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UNDERSTANDING YOUR INSURANCE BENEFITS & RESPONSIBILITES

The "insurance world" is in a constant state of change. **BE PROACTIVE** and understand your insurance benefits and your responsibility so that you can plan ahead for your child's therapy needs. Understanding and monitoring your benefits will eliminate any insurance reimbursement "surprises".

Most insurance plans operate on a calendar year (Jan 1- Dec 31). Your *DEDUCTIBLE*, if it applies*, will begin again on January 1, 2016 unless your BENEFIT YEAR* is different. Your policy may also have *CO-PAY** or *CO-INSURANCE**. Your *co-pay* is due at the time of service and your *co-insurance* is billed to you after your insurance company processes each claim.

Because it is impossible for a provider to know all the details about everyone's policy, it is ultimately your responsibility to understand your policy and benefits that it provides.

The following information is provided in attempt to educate and support you in understanding your insurance benefits and responsibilities.

All deductibles, co-insurance and co-pays are your financial responsibility. Check your medical insurance policy and know:

1) What is my ***benefit year***?
   Is it a "calendar year" (Jan 1 to Dec 31) or "plan year" (i.e. July 1 to June 30)?
2) What is my ***deductible*** amount per benefit year? Does the ***deductible*** apply to therapy services?
3) Does my policy require a ***co-pay***? How much is my ***co-pay*** per therapy visit?
4) Does my policy require a ***co-insurance***? What is my ***co-insurance*** % per therapy visit?
5) How many **therapy *visits*** are available on my plan?
6) Does my insurance require ***pre-authorization*** before my child can be seen for evaluation and/or treatment?
7) Does my plan have any ***exclusions*** for therapy services based on how my insurance company defines medical ***necessity*** (diagnoses or issues that are NOT covered).
8) Does my plan provide benefits for the treatment of autism under the "***PA Autism Mandate***" (if applicable)?

You will receive a bill from the Center for Pediatric Therapy if:

- You owe towards your deductible. You will continue to be billed until your deductible has been met ("*satisfied*").
- You owe a co-insurance % due for each visit. You will be billed AFTER your insurance processes the claim.
- You owe any other outstanding balance on your account.
- You owe a no show or late cancellation fee.

Please read the EXPLANATION of BENEFITS (EOB) notice that you receive from your insurance company.
Your EOB will indicate the amount of *deductible*, *co-insurance* or *co-pay* that is due for each therapy visit (typically indicated as "*member responsibility*"). If you do not receive EOBs from your insurance in the mail, set up an on-line account with your insurance so you can access your EOBs. You can also contact your employer or contact your insurance company directly for assistance.

By reading your EOB, you will specifically see what has been **paid by your insurance**, what is **your financial responsibility.**

If you are AWARE of the information on your EOB, you should not be surprised when you receive a billing statement. You may also be able to spot processing errors. Please notify your insurance and the Center for Pediatric Therapy IMMEDIATELY if you notice an error.

There is a lot of helpful information included on your EOB. If you need assistance in learning how to understand your EOB, please let us know and **we will gladly assist you**.

The following DEFINITIONS have been compiled to assist you in understanding your insurance benefits and the process that occurs when any health care services are provided. These selected *definitions are those most commonly encountered within our scope of practice.* *(Reference: adapted from http://www.healthinsurance.org/glossary/)*

A. DEFINITIONS: Determining Your Benefits or Eligibility for Services

- The **CERTIFICATE OF INSURANCE** is a printed description of your benefits and coverage provisions. It is a contract between the insurance carrier/company and the customer (you). It specifically discloses what is covered, what is not covered, and dollar limits.

- The **EFFECTIVE DATE** is the date your insurance coverage starts.

- The **BENEFIT YEAR** is a one (1) year time frame during which your policy is effective. The **benefit year** for most insurance plans is a "calendar year" (Jan 1 to Dec 31 of each calendar year). However, the **benefit year** for some plans is different and could start with any month of the year (i.e. May 1-April 30). Be aware….NON-calendar year plans are becoming increasingly more common.

- The **DEDUCTIBLE** is the amount you must pay for your health care expenses (medical bills) BEFORE insurance starts to cover any costs. Insurance plans typically specify a yearly **deductible** amount. **High deductible** plans ($1,000 or more) are becoming increasingly more common because of the rise in health care costs. This allows employees to share the financial burden of rising healthcare costs with their employers. In some policies, the **deductible** does NOT apply to therapy services.

- **CO-PAYMENT** (or co-pay) is a predetermined (flat) fee that an individual pays for health care services, in addition to what the insurance covers. For example, some plans require a co-pay for each office visit. The **co-pay** amount may vary between $10-$75. **The co-pay amount is due at the time of service.**

- **CO-INSURANCE** refers to amount you are responsible for paying for your health care expenses (medical bills), after the deductible has been paid. **Co-insurance** is often specified by a percentage. For example, the employer or insurance company pays 80% and the member pays 20% toward the cost of medical services. If services are rendered by an out-of-network provider the member's **co-insurance** responsibility is typically higher (i.e. 70% / 30% or 50% / 50%).

- **MEDICAL NECESSITY** refers to specific criteria which determines if a service qualifies as a covered medical expense. This criterion is defined by your insurance plan and may vary depending upon your insurance carrier. ALL services MUST be **medically necessary** in order for your insurance to pay for the bill.

- The number of **THERAPY VISITS** "allowed" (maximum number of visits eligible to be paid for by your insurance) is determined by your specific insurance plan. It is typically a specific number limit (i.e. 12, 20, 30, etc.) but occasionally is "unlimited". Because visits are "unlimited" or you have ___ # of visits on your plan, this does not entitle you (or your child) to automatically receive unlimited visits or the maximum # of visits available on your plan. All services must still meet "medical necessity" criteria and be documented accordingly in order to be reimbursed by your insurance company.

- **PRE-AUTHORIZATION** (if required by your specific plan) is a process that MUST occur PRIOR to the services being provided or the insurance will NOT pay for the services. Some insurance plans now impose a penalty if pre-authorization is not obtained prior to services being rendered. The initial and subsequent preauthorization requirements and authorization periods vary greatly from plan to plan (i.e. every 4 visits; every 12 visits; after the first 8 visits and then every ___visits thereafter; etc.) This process is not required by all insurance plans. It is in place to assure that the services provided meet the "medical necessity" requirements and to monitor potential excessive

and/or inappropriate use of medical benefits. Some insurance companies contract with another company to provide this level of monitoring which is referred to as *utilization review* or *medical management*.

- An **EXCLUSION** is a specification within a health insurance policy that eliminates coverage for certain diagnoses, services, provider types or provider locations (i.e. hospital-based vs. professional provider). If we are aware of a specific exclusion with your plan, we will discuss it with you (i.e. Capital Blue Cross does not cover sensory treatment).

- **IN-NETWORK** refers to health care providers that are part of a health plan's network of providers with which it has negotiated a discount. You will typically pay less when using an in-network provider, because those networks provide services at lower cost to the insurance companies with which they have contracts.

- **OUT-OF-NETWORK** (out-of-plan) refers to health care providers that are NOT part of a health plan's network and therefore are considered non-participants in an insurance plan. Depending on an individual's health insurance plan, services provided by out-of-network provider may not be covered (i.e. if HMO) or covered only in part (i.e. if PPO) by an individual's insurance plan.

B. DEFINITIONS: Understanding the Billing Process and Payment for Services:

- A **CLAIM** is a written request ("bill") submitted by the provider to the insurance company for services rendered. A standardized insurance form which requires very specific and complete information is used throughout the insurance industry. Most providers now submit insurance claims electronically. You may self-submit your claims if we do not participate with your specific insurance plan. In this case your insurance company would provide a form for your use. A claim may be paid or denied based on your insurance company's policy.

- An **EXPLANATION OF BENEFITS (EOB)** is the insurance company's written explanation regarding each **claim**. Each EOB shows what the insurance company paid to the provider (or individual if you self-submit your claims); what the patient/insured is responsible to pay (co-insurance, deductible, non-covered services, etc.). If a claim is **denied** (the insurance will not pay), an explanation code is usually provided. Please note…it is often very difficult to interpret what the code means or if the accurate code was used to indicate the real reason the claim was denied. A copy of the EOB is sent to the insured (you) and to the provider (us). The provider then uses this information to bill the patient/insured the portion of the cost that is their responsibility or to argue why the claim denied.

- The **USUAL, CUSTOMARY and REASONABLE (UCR) or COVERED EXPENSE** refers to the amount your insurance company will reimburse for a specific covered services regardless what a provider charges for that service.

C. DEFINITIONS: Miscellaneous

- **COBRA** is the *Consolidated Omnibus Budget Reconciliation Act of 1985*, federal legislation that allows you (if you work for an insured employer group of 20 or more employees) to continue to purchase health insurance for up to 18 months if you lose your job, or your employer-sponsored coverage is otherwise terminated.

- The **OUT-OF-POCKET MAXIMUM** is a predetermined limited amount of money that you must pay out of pocket, before your insurance company will pay for 100 % of your eligible health care expenses.

- **STATE MANDATED BENEFITS** may be available when a state passes laws requiring that health insurance plans include specific benefits (i.e. **ACT 62 – Penna. Autism Mandate** benefits). In the case of the ACT 62 Autism Mandate, if a child has a confirmed medical diagnosis of autism, he/she will be able to receive certain approved services (therapy, behavioral, etc.) beyond the limits of their insurance plan up to approximately $36,000+ per benefit year. There is also specific employer criteria that must be met for the benefits to be mandated.

*If you need assistance, please let us know and **we will gladly assist you**.*