Health Insurance FAQs (Frequently Asked Questions)

You are responsible for knowing your plan benefits for in-network and out-of-network providers and your deductible status prior to your appointments with any doctor. The following information may be useful to you in understanding the payment due at the time of your visit and general insurance billing include Medicare:

1. **What is a Deductible?** Most insurance plans have a deductible. This amount varies significantly by insurance company and specific plans. Your plan deductible is the amount you must pay before your insurance company will begin to pay for any services. This amount pertains to all health care providers providing covered services and not specific to any one provider. For example, if your deductible is $500, you will be required to pay $500 before your insurance begins to pay. You can satisfy this deductible amount at one visit to one provider or a little bit at a time to several providers. Every amount you pay to any provider for covered services counts towards satisfying your deductible. Keep in mind you may have no deductible for in-network providers yet have one for out-of-network providers.

2. **What is a Co-Pay?** For those insurance plans that require patient co-pay, this is the amount you pay per visit to the doctor, and may differ between in network and out of network. This fee only covers the "visit" with the doctor and does not cover any co-insurance for procedures performed during the visit. If your doctor is not in your network, you may be required to pay the full fee at the time of the visit and submit your own claim to your insurance company, or pay the full amount and your doctor may submit a claim for you.

3. **What is Co-Insurance?** Co-Insurance is the amount you are responsible to pay for procedures and supplies that is over the allowed or paid amount by your insurance company for in network physicians. This is the amount that you may be expected to pay after services have been rendered, that is, at the time of your visit with the doctor.

4. **Does my Co-Pay count toward my deductible?** Your doctor does not know this. You can get this information from your insurance company.

5. **What is an EOB?** An EOB is an Explanation Of Benefits and is what your insurance company sends to you regarding each visit. It shows what visits and procedures were covered, what percentage they covered, allowed amounts (may differ between in network and out of network), and what your responsibility is. The EOB should arrive in about two weeks after the visit, but can take much longer depending on your insurance company.

6. **What does "allowed amount" mean?** The majority of insurance companies do not pay a percentage of doctor visits or procedures. What they do pay is a percentage of an amount that they have "allowed" for a visit or procedure. For example, if your visit to the doctor costs $100 and your insurance covers 80%, they will not pay $80 – they will pay 80% of what your specific plan allows for a visit. If, for example, they allow $50 for the visit: So 80% of $50 equals $40 therefore your responsibility is $100 less $40, which equals $60. The $60 would be your co-insurance. This is only an example as insurance plans widely differ.

7. **How much will I have to pay at the time of the visit?** If you are visiting an in-network doctor, you will be expected to pay your co-pay and you may be expected to pay your co-insurance. You will also have to pay more if your deductible has not yet been met. See #1 & #3 above. If your doctor is not in your network, you will need to pay the full fee at the time of the visit – call your doctor's office to ask the cost.

8. **Why do so many doctors now take no insurance at all?** Every insurance carrier contract with doctors restricts what options the doctor can discuss with you as well as what procedures, treatments, and medications that may be offered you. Health care has been changing dramatically over the past few years in response to insurance company restrictions imposed on physicians. Insurance companies have been managing costs, restricting access, dictating courses of action, and decreasing benefits, while increasing red tape. Many doctors find that they can no longer practice under these constraints. By taking no insurance, their decisions regarding your care will be made solely between you the patient, and the doctor. You insurance company will still be required to reimburse you to the extent of your coverage (except HMOs which will pay nothing when out of network). Some doctors will bill your insurance company for you and others will not. To be safe, always be prepared to pay for your visit.

9. **I have a Medicare secondary (not supplement) policy, how does that work?** If your primary is not Medicare but you use Medicare as a secondary and your doctor accepts Medicare, you may have to send in a copy of your primary EOB to your Medicare. Medicare will not consider your claim until your primary has acted on it.

10. **My plan has no deductible, so why do I have to pay anything?** Your plan may have no co-pays or no deductible, but it will not pay 100% of all charges. You may be expected pay your co-insurance, the amount your insurance company will not pay, at the time of your visit. Please see #6 for "allowed amounts". Additionally, even though some plans say they have no deductible, they may actually mean they have no deductible for procedures, but have one for office visits or vice versa. Furthermore, you may not have a deductible for in-network providers, but have one for out-of-network providers. Call your insurer to verify.

11. **Can't I just call my insurance company and find out a head of time what they will pay for a specific visit and procedure?** You can call your insurance company any time. They, however, cannot tell you what will be covered until they receive the visit and procedure codes from the doctor. For example, there are several visit codes that can be used, but the specific code used by the doctor will be dictated by what procedures are performed. Since the scope of the procedures will not be known until your visit is completed, your insurance company will not know what to tell you. They will only tell you what percentage of their allowed amount will be covered.

12. **I have Medi-Cal or a Covered California plan and was told I can see any doctor I want, but many will not see me - why?** Medi-Cal and Covered California are similar to all other insurance companies in that you can see any doctor you want <u>providing</u> that doctor is a member of your network. Medi-Cal and Covered California, however, differ in that the reimbursements to doctors are very small. Most doctors cannot afford such small reimbursements unless they have a volume practice – that is, they see a high volume of patients per day.

13. **May I still be seen even if doctor does not "take" my insurance?** Yes, but even though you will not have a co-pay, you will most likely have to pay the full fee at the time of your visit. Regardless of whether the doctor will bill your insurance for you or you have to do so, your insurance will reimburse you at their rate for an out of network provider. You may also have an out-of-network deductible to satisfy.

14. **Do all doctors accept Medicare patients?** No. Medicare is a single-payer system for people over 65 or on disability. As with all single-payer systems, the one-size-fits all approach significantly limits what options the doctor can discuss with you as well as what treatments are available to you. Medicare does not cover any preventative procedures and many other charges. Medicare also sets the doctor's fees, so no matter how much time the doctor spends with you, they will only be reimbursed a set amount. Because of these restrictions and the lower reimbursement fees, many doctors cannot afford to see Medicare patients and have opted out of Medicare. You must verify a doctor accepts Medicare before your treatment or you will be liable for the full fee.

15. **Are all Medicare policies the same?** No. There are two basic types of Medicare: Original Medicare issued through the Federal Government (white card with blue and red stripe), and Medicare Advantage Plans issued by private companies. If you have an Advantage Plan, you are in an HMO and can only see a doctor in that HMO. Most doctors that accept Medicare will only accept Original Medicare. Because Medicare Advantage Plans have restrictions and reimburse less, many doctors do not accept them. When making appointments, you must determine if the doctor accepts your particular kind of Medicare or you will be responsible for the full fee. Keep in mind if you do not have a Medi-Gap secondary policy, will be responsible for the 20% Medicare does not pay and any non-covered Medicare services and supplies.

16. **Do all Medicare Medi-Gap policies cover the entire 20% Medicare does not pay?** No. Just like primary policies, the Medi-Gap ones vary widely. Some pay the 20% Medicare does not pay, some only pay a portion of the 20%, some do not pay anything for certain procedures and some have deductibles. Some pay nothing if you go out of network. Many doctors that accept Original Medicare will expect you to pay the fees for anything Medicare will not cover, at the time of your visit. Keep in mind, you are responsible for any amount not paid by Medicare and your Medi-Gap policy combined. Additionally, Medicare does not pay for most supplies so you have to be prepared to pay for them at the time of your visit. All Medicare patients have a yearly deductible that is their responsibility also. Note that you will be expected to arrange with your Medi-Gap plan to have Medicare automatically forward claims to them. The doctor cannot do this for you. If you do not, you will have to pay the doctor and manually bill your Medi-Gap insurance after Medicare pays their portion.

17. **Does a doctor that accepts Medicare send claims to my Medi-Gap?** No. Medicare forwards all claims to your Medi-Gap insurance company. You must however, make sure Automatic Crossover of Claims has been set up. Only you can do this, not your doctor. Call your Medi-Gap company and have your Medicare card and Medi-Gap card handy. Tell them you want to set up Automatic Crossover of Claims.

18. **Do I have a Medi-gap policy or a Medicare Secondary policy?** A supplement policy pays a portion of the amount Medicare approved, the maximum of which is 20%. If Medicare pays nothing, then the Medi-Gap will pay a maximum of 20% of nothing. If, however, you have a secondary plan, it acts as a second insurance and will pay according to your policy regardless if Medicare pays or not. These are rare policies and are expensive. The way to find this out to call your insurance company and ask them this: If Medicare pays nothing, will my policy pay anything? If the answer is no, then you have a Medi-Gap.

19. **My Medicare secondary is Medi-Cal – do all doctors that accept Original Medicare also accept Medi-Cal?** No. Many doctors do not accept Medi-Cal. When you call for an appointment is it important to not only ask if Medicare is taken, but also Medi-Cal. The same goes for any supplement or secondary because many doctors do not accept HMOs, Advantage Plans, Attrix, or any other plan that reimburses very little.

20. **Can I see any doctor I want for Worker's Comp?** No. You may only see the doctor of your choice providing the doctor accepts Worker's Comp insurance. This type of insurance is very restrictive on the doctor, so many do not see these patients. If you are seeing a doctor because of a work related injury, make sure to ask the office staff if the doctor accepts Worker's Comp.

21. **My doctor won't see me because my insurance company will only take electronically submitted claims – why?** Many doctors are not set up to file electronic claims. Doing so requires an intermediary and significant fees apply. Especially in small practices, doctors only submit paper claims. If you choose to see the doctor anyway, you will be responsible for the full fee at the time of your visit, as the doctor cannot bill for you.

22. **Why does my EOB show my insurance was charged for a surgery when I did not have one?** EOBs can be confusing. Depending on your insurance company and your provider's specialty, many procedures are classified under the broad category of "surgery" for billing purposes. It is your insurance company that dictates which billing codes must be used for which procedures, not your doctor.

23. **What does "reasonable and customary" mean?** This is a term your insurance company may use when they quote benefits. How they arrive at this amount is unique to every company. Most use nation-wide averages, so none will relate to a specific doctor's charges. This is why the percentage paid by your insurance company will most likely never be a percentage of the doctor's actual charges but rather a percentage of their corporate-determined allowed amount for the doctor's charges. See #6 above.

24. **Do all doctors communicate via email?** No. If this method of communication is important to you, check with your doctor's office prior to making an appointment. Keep in mind that no doctor can decide if you require an appointment for your concern by an email, even if it contains a picture of the problem area.

25. **Can I assume if my doctor is listed on my insurance website that they accept my insurance?** No. Websites are only sporadically updated. Never rely on what you see on a website is accurate. Always check with the specific office you want an appointment with.

26. **To best prepare for my office visit, what questions would be beneficial to ask my insurance company ahead of time?**

1. What is my deductible for office visits to a specialist for an out-of-network Provider?
2. What is my deductible for in-office procedures for an out-of-network Provider?
3. How much of my deductible has been satisfied this year for out-of-network Providers?
4. What percentage of <u>what amount</u> do you pay for an office for Out-of-Network (i.e. 60% of $40)
5. What percentage of <u>what amount</u> do you pay for a follow-up office visit to an out-of-network Provider (i.e. 80% of $50)
6. Am I covered for L3000 orthotics (Podiatry)? What percentage of what amount to you pay and what is the yearly maximum for an out-of-network Provider?
7. Do you allow paper claims to be submitted? If not, because my doctor only submits paper claims, can I send in the receipt to you after I pay?