Midwifery Business Consultation

A Guide to Understanding Health Insurance

Our goal is to strive to help you get the most out of your insurance plan. Use this guide to help you understand what health insurance is, as well as the following most common questions asked by individuals like you:

How Much Will You Pay Out of Your Pocket?

Your premium + your deductible + any coinsurance you must pay (up to your out-of-pocket maximum) + any copayments = the most you will pay for healthcare each year (for covered services).

Out-of-pocket maximums are typically between $1,000 for an individual and up to $11,000 for a family. Once you reach the out-of-pocket maximum, insurance pays for 100 percent of your medical care (for covered services).

How you reach that out-of-pocket maximum is based on how much you pay for your medical care up front. This depends on your deductible and coinsurance percentage. The higher your deductible, the lower your monthly premiums will be, because you are willing to pay for some of your care up front.

It is important to understand that premiums are costs that you pay regardless of whether you use medical services. Deductibles only become expenses once they are incurred.

Understanding How Health Insurance Works

Let's say that you are in a serious accident. You've accumulated $50,000 in covered medical expenses.

A sample health insurance plan might offer:

- Deductible: $5,000
- Coinsurance: 20 percent
- Out-of-pocket maximum: $6,000
  - In the example above, you would be responsible for the first $5,000 (your deductible).
  - After you pay your deductible of $5,000, you would be responsible for 20 percent coinsurance until you reach your out-of-pocket maximum of $6,000 (in this case, you would be responsible for another $1,000).
  - Your health insurance plan would pay the rest of the covered medical expenses (in this case, 80 percent).
  - After you reach your out-of-pocket maximum, you would pay nothing for any additional covered medical expenses for the rest of the plan year.

  - **Deductible**: The amount you're responsible for paying for covered medical expenses before your health insurance plan begins to pay for covered medical expenses each year.

Coinsurance: The percentage you must pay for care after you've met your deductible. This is shared costs between you and the health insurance plan. For example, you pay 20 percent of

costs and your plan pays 80 percent. These percentages may be different from plan to plan. Some plans may not have coinsurance.

Copayment: The payment you make, usually a fixed dollar amount such as $15, each time you visit the doctor or fill a prescription medication. Not all plans have copayments. These typically do not accumulate toward the deductible.

Out-of-pocket maximum: The most you will have to pay for covered medical expenses in a plan year through deductible and coinsurance before your insurance plan begins to pay 100 percent of covered medical expenses.

Covered Services

Services or supplies for which your health plan will pay (or "cover") all or a portion of the cost. Most health plans do not cover all services and supplies, and it is important to be aware of any limitations and restrictions that apply to your covered services.

Is my doctor or hospital covered by the plan?
You need to check the insurance plan's network provider directory to confirm that your doctor or hospital is included in the plan's network. If you use doctors that are in the plan's network, you will receive the highest level of benefits. Does the plan cover Certified Nurse Midwives? What is the specific maternity care policy for their plan?

Does the health insurance plan cover my family?
Make sure to purchase family coverage and not single-only coverage just for you if you need coverage for your family now or in the near future. Will the plan cover newborn care by a Certified Nurse Midwife and home visit services?

Are prescription drugs covered under my health insurance plan?
Prescription medication coverage varies by plan. Some plans require that you pay a copayment depending on the type of drug purchased, after which the insurance will pay the rest of the cost. Other health plans require that you must first meet your deductible before anything is paid. Most drugs have a formulary, or list of drugs, that the plan covers.

In-Network

A group of physicians, hospitals, and other health care providers who participate in a specific managed care plan. When you receive care from an in-network provider, you pay only a copayment for covered services.

Out-of-Network

Physicians, hospitals, and other health care providers who do not participate in your plan's network. Services obtained from an out-of-network provider are subject to deductibles and coinsurance. Make sure your plan has out-of-network coverage.

Pre-Authorization
Does your insurance require pre-authorization for any services?

Out-of-Pocket Maximum
When the deductible and coinsurance amounts you have paid in a plan year add up to the out-of-pocket maximum, the health plan will begin covering 100% of eligible charges for the remainder of the year.

Preferred Provider Organization (PPO)
A type of insurance product that combines in-network and out-of-network coverage. When you use in-network (or "participating") physicians and hospitals, you pay only a copayment for covered services. You also have the flexibility to see out-of-network ("non-participating") providers, but you will be responsible for a deductible and coinsurance for inpatient and outpatient covered services. The Harvard Student Health Insurance Plan is a PPO plan.

Exclusions
Specific conditions or circumstances for which a health plan will not provide benefits

Medically Necessary Services
Services or supplies which are appropriate and necessary for the symptoms, diagnosis, or treatment of a medical condition, and which meet additional guidelines pertaining to necessary provision of medical or mental health care. Services must be medically necessary in order to be covered.

Usual and Customary Fee/Allowed Amount
The common cost of a specific medical service; this fee can be lower than what a physician charges and is based on a variety of criteria including provider type and service region.