Insurance & Billing FAQ's

The health insurance process is complex. Here are some basic facts to help you better navigate the insurance system.

Insurance companies have created many rules to try to keep costs down. Every plan has different rules, and there are hundreds of health plans. Because of this, we encourage you to learn more about your own insurance plan and what is covered/not covered. **This is best done by calling the Member Services number on the back of your insurance card.**

Insurance Terms

- **PPO Plans (Preferred Provider Organization)** typically do not require any referral but it is important to call the plan before any consultation/treatment to check.
- **HMO plans (Health Maintenance Organization),** also known as a *managed care plan*, **ALWAYS** requires a pre-authorization from your PCP for a specialist visit (with the exception of ObGyn).
- **EPO plans** can be considered a "hybrid" PPO/HMO plan. Please check with your plan to make sure any pre-authorization/certification issues have been resolved prior to your first consultation.
- **FSA (Flexible Spending Account)** is a pre-tax amount taken from your paycheck to be spent on medical-related costs. Ask your employer specifically what medical expenses are covered.
- **Co-payment** is the amount due for an office visit. This fee is due at the time of service and is a pre-determined amount set by your health plan.
- **Co-insurance** is the percentage of patient financial responsibility pre-specified by your health plan.
- **Deductible** is the pre-determined amount (or percentage) that must be paid out-of-pocket before a health plan will cover any expenses or claims.