Understand the fine print of your plan:

Your health insurance policy is an agreement between you and your insurance company. It is generally negotiated by your employer if it is an employee benefit. The policy lists a package of medical benefits such as tests, medications and treatment services. The insurance company agrees to cover the cost of certain benefits listed in your policy. These are called "covered services." Coverage does not guarantee full payment and your insurance company may require partial coverage by the policyholder. Your policy also lists the kinds of services that are not covered by your insurance company. You have to pay for any uncovered medical care that you receive.

Be aware that a medical necessity is not the same as a medical benefit. A medical necessity is something that your provider has decided is necessary based on clinical presentation and standard of care. A medical benefit is something that your insurance plan has agreed to cover. In some cases, your provider might decide that you need medical care that is not covered by your insurance policy. Common examples of this might be a splint for a sprain or a spacer device to use with an inhaler for wheezing.

Since we are unable to know the specifics of every insurance plan, we encourage families to read their insurance information to make an informed decision of which plan to choose (if more than one is offered by the employer).

- Take the time to read your insurance policy. It's better to know what your insurance company will pay for before you receive a service, get a lab or x-ray or fill a prescription.
- Some medications, tests or hospitalizations may have to be approved by your insurance company before your doctor can provide them.
- If you still have questions about your coverage, call your insurance company and ask a representative to explain it.

Remember that your insurance company, not your provider or the physician's office, makes decisions about what will be paid for and what will not.

What if something isn’t covered by my plan?

Most of the things your provider recommends will be covered by your plan, but some may not. When you have a test or treatment that isn't covered, or you get a prescription filled for a drug that isn't covered, your insurance company won't pay the bill. This is often called "denying the claim." You can still obtain the treatment that is recommended, but you will have to pay for it yourself. Some companies will pay a percentage and the patient is responsible for the remainder. This is in addition to your co-pay. If more than one issue is covered at a single visit (such as a hurt finger and asthma or a well visit and ear infection) separate co pays may apply, depending on an insurance plan. If your insurance company denies your claim, you have the right to appeal (challenge) the decision. Before you decide to appeal, know your insurance company's appeal process. This should be discussed in your plan handbook. Not all appeals will end in your favor, but some challenged claims will be covered eventually by the insurance company.

Most insurance companies have different levels of co-pays for the primary care office, specialist, urgent care, and emergency room. These are often printed on your insurance card and can change yearly with new contracts. Some insurance plans require a referral to see any provider other than your primary care provider on your insurance card.

Why does the front desk always ask for my card?

Bring your insurance card with you to each visit. Although you have the same plan as last year, the copays might be different. Sometimes the insurance billing address has changed. We cannot file your claim properly without the correct information.

How do I know what medicines will be least expensive?

A formulary is a list of medications that your insurance company will help you pay for. It puts medications in two or three categories (tiers) based on co pay. The first tier is usually generic medications, the second more expensive medications and the third the most expensive medications. Each tier has a higher co pay. This list is reviewed and changed by the insurance company every few months, so your cost might go up or down. Be aware of the formulary before you begin any medication, especially one that will continue long term. Learn if your insurance gives a discount for using their mail in prescription service. Insurance companies, not the pharmacy, decide on the cost of the co pay. They might contract with particular pharmacies and your cost will be lower at those pharmacies. We are happy to write for prescriptions with lesser co pays if they will treat the condition properly and you know your formulary. Because we see hundreds of plans and formularies change, we do not know what your plan prefers. Know your formulary!

What if I have a question about a bill?

If you do not understand a bill or explanation of benefits (EOB), please call your benefits administrator or human resources administrator, or our office billing department.

I received a bill that I don't think I should have to pay.

Sometimes insurance companies believe that a test, procedure or therapy is warranted, but they will not cover it and require the patient to pay. For example, our office has received several complaints from parents about the charge for the autism screen we recently started performing. In October 2007, the American Academy of Pediatrics initiated a new standard of care that all children at 18 and 24 months be screened for autism with a standardized test. Prior to this, our office asked screening questions for both motor and verbal development at each well check. According to the new guidelines, questions that are not part of a standardized evaluation are not sufficient. We chose to use the MCHAT (Modified Checklist for Autism in Toddlers) because of its ease of use, validity and reliability.

We use numbered codes to submit services to insurance companies. These codes vary from the visit itself to diagnoses made and tests performed. We are encouraged to use codes for everything we do to document to the insurance company what care was given at a visit. Insurance companies use these codes to monitor practice patterns and optimum care.

When there is a new standard of care, such as the Autism screen, it takes time for the insurance companies to recognize the new code. Sometimes a company never pays on that code. Unfortunately, in order for us to able for us to provide the standard of care, which we strive to follow for all patients in all instances, we must provide this service and submit the code to the insurance companies. The service may seem minimal, but it does incur a cost to our business. With the MCHAT, we must print the forms, monitor inventory, and assure that each child at the appropriate age has a completed form.

How can I help my insurance company begin to cover costs of currently allowable but not covered benefits?

We encourage parents to call their insurance companies and talk with their Human Resources personnel to discuss billing disputes. When insurance companies review the concerns of consumers, they may change policies.

If your insurance company is one that does not recognize the value in any medically indicated service, please call your insurance representative to demand coverage for recommended services. Every call they receive may or may not immediately change their benefits, but if enough concern is raised with a particular issue, there is a better chance it will at least be discussed.