Stanislaw P. Chorzepa, D.O.
211 New Britain Road,
Suite 103
Berlin, CT 06037
Phone: (860)893-0300
Fax:(860)893-0301

The Patient's Basic Guide to Understanding Insurance

Insurance 101 for Patients

So, your insurance "covers" your healthcare needs—which means you won't have to pay anything out-of-pocket for your radiology, labs, physician and/or therapy visits, right? Not quite. The fact that your insurance plan covers medical services doesn't necessarily mean you're off the hook as far as payment goes. In many cases, you'll still have to pay a deductible, a co-insurance, or a copayment. Talk about tricky.

To better understand the terms of your plan, you first must understand the terminology. Here are a few common questions regarding insurance lingo:

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). Furthermore, even after you've met your deductible, you may still owe a copay or co-insurance for each visit.

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, copay amounts are fixed—which means you will always pay the same amount, regardless of visit length. In most cases, copayments go toward your deductible.

What is a 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.

Medicare Part B Deductible

The annual deductible for all Medicare Part B beneficiaries is $185 in 2019. You are responsible for that full amount before Medicare pays 80% of your charges unless you have secondary insurance that covers deductibles. After the annual deductible has been satisfied, Medicare will cover 80% of your charges.

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What is the coinsurance for Medicare Part B?

Medicare Part B patients are responsible for a 20% coinsurance, which typically amounts to $11-25 per visit. 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.

*So, how much will I owe for each visit?

If you have not yet met your deductible, then you will pay whatever amount the insurer has contracted on behalf of you/your company/your employer per visit. Coinsurances are usually a dollar amount equal to the percentage of a predetermined/contracted price as per your insurer's instruction. Other than copayments, we collect coinsurance and deductible balances after we receive the Explanation of Benefits (EOB) from your insurance company.
You will get a bill either via text, email or USPS indicating that amount due. All charges/balances are due upon receipt of your bill. As for copays—these amounts rarely vary, so if your copay for is $10, you will owe $10 at each visit.

Regardless of whether you want to see the physician or the physician wants to see you, there is a charge for each visit submitted to your insurer and therefore, you incur a charge. Surgery is the only time there is a “global period” which is defined as a period before and after your surgery, that care(office visits) are included in the surgical price. However, Dr. Chorzepa is not a surgeon and that would be unlikely to apply at our office. Sometimes people feel that it is a follow-up to another visit. Even if it is, meaning you started on a medication or are being called back to discuss lab work or any other similar situation, the visit requires us to submit a claim to your insurer and therefore you may owe your deductible, a co*payment or coinsurance as no matter who requests the visit, the fact is a visit with your physician requires the time of the physician. Physicians get paid based on complexity of visit, length of time of visit and/or how much was addressed/ordered. For example, if a physician orders lab work and x-rays, eventhough you may have only seen the physician for 15-20 minutes and discussed 3 problems, reviewing the labs and other tests takes time as well. That time is figured into the complexity of your visit and therefore it is coded accordingly.

A Few Handy Definitions

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.

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A Couple of Notes

- Most insurance companies offer several different plans or subsidiaries. Thus, two patients with Blue Cross Blue Shield, for instance, may have completely different benefits, and therefore, completely different financial responsibilities. Some plans have no copays or deductibles; others may have a $10,000 deductible. Furthermore, some providers may not accept all plans from a particular insurance. This is why it is crucial that you investigate the details of your specific plan.
- If your insurance offers an online patient portal, sign up for it! These resources typically enable you to:
    - check your benefits,
    - track your deductible,
    - see which providers in your area accept your particular plan,
    - track your claims, and
    - compare claims to your receipts from the doctor's office (if they don't match up, you can then follow up on any discrepancies).

If you have further questions about your particular insurance, please contact them directly. This is a general informational outline for our patients who are unfamiliar in general terms with how health insurance works. Unfortunately there are 100s of insurance plans that we deal with. Our office cannot familiarize ourselves with all of them in terms of details and what is covered, etc. However, as the insured of a plan, it is your responsibility to get to know your OWN plan. You have one insurance plan, take some time to familiarize yourself by reading materials provided by the insurer or call them directly to get anything you don't understand explained and also, there is always the internet where so many plans do offer patient portals and other resources.

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Tips for Choosing an Insurance Plan

Whether you're shopping for your own insurance or going through the benefits selection process with your employer, choosing the right plan can seem like an overwhelming task. While we can't tell you which specific plan to choose, the following questions should help you with the selection process.

Questions to Ask Potential Insurance Carriers

What is my premium?

This is the monthly amount you pay for coverage. The lower it is, the higher your deductible will typically be. Plans with low premiums and high deductibles often are called "catastrophic" plans. Conversely, higher premium plans often feature lower deductibles, copays, and coinsurances.

What is my deductible, and what does it apply to?

This is the total amount you must pay each year before your insurance begins to pay. For example, if your deductible is $4,000, then you must pay $4,000 toward deductible-applicable services before your insurance will pay anything. Once you reach your deductible, your copay or coinsurance will apply.

What is my copay?

High copays are another common drawback to low-premium plans. Remember, the copay applies even after you have met your deductible, and the copay for specialist visits—including PT visits—can be as high as $80. So, if you anticipate a lot of office visits during this plan year, you will definitely want to factor the copay into your decision process.

What is my coinsurance?

As previously noted in this document, coinsurance is another version of cost-sharing. So, you'll likely have to pay either a coinsurance or a copay. However, while copays are fixed amounts—and thus, are more predictable—coinsurances are percentages. Therefore, your financial responsibility varies based on how much your provider charges for the services rendered.

Are there any restrictions on the types of providers I can see?

Some insurance plans (e.g., PPOs, HMOs, and EPOs) are limited to a certain network of providers. So, make sure you have a good selection of covered providers and facilities in your area. If you travel frequently or live in a rural area, you may want to choose a plan that has no network restrictions.

Do I have to get a referral to see a specialist?

If your insurance plan requires you to obtain a referral before seeing a specialist (e.g., a physical therapist, a neurologist, cardiologist, etc), and you fail to do so, the insurance company may deny coverage for services rendered. So, if you do not want to go through a primary care provider (e.g., your family physician) each time you want to see a specialist, make sure your plan does not require a referral for specialist services.

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How many visits of "X" am I allowed each year?

In this case, "X" represents a specific type of service (e.g., physical therapy, occupational therapy, or chiropractic). Some plans place a limit on the number of covered visits per year (e.g., 20 visits), while others allow for unlimited visits. If you're athletic, have chronic joint pain, or anticipate needing a joint replacement in the near future, you may not want any restrictions on the number of rehabilitative visits allowed.

For Medicare secondary payers: Will this plan cover the entire 20% not covered by Medicare?

Medicare only pays 80% of the cost of care, so many Medicare beneficiaries seek secondary insurances to pay the other 20%. However, even those plans often feature deductibles, copays, coinsurances, or visit limitations. Thus, we recommend posing all of the above-listed questions to any secondary insurances you are considering.

The Bottom Line

Higher-premium plans are generally better for individuals who expect to receive medical care on a regular basis. Lower-premium plans will save those individuals money monthly, but those savings won't make up for the cost-sharing portion.

Our office has had some good experiences with a few local agents if you are looking for a name of one to help choose your Medicare insurance or to buy insurance, we will be happy to share the names of those individuals with you. We do not endorse them nor do we get anything for recommending them. We use some of these individuals for ourselves and our families and feel that if we are comfortable and trust them after many years, we can easily recommend them to our patients. We have heard nothing but praise for these agents from those patients we have referred and there is no charge from the agent for consulting with them or even just getting a second opinion. Please ask us if you would like us to help with such a recommendation.