SPRING MOUNTAIN REHAB
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Billing and Insurance FAQS

What is the difference between coinsurance and co-pay?
Coinsurance and co-pay (copayment) are both ways that you share the cost of healthcare with your insurance plan. Your plan sets the amounts. Coinsurance is a percentage of the total cost for health care. Co-pay is a small, flat fee you pay at the time of service. Not all plans have co-pays, but many plans have coinsurance.

When do I pay coinsurance?
You begin to pay coinsurance after you reach your deductible. Your plan tracks how much you pay toward your deductible. This information is on the Explanation of Benefits (EOB) your health plan sends after you receive care. The EOB shows how much coinsurance, if any, you must pay. You pay this amount directly to the doctor's office, hospital or pharmacy.

How do I calculate my coinsurance costs?

How much you need to pay depends on the "allowed amount" that a doctor can bill for a health care service. This amount is a discounted cost that doctors in your plan network agree to charge.

Here's an example of how coinsurance costs work:
John's health plan has 80/20 coinsurance. This means that after John has met his deductible, his plan pays 80% of covered costs, and John pays 20%.

The allowed amount for a doctor visit:	$100
The health plan pays 80% coinsurance:	$80
John pays 20% coinsurance:	$20

Before his visit, John checked to make sure his doctor was in the plan network so he could get the most coverage and pay less out of his own pocket. If John visits a provider outside his plan network, he may pay more.

- **HSA (Health Savings Account):**
  - If you're insured under a plan with a high-deductible you may be able to open an HSA, an account used solely to save money that is used for future medical expenses.
  - Monies distributed from an HSA used for medical expenses of the account-holder or his/her dependents are non-taxable
  - Disbursed monies not used for medical expenses must be included as part of your gross income on your tax return and may be subject to an additional tax penalty of 20%.
  - After the age of 65, account-holders may withdraw all funds in the account with no tax penalty.

- **HRA (Health Reimbursement Arrangements):**
  - The HRA is a savings account used exclusively to generate funds for medical expenses.
  - Unlike the HSA, an HRA must be purchased and maintained by an employer on your behalf.
  - If and when HRA funds are disbursed, you are required to declare the amount on your tax return as long as the money is used for medical expenses.
  - The availability of an HRA is entirely up to the discretion of your employer, who is also responsible for establishing the fund's contribution limit.
  - Employers cannot reduce your salary in order to contribute to the HRA, and self-employed workers cannot obtain an HRA.

- **FSA (Flexible-Spending Account):**
  - An FSA is similar to an HRA in that both are tax-advantaged savings accounts established by your employer.
  - However, with an FSA, you – not your employer – technically owns the account and makes regular contributions via paycheck deductions.
  - Like an HSA, contributions to an FSA are not taxable; annual contributions cannot exceed $2,500.
  - FSA monies can generally be used to cover a wider range of medical expenses and medications then HSA or HRA funds.
  - FSAs are typically a "use it or lose it" type of account. Account holders must make use of the fund while it is active. However, recent amendments allow employers to change their plans to allow employees to roll over up to $500 of an unused fund into the next plan year without losing the maximum FSA contribution.

- **Deductible:** The amount of money you must pay out-of-pocket before coverage kicks in. Deductibles are usually set at rounded amounts (such as $500 or $1,000). Typically, the lower the premium, the higher the deductible.
- **Coinsurance:** The amount of money you owe to a medical provider once the deductible has been paid. Coinsurance is usually a predetermined percentage of the total bill. If the policy's co-insurance is set at 15% and the bill comes to $100, the policy-holder owes $15 in co-insurance.
- **Co-pay:** This type of insurance plan is similar to co-insurance, but with one key exception: rather than waiting until the deductible has been paid out, you must make their copayment at the time of service. Most often, copayments are standardized by your plan, meaning you'll pay the same $30 each time you see a physician, or the same $50 each time you see a specialist.
- **Out-of-pocket maximum:** The amount of money you pay for deductibles and coinsurance charges within a given year before the insurance company starts paying for all covered expenses.
- **In-network:** This term refers to physicians and medical establishments that deliver patient services covered under the insurance plan. In-network providers are generally the cheapest option for policyholders. Insurance companies typically have negotiated lower rates with in-network providers.
- **Out-of-network:** This term refers to physicians and medical establishments *not* covered under your insurance plan. Services from out-of-network providers are usually more expensive than those rendered by in-network providers. This is because out-of-network providers have not negotiated lower rates with your insurer.
- **Dual coverage:** The act of maintaining a health plan with more than one insurer. For example, many married people receive coverage from both their employers and their spouse's employer. Others may opt to receive individual coverage from more than one insurer.

  It is common for family members to be covered by more than one health care plan. This happens, for example, when a husband and wife both work and choose to have family coverage through both employers.

When you are covered by more than one health plan, state law permits your insurers to follow a procedure called "coordination of benefits" to determine how much each should pay when you have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered health care expenses.

Why is coordination of benefits important?

There are several reasons why coordination of benefits is important, including:

▪ **Ensure payment integrity:** Health plans want to make sure they pay only the amount they are responsible for and do not make duplicate payments.

▪ **Establish who the primary and secondary health plan is:** The primary health plan pays first, and the secondary health plan pays any remaining balance after the beneficiary share of the cost is deducted.

▪ **Prevent payment inaccuracies:** Health plans want to know their financial responsibilities ahead of time which alleviates administrative headaches resulting from overpayment or other payment problems.

- **Coordination of benefits:** This process is applied by individuals who have two or more existing policies to ensure that their beneficiaries do not receive more than the combined maximum payout for the plans. For example, a person could have healthcare coverage through Their employer but also through their spouse and their spouse' employer. Those health plans will have to work together to pay claims correctly. This process is called coordination of benefits (COB)

  COB is complicated, and covers a wide variety of circumstances. This is only an outline of some of the most common ones. If your situation is not described, read your evidence of coverage or contact your state insurance.

Examples of how COB works:

Example #1

Josie incurred medical expenses in the amount of $100. Both health plans considered the allowable expense to be $80 payable at 80%. Deductibles have been satisfied for both plans.

	Coordination
Total charge	$100
Allowed amounts by both	$80

	Coordination
Primary paid	$64 (80% of $80)
Secondary paid	$16 (subtract $64 from $80)
Patient responsibility	$0

Posting payments	**Coordination**
Total billed charge	$100
Primary payment	$64
Secondary payment	$16
Primary reduction	$20 ($100 charge - $80 allowed)
Secondary reduction	Not taken, already zero balance
Patient responsibility	$0

Example #2

Thomas incurred medical expenses in the amount of $100. The primary plan allowed $80 payable at 80%. The secondary plan allowed $90 payable at 80%. Deductibles have been satisfied for both plans.

	Coordination
Total charge	$100

	Coordination
Higher allowed expense	$90
Primary paid	$64 (80% of $80)
Secondary benefit	
Secondary paid	$26 (subtract $64 from $90)
Patient responsibility	$0

Posting payments	Coordination
Total billed charge	$100
Primary payment	$64
Secondary payment	$26
Primary reduction	$10 (only take $10 of the $20 reduction to get to zero balance)
Secondary reduction	Not taken, already at zero balance
Patient responsibility	$0

There may be some patient responsibility depending on the type of coordination the member's plan requires.

- **Continuation of coverage:** This is essentially an extension of insurance coverage offered to individuals no longer covered under a particular plan; it most often applies to former employees and retirees of companies that offer employee coverage. COBRA benefits (see **Group Coverage** section below) qualify as continuation coverage.

- **Referral:** An official notice from a qualified physician to an insurer that recommends specialist treatment for a current policy-holder.
- **Prior Authorization:** 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. This does not guarantee that your insurance company will pay.