INSURANCE 101: WHAT DOES MY INSURANCE COVER? HOW CAN I MAKE SENSE OF THIS BILL?

**This information is based on Dr. Shinsato's clinical experience and current research for the general population. Implement at your own risk. This does not constitute a doctor-patient relationship. It is best to work with a trained healthcare provider who is familiar with your health conditions to help guide you.*

Over the years many people have told me that they get confused over what the approximate costs would be for a visit or how to understand the charges on their bill. I have created the following tools to make it easier for people to understand health care costs: insurance coverage worksheet, health insurance comparison chart and this article, Insurance 101.

Some basics to know:

- Charges vary based on the services done by your health care provider
  - Common charges in my office include:
    - Evaluation and management of a new condition or re-assessing an old condition
    - Counseling
    - Earwax removal
    - Manual therapy (including myofascial release, craniosacral therapy, pin and stretch, visceral manipulation; bills as a rehab code)
    - Acupuncture
    - Heat lamp (infrared therapy billed under a rehab code)
    - Physical check-up
      - Usually is covered under preventive services (no charge if no diagnosis is made during the examination. For example, if you come in for a general check up but are complaining of abdominal pain and your practitioner focuses on this and does a check-up, insurance will not consider this a general check-up as you were being evaluated for a complaint
    - Consultation

There are diagnosis codes for a condition treated (ICD-10 codes) and procedure codes (CPT codes) for the services completed at your visit. These usually do not show up on your bill that you receive from the provider as it may just state it was an office visit.

Below is a list of definitions and explanations to help you navigate your visit bill.

* Please visit https://www.wahealthplanfinder.org/_content/Homepage.html as a guide when shopping for insurance benefits.

* Please also see the insurance coverage worksheet (see ***appendix*** at the end of this document) to use when you call your insurance company to see what benefits you have before you visit a health care provider.

- Take charge of your health and know what your expected charges are
- Health care providers check your benefits as a courtesy and it is still your responsibility to check with your insurance for coverage as they sometimes misquote benefits.
  - If you have two quotes of coverage, you are more likely to have it covered if they deny it – I have seen this happen in several cases.

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DEFINITIONS:

Copay
The amount you pay each time you visit your health care practitioner. Amounts vary from:
- None – rare
- $10-15 – low copays
- $20-30 – average copays
- $35-50 – high copays

Deductible
The amount that you or your dependents must pay toward your health claims each year (usually a calendar year meaning January-December) before your insurance begins to pay for your benefits.
- Low deductibles $250-$1,000
- Average deductibles are $1,500-$2,500
- High deductibles $5,000-$10,000 (catastrophic insurance coverage – meaning you have coverage if a major accident or illness occurs)
    - **High Deductible Health Plans** – A health plan that offers a low premium (monthly payment) and a high deductible to fulfill for the year. This is often paired with health savings account or health reimbursement arrangement (offering pre-tax dollar savings) towards the deductible that is not covered.

Explanation of Benefits (EOB)
A form from your insurance carrier that explains your health care benefits you received, what was billed by the provider, paid by your health insurance plan and what you owe your provider.
- You will usually receive this before your actual bill from your provider

Premium
The amount that you need to pay per month to receive insurance benefits.
- On average, it is about $100/decade of coverage for a decent insurance coverage
    - If you are 22 years old, your premium may be $220/month with a low deductible, low copay and low co-insurance
    - If you are 43 years old, your premium may be $430/month with a low deductible, low copay and low co-insurance
    - Your premiums may be higher if you:
        - Are older
        - Have more comprehensive coverage (lower copays, lower deductibles, lower co-insurances)

Co-insurance
Once a deductible has been fulfilled for the year, the co-insurance is the amount that you are responsible for after the insurance pays their portion to the provider.
- Some companies cover 100% after your copay; this is rare but common in older grandfathered in plans for larger companies. For example (based on a 80% co-insurance plan):
    - Your deductible is $1,000
    - Your copay is $20
    - You visited your doctor (who is an in-network provider) for a back pain that is not getting better after 2 weeks.

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- This year you have seen a doctor 3 times, an eye doctor for an annual check-up and had some blood work done.
- You have reached your deductible of $1,000 (you have paid bills for all your prior visits and it has reached $1,000).
- Your most recent insurance bill reads as:
  - $250 charges billed by the health care provider for your back pain visit
  - $150 allowed - the amount the insurance will allow the provider to charge per their contract agreement
  - $100 disallowed/adjusted - the amount the insurance will not pay and you are not responsible for
  - Note: Your insurance covers 80% of your visit amount because your doctor was ***in-network***.
  - $150 (allowed amount billed) x 0.80 (80% covered) = $120 (amount your insurance paid to the provider)
- **Your co-insurance is as follows:**
  - $150-120 = $30 your coinsurance due to your provider
  - If you paid a $20 copay that at your visit, you will minus this amount out of your co-insurance:
  - $30 coinsurance due - $20 copay paid at visit = $10 total due to your provider
  - You owe $10 to your provider for your most recent visit

In-network

Practitioners who have a contract with the insurance company to provide their services for a set lower fee to have access to more clients.

- Insurance companies tend to reimburse for these services at 75-100%, and any amount billed over the visit amount allotted, is not allowed to be billed back to the client.
- At your visit, you are expected to pay the co-pay to your provider. They will then bill your visit to your insurance company and you will receive two letters within 4-6 weeks of your visit (billing and processing takes a while):
  - 1) Explanation of Benefits (EOB) – A form from your insurance carrier telling you what was billed, what was paid to the provider and what you owe to the provider.
  - 2) A bill from your provider – A bill stating what was billed, what your insurance carrier paid, your copay collected and what you owe.
  - 3) Please pay the bill as soon as possible as there is already a delay from the visit to the time the visits are processed and paid to the provider.

Out-of-network

Practitioners who DO NOT have a contract with the insurance company to provide services for a set fee.

- Many of these providers expect payment in full at the time of your visit.
- They can provide you with a bill (called an invoice or superbill) to submit to your insurance company to get reimbursed for their services (request this from them so you may submit to your insurance company).
- Companies tend to reimburse for out-of-network services at a lower percentage for out-of-network providers (typically 20-40% of the charged fee) therefore encouraging you to use their contracted providers.

Preferred Provider Organization (PPO)

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A group of hospitals or physicians that contract on a fee-for-service basis with insurance companies to provide comprehensive medical service.

- PPO health plans tend to heave lower out-of-pocket costs than non-PPO plans

Provider aka health care provider or health care practitioner (i.e. doctor, naturopathic doctor, chiropractor, nurse practitioner, massage therapist, nutritionist, physical therapist, optometrist, etc).

Health Savings Account (HSA)

This is a savings account that you save pre-tax dollars for health care spending. Usually offered through your employers, you will pre-determine how much money you will deduct from your paycheck per pay period. ***Used for:*** Copays, co-insurance, medications, supplements, statement payments, over the counter medications, first aid supplies, condoms (sometimes)

- When you go to a drugstore, they will often have FSA or HSA next to items on your ticket if they qualify for FSA/HSA reimbursement
- A health savings account usually rolls over to the next year.
  - You usually receive a HSA credit card that you present for your eligible purchases.
  - If you forgot your card and paid by other means, you can submit your receipt to your insurance company so they may apply it to your account and you may get reimbursed for it (more tedious and takes longer). HIGHLY Recommended to use for payment at time of purchase.

Flexible Spending Account (FSA)

A savings account to save pre-tax dollars for health care spending. Usually offered through your employers, this account is one that you pre-determine how much money you will deduct from your paycheck per pay period. ***Used for:*** Copays, deductibles, statement charges, medications, supplements (if prescribed by your licensed practitioner and noted on your treatment plan).

- You usually receive a FSA credit card that you present for your eligible purchases.
- If you forgot your card and paid by other means, you can submit your receipt to your insurance company so they may apply it to your account and you may get reimbursed for it (more tedious and takes longer). HIGHLY Recommended to use for payment at time of purchase.
- **NOTE: The only downfall of this account is that you need to use most of health savings account yearly or risk losing access to it.**
- Unused funds are lost after a grace period (usually within a calendar year (i.e. January-December), even though it is your money that you saved pre-tax.
- Some companies may allow you to carry over $500 of unused funds from one year to the next.

Health Reimbursement Arrangement

A program that allows employers to set aside an amount of funds to reimburse participating employees for medical expenses. This is often combined with another health plan.

Out of pocket maximum

The maximum amount that the patient (and their dependents) will pay per year (in terms of deductible + co-insurance). Once an individual fulfills their out of pocket maximum, they usually do not have to pay any copays or co-insurance when visiting their provider (eligible expenses are covered 100% by your insurance).

- This amount is usually $7500 or $10,000 in most cases that I have seen

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APPENDIX

CHECKING BENEFITS

Call your insurance company's customer service number and ask the following:

- When did the coverage:
  - Begin? _____
  - End? _____ (important for COBRA or if insurance changes in the year)
  - Is there a waiting period for coverage?
    - ☐ Yes. How long? _____ ☐ days ☐ weeks ☐ months
    - ☐ No
- What is their deductible? ☐ none ☐ Other, amount _____
- Is this based on:
  ☐ A calendar year (Jan-Dec) ☐ A fiscal year (July-June) ☐ Other _____
- Has this deductible been met this year?
  - ☐ Yes ☐ No
  - Amount applied toward deductible as of today's date: $_____
  - Do I have in-network coverage for (only check if coverage is available):
    ☐ Naturopathic Physician (ND)
    ☐ Acupuncturist (LAC)
    - Is this for anesthesia only? ☐ Yes ☐ No
    - Does the LAC need to be employed by and under the direct on site supervision of an MD? ☐ Yes ☐ No

    ☐ Massage Therapist (LMP)
    - By a certain provider type? ☐ LMP ☐ MD ☐ DO ☐ PT ☐ ND
    - Combined rehab benefit with PT? ☐ Yes ☐ No
    - Do they need authorization (prescription) by a PCP or MD? ☐ Yes ☐ No

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- Are the visits subject to a deductible?
  - ND ☐ Yes ☐ No
  - LAC ☐ Yes ☐ No
  - LMP ☐ Yes ☐ No
- What is the copay for the following?
  - ND ☐ none ☐ $10 ☐ $15 ☐ $20 ☐ $25 ☐ $30
  - LAC ☐ none ☐ $10 ☐ $15 ☐ $20 ☐ $25 ☐ $30
  - LMP ☐ none ☐ $10 ☐ $15 ☐ $20 ☐ $25 ☐ $30
- What percentage will it cover for office visits?
  - ND ☐ none ☐ 100% ☐ 90% ☐ 85% ☐ 80% ☐ 75% ☐ Other _____
  - LAC ☐ none ☐ 100% ☐ 90% ☐ 85% ☐ 80% ☐ 75% ☐ Other _____
  - LMP ☐ none ☐ 100% ☐ 90% ☐ 85% ☐ 80% ☐ 75% ☐ Other _____
- Is this a percentage of the allowed amount?
  ☐ Yes _____ ☐ No _____
- What is the visit limit?
  - ND ☐ none ☐ 4 ☐ 10 ☐ 12 ☐ 30 ☐ other _____
  - LAC ☐ none ☐ 4 ☐ 10 ☐ 12 ☐ 30 ☐ other _____
  - LMP ☐ none ☐ 4 ☐ 10 ☐ 12 ☐ 30 ☐ other _____
- How many visits do I have remaining for:
  Naturopathic medicine? _____ Acupuncture? _____ Massage therapy? _____
- What lab coverage do I have?_____
  - Do you have in-network preferred laboratories? ☐Yes ☐ No
  - Bloodwork: ☐ Labcorp ☐ Paclab ☐ Dynacare ☐ PPL ☐Quest ☐ AnyLabTest
  - Imaging: ☐ Radia ☐ CDI ☐ Bellevue Women's Clinic ☐ Swedish
  - Specialty: ☐ Diagnostechs ☐Metametrix ☐Cyrex ☐ Spectracell Labs ☐ USBiotek
- What out-of-network lab coverage do I have?
  ☐ Biohealth → Amount covered? _____
  ☐ Health Diagnostic Research Institute → Amount covered? _____

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