Understanding Insurance-Speak

Dear Patient:
The language of healthcare used to be a while lot simpler. Today, under managed care, new, sometimes bewildering terms seem to crop up every year. If you feel confused, don't worry – you are not alone. We've put together the following glossary of some of the most widely used managed care terms. If you'd like a fuller explanation of anything you see below, please don't hesitate to ask a member of the staff.

Access – your ability to see the physician, or to obtain other healthcare services, whenever necessary.
Ancillary services – services other than orthopaedic surgery (home healthcare, physical therapy, occupational therapy) that your surgeon may suggest to help you get better quicker.
Appeal – your right to have a coverage decision by your health plan reviewed. Our physicians and staff stand ready to assist you, if necessary, in this process.
Capitation – the way some health insurers pay doctors, not on the cost or number of services we actually deliver, but on a fixed formula. Typically this is some dollar amount per patient (or "covered member") per month.
Copayment (copay) – a flat, out-of-pocket fee (typically $5-25) that your health plan requires the physician collects each time you visit. You will also pay this flat fee for many of the prescriptions your pharmacist fills.
Deductible – a flat amount you must pay before your health plan will pay for any of your care.
Fee schedule – the fee determined by your health plan and accepted contractually by the physicians for specific procedures or services. Also known as a *fee allowance, fee maximum,* or *capped fee*.
Formulary – a list of drugs that your health plan encourages, and in some cases requires, the physician to prescribe in order to reduce costs. You'll usually have a lower copay for such formulary medications than for other drugs.
Health Maintenance Organization (HMO) – a health plan that offers a full range of medical services for a set, prepaid premium. In an *open-panel HMO,* you may receive non-emergency services from a specialist, without first getting approval from your primary care doctor. In a *closed-model HMO,* the doctors you see are all employees of the HMO or belong to a physician group that contracts with the HMO.
Medically necessary services – diagnostic or treatment measures that the surgeon believes are appropriate given your physical condition. Your health plan may refuse to pay for something, claiming it's not a medically necessary services when, in fact, they may just not cover it because its' too expensive. You have the right to appeal that decision (see appeal above).
Network – the group of physicians, hospitals, and other healthcare professionals that a health plan contracts with to deliver medical services to its members. Patients receiving services from providers outside this group are said to be going "out-of-network".
Point of service plan (POS) – a health plan option that permits you to choose, at the time you need medical services, whether to go toa network doctor or an out-of-network doctors.
Pre-authorization (also called "precertification") – the approval we must get from your health plan before admitting you to the hospital or proving or referring you fro other types of specialty services. Without this approval, your medical care may not be covered.
Preferred provider organization (PPO) – a benefit arrangement that offers you a discount for using designated doctors but that also permits you to use, at a higher fee, physicians that haven't contracted with the PPO.
Usual and customary – the measure insurers use to determine physician reimbursement for a certain medical services within a specific geographical area. To determine usual and customary fees, insurers look at the range of fees doctors in the area charge for the same service. If they choose to reimburse at the lower end of the range, our charge *could* be higher than the "usual and customary" fee because that fee doesn't adequately cover our cost of providing the service.

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