Defining Terms

The amount you pay for medical expenses before the insurance plan begins to cover any additional costs. You will have to pay this amount before any payment is made by your insurance company.

Formulary

A list of medications drugs covered by a plan’s medical policy.

Genetic testing

A test to look for changes in your DNA that can be linked to an increased risk of disease or a specific medical condition or trait. It uses your information to help choose treatments or personal health decisions.

Pharmacy Benefits

A comprehensive medical policy contains several areas of coverage. In order to plan what will be covered, you may need to check with your health insurer to find out what is covered in your plan. Virtual limitations or exclusions may include eye exams and contact lenses, dental care, fertility treatment, cosmetic surgery and alternative or complementary care such as acupuncture therapy. Some plans will limit coverage for some expensive insurance-covered treatments. This is an important consideration before you make a medical decision.

Diagnosis

If you are unable to Afford Your Care — Investigating how to pay for healthcare costs can make a chronic condition worse, or cause you to delay seeking care, can be stressful, inspire you to change your approach to your health care, and can lead to increased costs in the long run. For patients who are looking for financial help, many providers will discuss a payment plan or offer solutions that may help you pay for your care.

Choose Generic Medication When Possible

Over the Counter Medications

These are drugs covered by a patient’s prescription drug plan. They are generally less expensive than brand-name drugs. They have the same dosage, intended use, effects, risks, outcomes, save the patient from many unnecessary and unpleasant side effects, and can save a lot of money for both you and your insurer.

Talk to your insurance company about what genetic tests and treatment options are covered in your plan.

Essential Health Benefits

Defined by the Affordable Care Act

The subset of health benefits required under the Affordable Care Act. These benefits cover certain preventive and essential services.

For more information, visit patientadvocate.org or call 1-888-808-2583.

For more information about your Affordable Care Act coverage, visit healthcare.gov to explore health plan options and compare plans.

Health Insurance Matters

If you have health insurance, you are more likely to seek care for certain health conditions and illnesses. Keeping your coverage current by paying your premiums on time is an important part of your health insurance plan. Your payment of premiums and your insurance will be in effect until the end of the year.

Preauthorization

Your insurance plan may require prior approval for certain services, drugs or regulations to consider any charges. Preauthorization is a prerequisite that your insurance plan will cover the cost of the service.

Essential Health Benefits Defined by the Affordable Care Act

These are services and medical devices not covered under the Federally defined essential health benefit categories. They are services and medical devices that are used to treat a particular illness or injury in the same way that other medical devices are used.

A Trend in Treatment: Personalized Medicine

Genetic testing and personalized medicine are rapidly evolving as breakthroughs in medical science. Genetic testing only helps identify an underlying risk for developing certain diseases or conditions, but it can also provide additional information as it becomes a trend to treat a condition. In addition to cancer, personalized medicine is helping with the development of new treatments for complex diseases like diabetes, leukemic-familial, and Alzheimer’s disease, which are thoughts to be caused by a combination of genetic and other factors.

Words That Impact Your Bill

The amount you pay for medical expenses before the insurance plan begins to cover any additional costs. You will have to pay this amount before any payment is made by your insurance company.

Out of Pocket Maximum

The highest amount of money you will have to pay during the year. It includes your premiums, deductibles, co-insurance, and copays. Once you reach this amount, the insurance company will pay 100% of any medical expenses that you incur, no matter how much they cost.

Non-Covered Benefits & Exclusions

Services and treatments the insurer considers unnecessary or not needed. Some plans will limit coverage for treatments like massage therapy, chiropractic care (such as massage therapy), and alternative or complementary treatments (with the exception of acupuncture). Limitations or exclusions may include a list of medications drugs not covered or are only covered with approval pre-authorization.

How to Read a Pharmacy Benefit Provider

Your insurance policy—does not pay for services, products, or drugs based on your specific genetic makeup. For example, many unique tumor types are covered in your plan.

Know Your Plan, Save Your Wallet

Reading and understanding your health plan’s key words and phrases will help you understand ways to control costs.

Pharmacy Benefits

In order to fill a prescription drug, most insurers will require you to meet your deductible amount. Once you have met your deductible, the insurance company will pay a certain percentage of the cost of the drug. Your copay will depend on within the formulary drug plan formula. The three drug classes usually range from 1% to 5%. Higher tier drugs will have a defined out-of-pocket cost based on the type or usage of the medication.

A list of medications drugs covered by a plan’s medical policy. This is an important consideration before you make a medical decision.

Talk to your insurance company about what genetic tests and treatment options are covered in your plan.

Know Your Plan, Save Your Wallet

Words That Impact Your Bill

The amount you pay for medical expenses before the insurance plan begins to cover any additional costs. You will have to pay this amount before any payment is made by your insurance company. If you have insurance through the workplace, your employer may pay all or part of your insurance costs out of the workplace, on behalf of all or part of your employee benefits package.

Premium

The amount you must pay for your health insurance plan’s coverage. If you have insurance through the workplace, your employer may pay all or part of your insurance costs out of the workplace, on behalf of all or part of your employee benefits package.

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How is My Plan Structured?

What is my plan called? In addition to a copay or deductible, understanding the co-payment structure can help you see how your benefits work.

Benefits and Coverage

You could be seeing a group or individual plan, understanding the copayment structure can help you understand how costs are calculated.

Inpatient Services:

When seeking care, be aware of the providers available through your health plan. If you choose a short-term health plan, you may not have access to all the services you might receive from a traditional, comprehensive plan, such as in the types of care and providers you can access.

Primary Care

Many providers specialize in primary care, including family physicians and trained medical personnel who practice family medicine, pediatrics or internal medicine. A primary care physician is your main healthcare provider and usually your first point of contact. This physician will follow-up preventative care services, such as physicals, in addition to other specialty services.

This can be a less expensive way to access care. You will pay a lower copay for a visit to see your primary care physician than you would if you went directly to a specialist.

Primary care services include:

- Well-visits
- Preventive screenings
- Basic healthcare services
- Scheduled care

High Deductible Health Plan (HDHP) insureds lower premiums and a higher yearly deductible than a traditional health plan. These plans are geared toward healthy people who cannot or don’t want to pay large monthly premiums.

Advantages of HDHP:

- Lower monthly premiums
- Higher deductible
- Known out-of-pocket costs
- Tax advantages

Disadvantages of HDHP:

- Deductible is paid before co-insurance or copay applies
- Insurance company cannot guarantee coverage
- Deductible amount can increase
- Certain services are not covered

High Deductible Health Savings Account (HDHSA) is a tax-advantaged personal bank account that is used to pay for eligible healthcare expenses. The HSA is a savings account that is used to pay for qualified medical expenses such as deductibles, co-insurance payments and some preventive care.

The great thing about an HSA is that it is an individual savings account, which means that you can take your money with you when you change jobs or employers. If you have an HSA, your employer may contribute money to your account or you may be able to contribute on a pre-tax basis. If you make a withdrawal from your HSA, you will be penalized unless you have a qualifying event such as a medical emergency.

Emergency Care

All plans are required to have an emergency condition that poses an immediate danger to a person’s life or health. These plans are designed to cover unexpected services for conditions that are not considered to be a true emergency but are important to have coverage for in case of an emergency.

Emergency Care:

You may also find a way to pay for these unexpected injuries and illnesses.

Emergency care providers are providers who accept Medicare as payment from Medicare beneficiaries. If you have Medicare, your Medicare plan will cover the costs of care you receive from an approved emergency care provider. If you do not have Medicare, you will need to pay for the costs of care you receive from an approved emergency care provider.

Visit an approved emergency care provider and receive the same level of care that you would receive from a non-emergency care provider.

Emergency care is important to have coverage for in case of a medical emergency.

Emergency care providers are not required to offer emergency care to Medicare beneficiaries. If you have Medicare and you do not receive emergency care from an approved emergency care provider, you may be responsible for the costs of care you receive from a non-emergency care provider.

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