

HEALTH INSURANCE

Help!

YOUR STEP-BY-STEP GUIDE TO UNDERSTANDING
YOUR MEDICAL BILLS | ISSUE THREE

Understanding Medical Bills at a Glance

You have health insurance and you went to a healthcare provider for services – now you have a bill. You may be confused about what you are responsible to pay. Let's go over medical billing rules to help you understand each piece and put them together.

First, you received a summary of benefits and policy documents when you signed up for health insurance. These documents are always a good place to start when trying to understand your health insurance policy's rules. If you have specific questions about how much you may have to pay for any healthcare services or procedures you receive your health insurance company is always the best contact – they will know all of the specifics concerning your health insurance policy. The number is on your insurance card.



Understand Your Benefit Design

- Your benefit design refers to all of the specific features of your health insurance policy including what benefits are covered and what your financial responsibility may be.
- Your health insurance company is the best resource for specific information about your benefit design.
- A summary of benefits and coverage is an easy-to-read summary of your cost-sharing responsibilities for many of the most common healthcare services and procedures.
- The summary of benefits and coverage will also identify cost differences between in-network and out-of-network providers.



Understand Cost-Sharing

- Cost-sharing refers to the how the amount of the cost of a healthcare service or procedure is divided between the insurance company and you.
- There are three major cost-sharing types: deductible, coinsurance and copayments.



Reading Your Explanation of Benefits

- You should receive an EOB for every encounter with a healthcare provider.
- Every health insurance company's explanation of benefits looks slightly different but they all included the same basic information.
- It is always a good idea to compare your medical bills to your explanation of benefits.



Check for Errors

- Check your bill for errors, such as the doctor who saw you or the service you received.
- If you have any questions or find any errors on your bill, call your provider or insurance company.

Your Step-by-Step Guide to Understanding Your Medical Bills

1.

Understand Your Benefit Design

Sometimes people receive medical bills and don't understand why. This is reasonable: you pay your health insurance premium every month and you have a health insurance card you present to the healthcare provider. However, health insurance coverage can be hard to understand and the different rules can be confusing. It is important that you understand what your health insurance policy's benefit design features are so that you know what bills you may be responsible for.

Cost-sharing refers to how the costs of services covered by your policy are shared between you and your health insurance company and is usually divided into three categories: deductibles, coinsurance and copayments.

Healthcare Provider

A healthcare provider can refer to a doctor or facility that you received healthcare services from.

Benefit Design

The term benefit design refers to the all of the features of your health insurance policy including things such as the services that are covered and the cost-sharing obligations of a plan. Benefit design is part of how your monthly premium payment is determined.

2.

Understanding Cost-Sharing

The most common cost-sharing categories will have different dollar amounts and can apply differently based on your health insurance policy. But the terms all mean the same thing no matter what type of health insurance you have.

A deductible is the amount of money you must pay **before** your health insurance company pays any medical bills.

Coinsurance is often the most confusing of the three major cost-sharing features because it isn't a set dollar amount. Coinsurance is a shared responsibility with your health insurance to pay for certain services. The health insurance company will pay a percentage of the bill and you will pay a percentage. For example, your policy may have a 70 percent coinsurance rate for certain services. This means for a covered service you would pay 30 percent of the bill.

You must be careful though, if your plan has a tiered network <http://www.njha.com/media/491966/putting-the-pieces-together-guide-to-tiered-networks.pdf> it may have different coinsurance rates for each tier.

Copayments are fixed dollar amounts that you pay per visit or service. The most common copayment is the amount you pay when you visit your primary care doctor, typically

around \$20 dollars. But again, you must be careful to read your policy documents because for some services you may have to pay your deductible before the copayment rate starts.

Finally, most health insurance policies also include a maximum out of pocket limit (MOOP). This means that once you reach the MOOP, the carrier will pay for **all** of the allowed charges for your healthcare services for the remainder of the policy period, usually a calendar year. All charges the covered person pays towards the deductible, coinsurance and copayments help to reach the MOOP.

Payments that don't count toward the MOOP include:

- Services that aren't covered
- Out-of-network services
- Premium payments

Out-Of-Pocket

Money you spend on healthcare, not including your premium.

Using Your Documents

A very good place to start learning about your policy's cost-sharing requirements is your Summary of Benefits and Coverage (SBC). Your SBC is an easy-to-read summary that outlines cost-sharing responsibilities for many of the most common services. You should be able to access an SBC when you are shopping for coverage, during open enrollment through your job or you can always request an SBC from your health insurance company.

For a sample of what an SBC looks like <https://www.cms.gov/CCIIO/Resources/Files/Downloads/sbc-sample.pdf>.

There are four major sections of the SBC – Important Questions, Common Medical Events, Excluded Services & Other Covered Services and Coverage Examples.

The Important Questions and Common Medical Events sections provide details about what your deductible is, if there are services that will be covered before you pay your deductible in full and what your out-of-pocket maximum is for



the policy year. Typically, most health insurance companies provide preventive services such as medical screenings and vaccinations before your deductible is paid.

In the Common Medical Events section, you will find more information about the coinsurance and copayment amounts for many of the most common medical services you may need. For example, the SBC includes information on everything from your cost-sharing amounts for a doctor's visit to how much you will pay for a hospital visit. This section also includes information on potential cost differences between in-network and out-of-network providers. You must be very careful to look at those differences because going out-of-network usually costs more.

Finally, the Coverage Examples section provides real samples of what you may pay for having a baby, managing type 2 diabetes or fixing a simple fracture. The dollar amounts aren't exact, but it can help you better understand how the different cost-sharing features interact.

READING YOUR EXPLANATION OF BENEFITS

After you receive a healthcare service your health insurance company will send you an Explanation of Benefits, or EOB. Medical bills and EOBs can be confusing, but there are several things you can do to figure out how much – if any – of the bill you are responsible to pay.

Your EOB will explain how much of the bill the health insurance company paid based on the rules of your policy's benefit design and the services provided.

Every health insurance company's EOB looks a little different, but they all contain the same basic information. It may just be presented differently. You should carefully review an EOB every time you receive one.

Below are some of the key pieces of information you should find on your EOB.

A summary of some of the key details such as the patient's name and the healthcare provider's name, along with the amount paid by your health insurance company and the amount you must pay. This is sometimes referred to as the **“member or subscriber responsibility.”**

The second or back page will typically include detailed information about your services. Always check this section very carefully because this is where you will be able to tell if there are any mistakes. These details include:

- **DATES OF SERVICE** – Make sure the date(s) listed are dates you actually received services from the healthcare provider listed.

- **PROVIDER/TYPE OF SERVICE** – Check that the healthcare provider is the one you used and that the service is correct. But be careful, sometimes a service can be listed a little differently than you might expect. For example, you may go to your primary care physician for a physical but the bill may show the service as an outpatient visit.



■ **BILLED AMOUNT** – The full amount that the healthcare provider charged for the services you received.

■ **ALLOWED AMOUNT** – What the health insurance company is paying for the services. This amount will either be the in-network rate that the healthcare provider agreed to accept from the health insurance company or the out-of-network rate that the health insurance company considers usual, customary and reasonable.

■ **YOUR CO-INSURANCE/COPAY AMOUNT** – The amount you must pay because of your health insurance policy's cost-sharing requirements.

■ **YOUR DEDUCTIBLE AMOUNT** – This is usually shown as a separate amount because it is the amount you must pay before the health insurance company starts sharing costs.

■ **NON/NOT COVERED AMOUNT** - The portion of the amount billed that your health insurance company does not pay because of your health insurance policy's benefit design.

This amount can be the result of several reasons. For example, the healthcare service you received may not be covered under your policy or you may have exceeded the number of times your policy pays for a service. It can also happen because you used an out-of-network provider.

It is very important to be careful when it comes to using an out-of-network provider. Always check with your health in-

urance company to make sure you have an out-of-network benefit because not all types of health insurance do and you will be responsible for the entire bill. If you do have an out-of-network benefit ask the health insurance company what the allowed amount is because you will pay the difference between that amount and what the provider bills.

■ **INSURANCE COMPANY PAID AMOUNT** – What the health insurance company has paid the healthcare provider.

■ **MESSAGE CODE** - This area of the bill includes details about the reasons the health insurance company paid what it did. For example, if you needed a referral for service but did not get one there would be a code that explains that.

■ **SUBSCRIBER RESPONSIBILITY** – This section details the portion of the bill that is your responsibility to pay. This amount might include your copay, deductible, coinsurance, any amount over the maximum reimbursable charge or products/services not covered by your plan.

When you receive a bill from a provider for services always compare it to your EOB to make sure everything matches. If there seems to be a mistake you can always call the provider or call your health insurance company at the telephone number on the EOB.

Your health insurance company can usually provide much more information about your policy because they are the ones that sold it to you. Providers don't actually have copies of your policy and are working with information provided by your health insurance company.

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