

Understanding Your Insurance

We know that insurance can be very confusing and frustrating to navigate, but it is much easier to advocate for yourself and your family if you understand how your insurance works. While each plan is different, here are some important general terms to know:

Copay

Your copay is **a set amount that your insurance requires you to pay for every visit**. This amount is determined by your insurance plan, not your doctor's office, and may be different depending on what type of provider you see. **Copays are always due at the time of service.**

Coinsurance

Coinsurance is similar to a copay, but instead of a set dollar amount, it is **a percentage of the total cost of the visit**. Like a copay, your coinsurance is determined by your insurance plan, not your doctor's office, and the total amount will vary based on various factors such as the length of the appointment, the type of appointment, and the type of provider. Some plans include both a copay AND a coinsurance amount. While copays are always due at the time of service, your coinsurance will be calculated by your insurance when they process your claim.

Deductible

Most insurance plans have a deductible. Your deductible is **the amount your insurance company requires you to pay before they will begin paying toward your visits**. Just like copays and coinsurances, this amount is determined by your insurance plan, not your doctor's office. Deductibles can be particularly confusing because there are usually rules and exceptions on every plan. For example, the deductible may apply to certain services and not others, or they may pay for a certain number of visits before they require you to begin paying toward your deductible. Understanding your deductible is extremely important so that you aren't surprised by large out-of-pocket costs you weren't prepared for.

Out-Of-Pocket Maximum

Your out-of-pocket maximum is **the maximum you will need to pay during your plan year**. Once you have reached your out-of-pocket maximum, you will not need to pay anything toward any healthcare costs for the rest of your plan year, including copays. It is important to note that your deductible and your out-of-pocket maximum are not the same, and may be a different amount. For example, you may have met your deductible, but still have \$2000.00 more to meet before you have met your out-of-pocket max.

Prior Authorization

Some services require a prior authorization to be put in place before insurance will pay. These requirements are determined by your insurance company as well and vary from plan to plan. A prior authorization requirement means that your insurance plan wants to review the requested service and your specific situation and determine whether or not it is necessary before they agree to pay for it.

Plan Year

Your plan year is **the 365-day period after your insurance started**. Most plan years start over at the beginning of the calendar year, but not all do. This will depend on how you purchase your insurance. For example, if you purchase your insurance through the health insurance marketplace, your plan year likely begins on the first day of the calendar year. If you get your insurance through your employer, your plan year will begin on the date the plan was purchased. All deductibles and out-of-pocket maximums reset at the beginning of every plan year. **Your plan details will likely change a little every plan year, even if your ID and Group number stay the same.**

Claims Processing

Whenever you see any provider, they submit the details of your visit to your insurance company in the form of a claim. Your insurance company reviews the details of your visit and decides whether or not it is a covered service, how much they are willing to pay for it, and what they expect your financial responsibility to be. **The amount of time it takes insurance to process claims can vary greatly**, from 2 weeks to a few months, and they may not process in order. For example, a visit you had on February 3rd may process before a visit you had on January 15th because the first one was held back for review. After your insurance has processed the claim, they will send both you and your provider an EOB (Explanation of Benefit) or EOP (Explanation of Payment). Once your provider has received the EOB or EOP, they will update the visit in their billing software, and your balance, if any, will reflect the decision made by your insurance.

Timely Filing

Timely filing is **the amount of time an insurance company will allow before they will no longer accept a claim for processing**. This time limit varies by insurance. **Timely filing limits and prior authorization requirements make it imperative that you notify all of your providers whenever your insurance has changed** if you hope to have your visits billed to your insurance rather than having to pay for them out of pocket.

Contractual Agreements

By signing up for your insurance plan, you become legally responsible for all of your expected contributions, including copays, coinsurances, and deductibles. Your insurance company calculates how much they believe you have contributed, and base your coverage off of that amount. A refusal to pay those amounts is a violation of your contract with your insurer. Additionally, your provider has a contractual agreement with any insurance they are credentialed with. This means that your provider is required to follow the rules and guidelines established by their contract with the insurance company.

In-Network and Out-of-Network

In-network providers have a contract with your insurance company, out-of-network providers do not. **Your insurance coverage is based on in-network providers only.** You may or may not have out-of-network coverage, which will be different than your in-network coverage. It is important to always check before seeing any new provider whether or not they are in-network with your insurance, and what your out-of-network benefit includes if they are not.

We strongly encourage you to read your coverage documents carefully each year and to call your insurance company with any questions. Although it can feel overwhelming, it benefits you greatly to know how your insurance works and what to expect in advance.

Helpful questions to ask your insurance company:

- Do I have mental and behavioral health benefits?
- What is my deductible, and has it been met yet this year?
- Am I responsible for a copay or co-insurance fee when I see a mental health provider?
- Does my plan have any limits on the number of mental or behavioral health sessions I can have per year?
- How much does my plan cover for an 'out of network' provider?
- Is approval required from my primary care doctor?

If you have any questions about your account at Sendan, including questions about your balance and what your insurance is being billed for, please call our billing department at **360-305-3275, ext. 3**.

Want to send us your new insurance information from home? Go to sendancenter.com/current-patients/billing-questions and click the link for "Client Insurance Update Form."