As a healthcare practice, our commitment and priority is to provide you the care, treatment plan, counseling and understanding you require in our medical opinion. As a courtesy, we'll file your claim for you, but any financial responsibility you might have is decided by your insurance company and your benefits**. If we verify eligibility or plan benefits for you, this is still not a guarantee of coverage.** Only when the claim is filed, will the insurance company make a decision on how your claim will be paid based on the information on the claim and in your plan. Here are some terms to help you understand your benefits:

Routine and Preventive Care – A visit where it is only for a wellness check/ no issue. Not a follow up to an issue. If there is an abnormality or positive finding, symptoms addressed, etc. additional charges might be incurred.

Office Visit – A face-to-face meeting between a physician or other health professional and a patient. Patient responsibility is usually a co-payment and deductible if applicable. Specific amounts are determined by insurance upon the adjudication of the claim.

Procedure –Any intervention that is needed as a result of a condition. For Example, if you have an abnormal pap smear result there might be a need for a colposcopy. Benefits for a procedure are policy specific, meaning that if you have clauses such as pre-existing, waiting periods, or simply an exclusion that will affect the coverage/ coverage level.

Covered Charges – Or Covered Benefit are services that are typically covered under the terms of your contract with your insurance company. It is important to note that even those services may be covered charges or a covered benefit; they are often subject to your deductible and coinsurance.

Non-covered Charges –This is policy specific. They are services that are not a covered benefit under the provisions of your insurance plan. If your insurance does not cover a service you are liable for the entire amount. As providers there is nothing that we can do to reverse a non-covered charged.

In Network – It is ultimately your responsibility to assure that you are in network, only you are aware of your insurance policy specifics. We have contracted with many of the insurance companies, however in recent years there have been so many changes, that we suggest that you verify with your insurance.

Is it financially advantageous to make sure that you go to an in network provider, this guarantees that you will not be responsible for anything outside of your benefit level.

Contracted Rate – A contracted rate is the negotiated amount an insurance company has agreed to pay a provider for specified services subject to copayments, deductibles and coinsurance amounts.

Deductible – Almost every plan has a deductible. This amount represents the amount the policyholder or patient must meet (pay) out of pocket before the insurer will begin to pay benefits. In many plans, an office visit will not be subject to the deductible and the only cost-sharing is a **co-payment** (see below). Procedures are always subject to the deductible.

Co-payments – Is the amount for which you are responsible for at the time of every visit. This amount is determined by your insurance policy. There are services that are subject to co-pays as well as services where the co-pay is waived, for this we rely on the explanation of benefits for accuracy.

Out of pocket – This is a set amount determined by your policy. This figure is the most that you would be responsible for a given period. Some polices have a provision that the co-pays and deductible contribute to the out

of pocket maximum. If not, you have the responsibility for the co-pay, the deductible as well as the out of pocket amount. Once this is met the benefit level is typically 100%.

Coinsurance – The amount that you are obliged to pay for covered medical services after you've satisfied any co-payment or deductible required by your health insurance plan. This is typically represented by a percentage of an eligible expense that you are required to pay. For example, an 80/20 plan means the insurer pays 80% of the contracted rate on procedures while the insured will pay the remaining 20% of the contracted rate

As a patient, you are responsible for knowing the provisions of your health insurance plan (or plans), including which physicians are in your network as well as which services need pre-certification prior to service (labs, ultrasounds, etc.). We strongly recommend that you review your description of coverage, for an exact description of services that are covered and those which are excluded or limited. It is important to understand your insurance plan's current benefit and coverage rules. Policies and coverage determinations may vary from year to year. Failure to do so may results in a reduction of benefits or a claim denial. Per your agreement with your insurance company you are responsible for your co-payments at time of service as well as your payment for care not provided or coordinated, include paying for your deductible.