

Understanding Insurance Coverage & Your Bill From HealthCARE Express

After your visit to HealthCARE Express, our billing office will submit a claim to your insurance company. The **claim** lists the services provided to you during your visit. The insurance company uses the information in the claim to pay Healthcare Express for those services.

When the insurance company pays HealthCARE Express, you might receive a report from the insurance company called an **Explanation of Benefits (EOB)**, explaining how your insurance processed the **claim**. You need to be able to read and understand the EOB to know what your insurance company is paying for, what it is not paying for, and why. **An EOB is not a bill.**

HealthCARE Express will send you **statement** (see back of this page for a sample statement). A statement shows how much Healthcare Express billed your insurance company for the services you received. If you receive a statement before your insurance company pays HealthCARE Express, you do not need to pay the amounts listed at that time. **After your insurance company pays HealthCARE Express, you may need to pay the balance due.**

Not all insurance companies send EOBs. You should check with your insurance company if you do not receive an EOB and are unsure about paying your statement balance at HealthCARE Express.

BILLING QUESTIONS:

If you still have questions about you statement, please contact our Billing Company:

HealthCARE Express
3101 Kennedy Lane, Ste. 100
Texarkana, TX 75503
Phone: 903-831-7270

Actual Charge: the charge(s) for a particular service/treatment by a health care provider

Annual Limits: maximums on the dollar amounts the plan will pay for any given year

Approved Charge: the dollar amount on which your insurer bases its payments and your co-payments.

Benefit Maximum: the most a policy pays for a specified loss or covered service. This can be expressed as either a period of time, a dollar amount, or a percentage.

Claim: a request from the insured to the insurance company for payment (submitted by the healthcare provider).

Coordination of Benefits (COB): When the insured is covered under more than one plan (for example under a group plan at work, and as a family member on a spouse's plan) the benefits from the plans are coordinated so as to limit the total benefits from all plans.

Co-Pay: fixed payments the insured must pay directly to the provider at the time services are received.

Example: The contract for a certain network of doctors may require patients to pay a \$10 co-pay each time they visit one of the doctors who is a member of that network.

Deductible: the amount the insured is required to pay before the insurer begins paying benefits.

Example: The insured has bills amounting to \$400. The plan has a \$100 deductible. The insured is responsible for paying the first \$100 and the insurer will begin paying after that.

Explanation of benefits (EOB): the insurance company's explanation of its decision regarding your claim.

HMO (Health Maintenance Organizations): provide services through a network of hospitals, doctors, etc...

Lifetime Maximum: is the total dollar amount the plan will pay for all types of medical expenses, for all benefit periods, while the insured person is alive and covered under the plan

Network: all physicians, specialists, hospitals and other health care providers who agree to provide medical care to HMO/PPO members under the terms of a contract.

Out-of-Pocket Limit: is a dollar limit on the portion of covered medical expenses the insured must pay during a benefit period (usually a calendar year). When the out of pocket limit is met, the insured will not have to pay further deductibles or coinsurance for that year. *Example: Out-of-Pocket is \$1000 per calendar year, and the insured's coinsurance is 20%. When \$5000 of covered medical expenses have been incurred, the \$1000 out of pocket limit will be met (\$5000 at 20%). Thereafter, the plan will pay benefits at 100% and the insured's portion will be \$0 for the remainder of that year.*

Point-of-Service (POS): these plans allow members the option of using services outside the HMO network without prior approval

Preferred Provider Organization (PPO): a network of doctors, hospitals, and suppliers (preferred providers) who agree to provide services to members of a health plan for discounted fees.

Primary Plan: a plan that pays first when you are covered by more than one insurance plan

Reasonable and Customary Fees: when a doctor or other provider of medical services submits a bill, the insurer will make an evaluation of whether the charges are reasonable and customary for that medical service provider and for the type of service performed.

What is reasonable and customary depends on factors like the specific medical service provided, the qualifications and skill level of the doctor (or other care provider), the geographic area (fees can vary widely in different areas) and anything else the insurer may consider to be pertinent to the evaluation.

Secondary Plan: applies only when you have more than one health insurance plan. The second plan pays only after the primary plan has processed the claim.

Usual, Customary & Reasonable (UCR): the dollar amount the insurance companies believe to be a fair price for the medical service/procedure in a specific geographic area. Companies have developed their own UCR, which often do not reflect the doctor's actual bill. If the doctor's charges are higher than the company's UCR charge, you generally have to pay the balance.

FAQ

ACCOUNT SUMMARY

LAST PATIENT PAYMENT
\$30.00 5/14/2008

The Insurance Companies on file for these visits:

Jane Doe
-ABC Insurance Company

Out to insurance: \$0.00
You have paid \$0.00 as copays that are still pending.

You have \$45.00 currently in your responsibility.
You have \$0.00 available as a credit.
You owe \$45.00 today.

Visit Date: 05/14/2008
Visit ID: 3086
Patient: Jane
Location: Healthcare Express
Physician: Timothy Reynolds, MD

	1	2	3	4	5	6	RESPONSIBLE PARTY	DENIAL CODE
	CHARGES	INSURANCE PAYMENT	CONTRACT SAVINGS	PATIENT PAYMENT	ADJUSTMENT	BALANCE		
99203 Office Visit Level 3 New	\$241.00	\$25.18	\$140.82	\$30.00	\$0.00	\$45.00	Patient	COPAY
S9088 Services provided in urgent	\$125.00	\$75.00	\$50.00	\$0.00	\$0.00	\$0.00		
	\$366.00	\$100.18	\$190.82	\$30.00	\$0.00	\$45.00		

A finance charge is computed on a monthly periodic rate of 0.00%, 0% annually on any balances over 0 days.

Explanation of outstanding balance(s):
COPAY: This amount is the outstanding copay amount

Note: The explanation of outstanding balance will vary. Before calling our billing company, please consult your Explanation of Benefits (EOB) mailed to you by your insurance company.

If you still believe there is an error in your bill, please call 1-877-313-3846 to discuss the bill with our billing company.

- 1 - Total amount of your Healthcare Express visit
- 2 - Amount your insurance plan paid for your visit
- 3 - Total amount of Healthcare Express visit under insurance contract
- 4 - Amount you paid during or since your visit to Healthcare Express
- 5 - Any adjustments made to your bill
- 6 - Amount you still owe after insurance paid their part of your visit

PATIENT OWES:
\$45.00
INSURANCE OWES:
\$0.00

An S-Code is a code we bill to your insurance company stating services were provided at an urgent care facility.

Why am I receiving a bill when I already paid my co-pay?

At the time of service, your co-pay was collected. HealthCARE Express then filed with your insurance for the remaining part of your visits. Your bill represents your deductible, coinsurance or other non-covered services.

What is a deductible?

A deductible is the amount you pay out-of-pocket for expenses before your insurance company will begin to cover your medical bills. Typically, a deductible starts over at the beginning of the calendar year.

What is an "S-Code"?

An S-Code is a code we bill to your insurance company stating services were provided at an urgent care facility.

Why is my bill more expensive than visiting my family doctor?

Our prices are competitive with other walk-in clinics in the ArkLaTex. As an urgent care center, we are cheaper than a visit to your local emergency room, but in some cases, more expensive than a family practice. Our clinics are mid-level medical facilities. Our providers are over-seen by board-certified emergency physicians.

How can I understand my bill?

Review your Explanation of Benefits (EOB) for your insurance company. Most of the time, you can simply call your insurance company and give the requested information over the phone.

Help, I still have questions:

HealthCARE Express has an in-house billing company. All questions pertaining to a statement should be directed to them:

HealthCARE Express
3101 Kennedy Lane, Ste. 100
Texarkana, TX 75503
Phone: 903-831-7270

E-mail: billing@healthcareexpress.us

HealthCARE
Urgent Care & Occupational Medicine
Express[™]

PUTTING THE CARE BACK IN HEALTHCARE

3515 Richmond Road, Texarkana, TX 75503
Phone: 903-791-9355

4701 West 7th Street, Wake Village, TX 75501
Phone: 903-831-4065

1509 W. Loop 281, Longview, TX 75605
Phone: 903-759-9355

WEB CHECK-IN

On your next visit, save time by registering for your visit from the comfort of your own home. We'll call you when it nears your turn to be seen!

www.HealthCAREExpress.us