Is he or she in my plan's network? That seemingly simple question is anything but. Many practices participate in more than a dozen insurance plans. The list on the health plan's Web site might not be up-to-date, so it's best to double-check with the doctor's billing office, using the exact name of your plan.

• **What are the limitations and exclusions?** All plans must cover "essential health benefits," such as physicians, hospitals, drugs, maternity care, mental health care, tests, emergency care and rehabilitation, but specifics might vary. You'll find those details in the standardized "Summary of Benefits and Coverage" form that all plans must supply. Look to see if any services have limitations (such as a ceiling on physical therapy visits) or aren't covered at all (such as acupuncture, dentures or hearing aids).

• **Do I need a referral or prior authorization?** With many HMOs, you need to get approval from your primary-care physician to see other doctors or obtain certain tests or procedures. If you don't, the plan won't pay. Don't wait until the last minute, because offices are inundated with requests.

• **Will this test be covered?** A common reason for a claim denial is that an insurance company deems a service "not medically necessary." You can save yourself an unwanted bill by checking ahead of time with the insurance company and your doctor's billing office. Keep detailed notes on whom you spoke with and what they told you.

How will my medication be covered? Every health plan has its own formulary, or list of preferred drugs, typically organized into as many as four tiers in ascending order of price. Tier 1 usually includes generic medication. You'll probably be required to pay more for a prescription when a higher-tier, brand-name product is dispensed. When starting a new drug, check your plan's formulary to see what tier it's in. If it's expensive, ask your doctor or pharmacist if a similar drug in a lower tier would work as well.

Four payment terms you need to know

You'll pay your share of health-care costs in the following ways:

• **Out-of-pocket limit.** This is the most you'll have to spend from your own pocket for medical care in the policy year. Once you hit that limit, your health plan will pick up 100 percent of any additional costs until year's end. The maximum allowable "OOP" for 2014 is $6,350 for an individual and $12,700 for a household.

• **Deductible.** This is the amount you must pay for covered services each year before your insurance kicks in. Details may vary: One plan might have a single deductible for everything, while another might have a separate one for prescription drugs. With some plans, not all services are subject to the deductible.

• **Co-payment.** This is a flat amount (for example, $20) that you pay for a covered health-care service.

• **Coinsurance.** This is your share of the cost of a covered service. With 20 percent coinsurance, for instance, if a CT scan costs $1,000 and you've met your deductible, your share of the cost will be $200.

Four payment terms you need to know

You'll pay your share of health-care costs in the following ways:

• **Out-of-pocket limit.** This is the most you'll have to spend from your own pocket for medical care in the policy year. Once you hit that limit, your health plan will pick up 100 percent of any additional costs until year's end. The maximum allowable "OOP" will depend on what insurance plan you have.

• **Deductible.** This is the amount you must pay for covered services each year before your insurance kicks in. Details may vary: One plan might have a single deductible for everything, while another might have a separate one for prescription drugs. With some plans, not all services are subject to the deductible.

• **Co-payment.** This is a flat amount (for example, $20) that you pay for a covered health-care service.

• **Coinsurance.** This is your share of the cost of a covered service. With 20 percent coinsurance, for instance, if a CT scan costs $1,000 and you've met your deductible, your share of the cost will be $200.

EXAMPLE

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: 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.