

How does health insurance billing work?



Quick Reference Guide

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What are the different types of health insurance plans?

An insurance company will offer a variety of different plans to meet specific needs or provide various levels of coverage and benefits. When you visit a healthcare facility, it's not enough to just say the name of your insurance company - you'll also need to know your specific plan information.

Two of the most common types are:

Health Maintenance Organization (HMO)

An HMO has a specific network of healthcare providers that you can see that accept your insurance. If you see a healthcare provider outside of this network, you may be responsible for the full cost of any visits or services you receive.

Preferred Provider Organization (PPO)

A PPO also has a specific network of healthcare providers that accept your insurance, although you will have the ability to see healthcare providers out of network. If you see a healthcare provider out of network, your insurance will still cover the visit. But you'll pay more than if you saw an in-network healthcare provider.

There are also other types of health insurance plans beyond HMOs or PPOs.



Check out the definition guide created by the US Department of Health or contact your insurance company for an overview of how your plan works.



How does insurance billing work?

This chart outlines examples of various costs you **may** have to pay before, during, or after an appointment with a healthcare professional.

Before



Referral:

A written or electronic note from your primary care physician stating that you need to see a specialist. A specialist is a doctor or healthcare provider who offers specific types of care.

Prior authorization:

Approval from a health plan that may be required before you get a service or fill a prescription in order for the service or prescription to be covered by your plan.

During



Co-pay:

A fixed amount you pay each time you have a medical service provided, like a doctor's visit - your share of the cost.

Coinsurance:

Your share of the cost for a covered health care service, usually calculated as a % of the amount allowed for the service.

Deductible:

The amount you need to spend for covered health services before your insurance pays anything. Some plans will automatically cover preventive services, like your regular primary care physical and routine exams or screenings.

Out of network:

Health providers not contracted with your health care carrier. Seeing a provider out of network will cause you to pay a greater amount for the service.

After



Claim:

A claim is a request for your insurance company to cover the costs of a healthcare visit.

Reimbursement:

The amount the health insurance company pays you back for money you spent out-of-pocket for a service or if you overpaid. Reimbursements typically occur after a claim is submitted.



When you have an appointment with a healthcare provider, you'll be charged for the services provided. Your insurance plan coverage will determine what and when you pay for that visit.

You may encounter **one or more of these billing scenarios:**

You pay some costs at the appointment.



If your healthcare provider has a co-pay, or if your plan has coinsurance, you'll pay those when you check-in for the appointment.

Your insurance company re-imburses you.



You pay the full costs of a visit up front, and your insurance company sends you a check (or direct deposit) in the mail for the amount your insurance covers.

You're charged by your insurance company after a visit.



You'll go to the appointment and afterwards, you'll get a bill and an explanation of benefits from your insurance company.

You pay the full costs until you meet your deductible.



Once you reach a certain amount of out-of-pocket costs (like \$700 or \$1500), your insurance company will cover the costs of a visit.

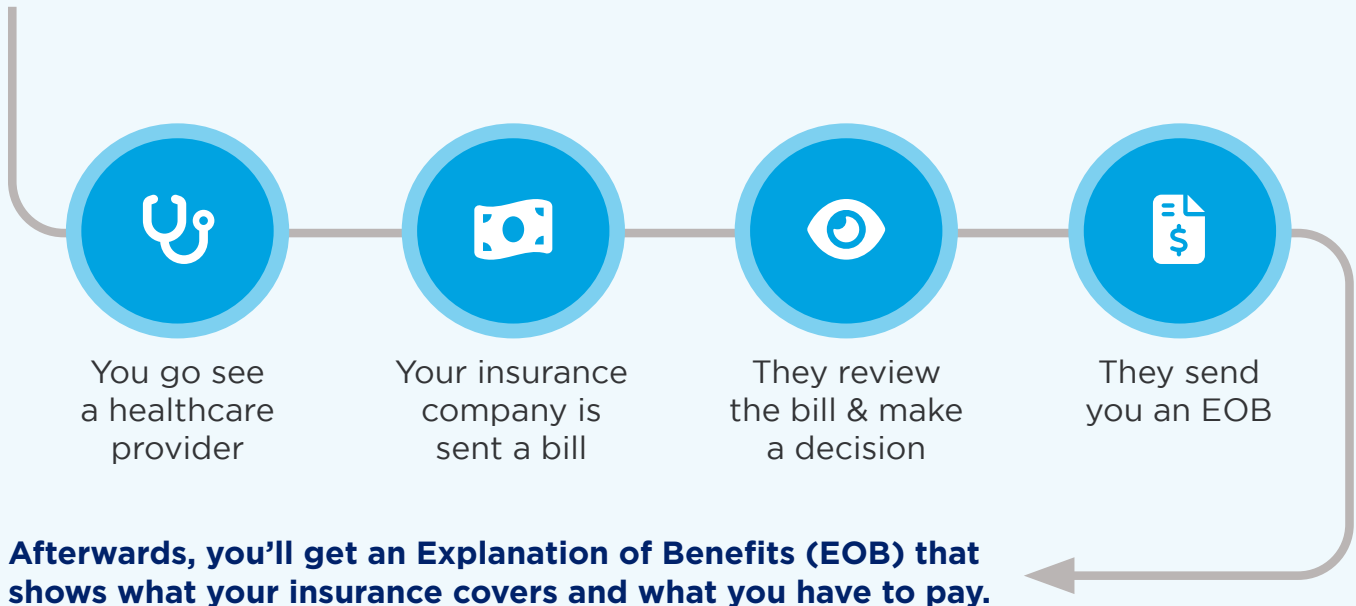
You pay the full costs of the visit.



If you see a healthcare provider that doesn't accept your insurance, your insurance may not cover any costs. Or, if your plan requires referrals, you may be charged for all costs if you don't meet with your primary care provider first.

What are insurance claims?

A claim is a request for your insurance company to cover the costs of a healthcare visit.



What's the difference between a healthcare bill and an **explanation of benefits (EOB)**?

A bill is sent to you by your healthcare provider, while an EOB is from your insurance company.

When visiting a provider's office (for primary care, a specialist, a hospital visit, etc.) you can request an **itemized bill** listing each service and the cost. These receipts will often list:

- › The full price of each service
- › How much you will pay out of pocket
- › The amount covered by your insurance

When your insurance company has received a claim, they may send you an **Explanation of Benefits**, (EOB). The EOB will list:

- › The cost of each service you received at a healthcare visit.
- › The amount your insurance company covered.
- › An explanation for any services your insurance will not cover, which you are responsible for paying.

Who can see a medical bill?

After an appointment, you'll be sent a bill and a receipt for services. The bill may be mailed to your address or sent to you via email. Anyone you live with (or has access to your email) can view the bill. If you use a credit or debit card, the charge will appear on that statement.

If you have concerns about where a bill goes, you can advocate for yourself:



Make sure your contact information is up to date, including your mailing address and email.



Choose how you pay for the visit.



Ask how services are listed on a bill. For example, is it possible for them to list a charge as "laboratory services" or a "specialist consult" as opposed to listing the exact services used.



Request to speak to the administrative team for your provider. Many hospitals and medical groups will have dedicated staff to support patients in navigating medical bills or providing financial assistance.



Want support with planning out conversations with your healthcare providers about your bill and the services provided?

You can schedule a Health Promotion Appointment with a Resource Specialist at Columbia Health.

Who can see a health insurance statement?

After an appointment, you'll be sent a statement and an EOB for services. These may be mailed to your address or sent to you via email. Anyone you live with (or has access to the insurance portal) can view the statement and EOB. If you use a credit or debit card, the charge will appear on that statement.

If you have concerns about where a statement goes, you can advocate for yourself by:



Make sure your contact information is up to date, including your mailing address and email.



Ask how services are listed on a bill. For example, is it possible for them to list a charge as “laboratory services” or a “specialist consult” as opposed to listing the exact services used.

You can also request that your insurance not be billed for any given visit or treatment.

This means that you will be responsible for paying **the full cost of services**. If you decide to do this, talk to your provider's administrative staff about potential payment plans or other financial assistance programs they may offer.



Want support with planning out conversations with your insurance policy holder or healthcare providers about your bill and the services provided?

You can schedule a [Health Promotion Appointment](#) with a Resource Specialist at Columbia Health.

How do I view my insurance statements & benefits?

To access your insurance information, log in to your insurance company patient portal. If you are unsure how to access your patient portal, you can do an internet search for “*your insurance company member log-in.*”

Some examples of directories for reference are:



[BlueCross BlueShield Access my Benefits](#)



[Aetna Summary of Benefits & Coverage](#)



[United Healthcare Summary of Benefits & Coverage](#)



[Cigna Plan Documents](#)

Medicaid.gov
Keeping America Healthy

[Medicaid Mandatory & Optional Benefits](#)

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