Understanding Health Insurance

Before you receive services from any healthcare provider, see if that provider is in-network and how your plan will cover costs for the type of service you will be receiving. You can do this in a few different ways:

- **Call your health insurance plan. You can typically find their number on the back of your insurance card.**
- **Use your health plan's website. Many offer interactive web tools to help you understand your coverage.**
- **Use your health plan's mobile app. Many offer mobile apps to help you understand your coverage.**

When calling to check on your plan's in-network status, here is some important information to help you correctly identify Philip Health Services, Hans P Peterson Memorial Hospital, Philip Clinic and/or Kadoka Clinic.

Tax ID# 46-0361016
Hospital NPI#1750300646

Philip Clinic NPI#1700838117
Billing Address: PO Box 790, 503 W. Pine Street, Philip, SD 57567

Kadoka Clinic NPI#1568416667
Billing Address: 601 Chestnut St., Kadoka, SD 57543

Check your plan against what type of service you will be receiving (e.g., physical therapy, immunizations, primary care visit, psychiatry care, etc.) and where you would like to be seen.

Try to determine the answers to these types of questions:

- **Is this healthcare provider in-network?**
  - If not, how can I find an in-network provider?
  - If I choose to see this provider anyway (out-of-network), what will the cost be?
- **Does my plan provide coverage for this service?**
  - Are there limitations or exclusions to my coverage for this service?
  - Does my plan require a Prior Authorization or Referral?
  - Does my plan limit the number of visits that I am entitled to?
  - If I am given supplies as part of my care, will they be covered?
- **Will I need to pay a deductible?**
  - If so, how much is my deductible?
  - When does my deductible reset each year?
  - Do I have a different deductible for in-network and out-of-network providers?
- **Will I need to pay a co-payment or co-insurance? If so, how much?**
- **Is my prescription plan different than my medical plan?**
- **Does my plan include dental coverage?**

Common Definitions:

Co-insurance: The percentage of each bill you must pay out-of-pocket.

Co-payment: The fixed amount of each bill you must pay out-of-pocket. The do-pay is usually due the time of service.

Coordination of Benefits (COB): When two or more insurance plans cover the same person, Coordination of Benefits is used to determine which plan pays first.

Covered Benefits: The health care items or services covered under a health insurance plan. Covered benefits and excluded services are defined in the health insurance plan's coverage documents.

Deductible: The amount you pay for covered health care services before your insurance plan starts to pay. With a $300 deductible, for example, you pay the first $300 of covered services yourself. The deductible may not apply to all services, Typically, health plans will have a separate deductible for in-network vs. out-of-network providers.

Durable Medical Equipment (DME): Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: medically-necessary splints, wheelchairs, crutches, or blood testing strips for diabetics.

Network: The facilities, providers, and suppliers your health insurer or plan has contracted with to provide health care services. Networks change, so it's important to check with your health plan to be sure your provider(s) are in-network at the time you receive care.

- **In-Network**: Provider or facility has a contract with the insurance company and has negotiated a contracted or discounted rate with the insurance. You generally pay less when you receive care from an in-network provider.
- **Out-of-Network**: The provider or facility does not have a contract with the insurance company. You generally pay more when you receive care from an out-of-network provider.

Non-Covered Benefits or Exclusions: Health care service that your health insurance or plan doesn't pay for or cover.

- Common exclusions: Travel vaccines and services, massage therapy, cosmetic procedures, non-medically necessary services, or supplies, etc.

Medically Necessary: Health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.

Out-of-pocket maximum: The most you will pay for covered medical expenses during the plan year. Once the out-of-pocket limit has been met, the plan will pay 100% of covered charges for the rest of that plan year. This limit never includes your premium, balance-billed charges, or health care your health insurance or plan does not cover.

Preauthorization or Prior Authorization (PA): A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval, or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost. Note: Prior authorization is not required during medical emergencies.

Premium: The amount you pay for your health insurance coverage. When shopping for a plan, keep in mind that the plan with the lowest monthly premium may not be the best match for you. If you need much health care, a plan with a slightly higher premium but a lower deductible may save you a lot of money.

Referral: A written order from your primary care doctor for you to see a specialist or get certain medical services. In many health plans, you need to get a referral before you can get medical care from anyone except your primary care provider. If you don’t get a referral first, the plan may not pay for the services.

Subscriber: The name of the policy holder of the insurance plan. In a family plan, this is typically a parent.