CEREBRALCOUNSELING
HEALING FOR THE MIND

A Guide to Understanding Insurance and Patient Responsibility

Insurance 101

Your insurance covers mental health services—which means you won't have to pay anything out-of-pocket for your therapy visits, right? Unfortunately, not quite. Insurance can be tricky to navigate and difficult to understand since every policy is different and full of jargon you might have never heard before. The fact that your insurance plan covers mental health services— or any other services for that matter— doesn't necessarily mean there are no payments to be made after your visit.

In many cases, you'll still have to pay a deductible, out-of-pocket costs, a co-insurance, or a copayment. Talk about complexity. Insurance companies can be difficult to work with and obtain information from. To better understand the terms of your plan, you first must understand the terminology.

Here are a few common terms regarding insurance lingo:

In-Network: In-network refers to providers or health care facilities that are part of a health plan's network of providers and has a signed contract agreeing to accept the health insurance plan's negotiated fees.

Out-of-Network: This phrase usually refers to physicians, hospitals, or other healthcare providers who do not participate in an insurer's provider network. This means that the provider has not signed a contract to accept the health insurance plan's negotiated fees.

What is a Deductible?

This is the **total amount you must pay out-of-pocket before your insurance starts to pay**. For example, if your deductible is $1,000, then your insurance won't pay anything until you have paid $1,000 for services subject to the deductible (keep in mind that the deductible may not apply to every service you pay for. Mental health services for instance mostly use out-of-pocket). Furthermore, even after you've met your deductible, you may still owe a copay or coinsurance for each visit which can also apply to your out-of-pocket costs.

What is a Copay?

This is a **fixed amount that you must pay for a covered service**, as defined by your health plan. Copays usually vary for different plans and types of services. Typically, you must pay this amount at the time of service. Again, copayments are fixed—which means you will always pay the same amount, regardless of visit length. In most cases, copayments go toward your deductible. Even if you have a copay, you might still have to pay toward your deductible, co-insurance, or out-of-pocket costs.

What is Coinsurance?

This type of out-of-pocket payment is calculated as a percent of the total allowed amount for a particular service. In other words, it's **your share of the total cost**.
For example, let's say: Your insurance plan's allowed amount for an office visit is $100.

> You've already met your deductible. You're responsible for a 20% coinsurance. In this situation, you'd pay $20 at the point of service.

The insurance company would then pay the rest of the allowed amount for that visit. Keep in mind that the coinsurance amount may vary from visit to visit depending on what services you receive.

What is an out-of-pocket maximum?

An out-of-pocket maximum is **the most you will have to pay each year** for healthcare services covered by your insurance plan. Once you meet your out-of-pocket maximum, your health insurance will cover all of the remaining costs for your covered services that year, as long as you use in-network providers.

For example, if your individual out-of-pocket maximum is $3,500, your insurance will cover all costs after you pay a total of $3,500 toward your covered healthcare services that year.

Which costs count toward my out-of-pocket maximum?

There are **three categories of expenses** that count toward your out-of-pocket maximum: deductibles, copayments, and coinsurance.

What is the coinsurance for Medicare Part B?

Medicare Part B patients are responsible for a 20% coinsurance, which typically amounts to $11 to $25 per visit. This can vary higher or lower depending on the services provided. If you have original Medicare as your primary insurance, but you also have a secondary insurance, the secondary payer becomes responsible for the 20%. In some cases, the secondary insurance also charges a copay, coinsurance, or deductible. We recommend contacting your secondary insurance carrier to find out. If you need assistance, we are happy to help you navigate your benefits.

Examples of EOBs - (Explanations of Benefits)

Here are a few examples of Explanations of Benefits (EOBs) for general health services. An EOB is a document your insurance sends to explain the various costs—including the amount you, as the patient, are responsible for— associated with your care. For definitions of the terms included in these examples, skip down to the bottom section of the page.

Insurance 1: Patient has not yet met his or her annual deductible. Therefore, the patient is responsible for 100% of the allowed amount. Patient responsibility has been adjusted for contracted rates.

Date of Service	CPT Code	Units	Billed Amount	Adjusted Amount	Patient Responsibility	Insurance 1 Paid
03/01/2017	97110	1	50.00	20.04	29.96	0.00
03/01/2017	97140	2	100.00	44.58	55.42	0.00
TOTALS:		3	150.00	64.62	85.38	0.00

Insurance 2: Patient owes a 20% coinsurance for services since the deductible does not apply.

Date of Service	CPT Code	Units	Billed Amount	Adjusted Amount	Patient Responsibility	Insurance 2 Paid
03/01/2017	97110	2	100.00	42.47	11.69	45.84
03/01/2017	97140	2	100.00	54.19	9.31	36.50
TOTALS:		4	200.00	96.66	21.00	82.34

Insurance 3: Patient owes a $10 copay for visits. Everything else is covered at 100% for eligible services.

Date of Service	CPT Code	Units	Billed Amount	Adjusted Amount	Patient Responsibility	Insurance 3 Paid
03/01/2017	97140	2	100.00	30.00	10.00	60.00
03/01/2017	97535	1	45.00	45.00	0.00	0.00
TOTALS:		3	145.00	75.00	10.00	60.00

A Few Handy Definitions

CPT Code: The code denoting each service provided to you during your visit (e.g., manual therapy, therapeutic exercise, self-care instruction, aquatic therapy, etc.). You can request a list of these codes—along with their explanations—from your insurance company or Cerebral Counseling.

Billed Amount: This is the amount we billed the insurance company for that particular service. The billed amount may vary depending on the duration of the service, the facility in which the service was provided, or the state in which the facility is located.

Adjusted Amount: This amount is not a payment, but rather a write-off or "reduction." It is based on the contract in place between your provider (us) and your insurance company. Neither you nor the insurance company pays this amount. The provider essentially writes it off (which is why it is sometimes called the provider's responsibility).

Patient Responsibility: This column may be labeled "Deductible," "Copay," "Coinsurance," or "Patient Pay." It is the amount that you, the patient, are responsible for paying. If a secondary insurance is on file, we will forward this amount to that insurance for payment. Once we get the secondary EOB back, you will receive a bill for any outstanding balances in the patient responsibility column.

Insurance Paid: This is the amount the insurance company paid us for the services you received on that date of service.

Questions and Concerns

What if I can't afford to pay these amounts as frequently as I need care?
Your health is our number-one priority. As such, we are happy to arrange a payment plan that works with your budget. That way, you can pay for your care over a timeframe that works for you. Simply ask to speak to our office/billing manager and we will be happy to provide you with a plan.

Can you comment on the practice of waiving copays and deductibles?
It is unlawful to routinely waive copays, coinsurance, and deductibles. Providers are at risk of violating Federal Anti-Kickback Statutes, Federal False Claims Act, and state laws. The only legitimate reason to waive a copay or deductible is the patient's genuine financial hardship and will be evaluated on a case-by-case basis.

What does "not subject to deductible mean?"
When a service is not subject to the deductible, it means you've actually got *better* coverage for that service. The alternative is having the service be subject to the deductible, which means you'd pay full price unless you'd already met your deductible for the year. Don't panic when you find out that services aren't subject to the deductible. As long as they're covered by your plan, this just means that you'll pay less for those services than you would if they were subject to the deductible.