physician before seeing a specialist or obtaining diagnostic imaging services within the same network.

Worker's Compensation

An insurance plan that employers are required to have to cover employees who get sick or injured on the job.