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Medical Management

UNDERSTANDING YOUR INSURANCE AND YOUR BILL

Health insurance has its own vocabulary, and most of it shows up on the statements you get after a visit. This page explains what each term means in plain language. Keep it with your insurance card.

THE PAPER FROM YOUR INSURANCE COMPANY IS NOT A BILL. It is called an Explanation of Benefits, and it is a summary of what was billed, what your plan paid, and what may be left for you. Do not send money in response to it. The bill, if you owe anything, comes from us.

THE ORDER THINGS HAPPEN IN

Understanding the sequence makes the rest of these terms much easier to follow:

- Your provider bills a charge for the visit.
- Your insurance plan reduces that charge to an agreed-upon amount, called the allowed amount.
- If you have not met your deductible yet, you pay the allowed amount until you do.
- Once your deductible is met, the plan starts paying its share, and you pay yours — a copay, coinsurance, or both.
- Once you have paid enough in a year to reach your out-of-pocket maximum, the plan pays 100 percent of covered services for the rest of that year.

THE TERMS

Term	What It Means
Premium	What you pay every month to have insurance at all, whether or not you see a doctor. It does not count toward your deductible or your out-of-pocket maximum.
Claim	The request for payment we send to your insurance company after your visit. You do not need to file it — we do that for you.
Explanation of Benefits (EOB)	The statement your insurance company sends after processing a claim. It shows what was billed, what the plan allowed, what the plan paid, and what may be your responsibility. It is not a bill.
Amount Billed	The full charge for the services you received, before any insurance discount is applied. Almost nobody with insurance pays this number.
Allowed Amount (also called Amount Covered)	The most your plan will count for a service. It is the discounted rate your insurance company and the provider have agreed on in advance. Everything you owe is calculated from this number, not from the amount billed.
Deductible	The amount you pay out of your own pocket each plan year before your insurance starts paying its share. If your deductible is $2,000, you pay the first $2,000 of allowed charges yourself. Some services, such as preventive care, may be covered before the deductible is met.
Copay (Copayment)	A flat dollar amount you pay for a particular kind of visit or service — for example $30 for an office visit. You usually pay it at the time of service. Not every plan has copays.
Coinsurance	Your share of the cost after your deductible is met, expressed as a percentage of the allowed amount. If your plan pays 80 percent, your coinsurance is the remaining 20 percent.

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Term	What It Means
Out-of-Pocket Maximum (Out-of-Pocket Limit)	The most you will have to pay for covered services in a plan year. Once you reach it, your plan pays 100 percent of covered services for the rest of the year. Deductibles, copays, and coinsurance count toward it. Premiums do not.
Participating Provider (In-Network)	A provider who has a contract with your insurance company and has agreed to its rates. Using an in-network provider almost always costs you less.
Non-Participating Provider (Out-of-Network)	A provider without a contract with your plan. Your plan may pay less, or nothing at all, and you may be responsible for the difference between what was billed and what the plan allowed.
Balance Billing	When an out-of-network provider bills you for the part of their charge that your insurance did not cover. In-network providers cannot do this for covered services, and federal law limits it in some emergency and surprise-billing situations.
Prior Authorization	Approval your insurance company requires before certain tests, procedures, or medications. Without it, the plan may refuse to pay even for a service you needed. We handle these requests, but they take time — which is why some things cannot be done the same day.
Non-Covered Service	Something your plan does not pay for at all. You are responsible for the full cost, and it usually does not count toward your deductible or out-of-pocket maximum. Weight management medications are a common example.
Plan Year (Benefit Period)	The twelve-month period your deductible and out-of-pocket maximum are measured across. For many plans it runs January through December, and the amounts reset to zero at the start of the next one.
Your Total Costs	Everything you owe for a visit added together — copay, deductible, coinsurance, and anything your plan did not cover.

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A WORKED EXAMPLE

Suppose you come in for an office visit and we bill $250. Your plan is in-network, your deductible is $2,000, and after the deductible your plan pays 80 percent. Here is how the same visit works out differently depending on where you are in the year.

SITUATION 1 — You have not met your deductible yet.

Step	Amount	Who Pays
Amount billed	$250	—
Allowed amount (in-network rate)	$150	—
Discount you never owe	$100	Written off
Applied to your deductible	$150	You
Paid by your plan	$0	Plan
YOUR TOTAL COST	$150	You

SITUATION 2 — You have already met your deductible this year.

Step	Amount	Who Pays
Amount billed	$250	—
Allowed amount (in-network rate)	$150	—
Discount you never owe	$100	Written off
Plan pays 80 percent of $150	$120	Plan
Your coinsurance, 20 percent of $150	$30	You
YOUR TOTAL COST	$30	You

SITUATION 3 — The same visit with an out-of-network provider.

Step	Amount	Who Pays
Amount billed	$250	—
Amount your plan allows out-of-network	$100	—
Plan pays 60 percent of $100	$60	Plan
Your coinsurance, 40 percent of $100	$40	You
Balance billed to you by the provider	$150	You
YOUR TOTAL COST	$190	You

This is why staying in-network matters. The same visit costs $30 in Situation 2 and $190 in Situation 3. The numbers above are examples only — your plan's deductible, percentages, and allowed amounts will be different.

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WHAT TO CHECK WHEN A STATEMENT ARRIVES

- Is it an Explanation of Benefits from your insurer, or an actual bill from us? Only the second one needs payment.
- Does the date of service match a visit you actually had?
- Was the provider listed as in-network? If they were in-network but the claim was processed as out-of-network, that is worth a phone call.
- Does the patient responsibility amount match what you expected based on your deductible and copay?
- If a service was denied, the EOB gives a reason code. That reason determines what can be done about it.

WHEN TO CALL US, AND WHEN TO CALL YOUR INSURANCE COMPANY

Call	About
Lemon-AID Medical Management	A bill you received from our office Payment arrangements or a payment plan A code or service on our bill you do not recognize Getting a prior authorization started
Your Insurance Company	Why a claim was denied or paid the way it was Whether a provider, test, or medication is covered How much of your deductible or out-of-pocket maximum you have met Appealing a denial — the phone number is on your insurance card

If you are not sure which one to call, call us first. We will tell you which it is, and we will help you sort it out either way.

This page explains terms in general. Your own plan's rules, amounts, and covered services are set by your insurance company and are described in your benefit plan documents. If this page and your plan documents disagree, your plan documents are correct.

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