



Understanding Your Insurance Claims

Insurance billing and reimbursement can be difficult to navigate. This document is designed to help guide you through the terminology used by insurance companies when processing claims, and also to clarify potential scenarios that may arise. This document is for informational use only.

There are countless insurance companies and healthcare plans. Each one is unique, and has its own regulations in which they follow. When Larsen Billing Service receives your Client Registration Form, a Verification of Benefits (VOB) will be completed. This will help us understand what type of insurance plan you have and any requirements or restrictions associated with that plan. Once the verifications have been completed, your midwife will be sent a copy of the findings for her to keep in your file. If you provided your email address on the Client Registration Form, you will also be emailed a completed copy of these findings.

Note: *It is ultimately your (the patient's) responsibility to understand your benefits. The information obtained in a VOB is for verification purposes only and is not a guarantee of coverage.*

Frequently Used Terms

EOB: Explanation of Benefits. This is what the insurance company sends you to explain how a claim processed. Your midwife should also receive a copy; however, if a payment is sent directly to you, your midwife **does not** receive a copy. It is very important that you give, mail or fax a copy of the EOB directly to her office, if payment is sent to you.

Co-Insurance: This is the portion that you are responsible for. If your insurance company pays at 70% of allowed charges (the insurance company pays their percentage based off of the *allowed amount*, not the amount billed), then 30% would be your responsibility.

Deductible: This is the amount that you must pay out of pocket for your healthcare before the insurance company will start reimbursing for services. Deductibles reset either at the end of the calendar year, or at the end of your plan year.

Out of Pocket Maximum: This is the amount in which you pay out of your own pocket for fees for services rendered. This *includes* your deductible and co-insurance payments. The patient is legally responsible for all deductible and co-insurance amounts.

Over Usual & Customary: This is the portion of the fees for service in which your insurance company has determined is more than they are willing to pay for the billed service. There is no way of knowing what this amount will be until your claim has been filed. If a portion of the fee is considered "over usual and customary," this does not mean your midwife has charged too much. This is an amount that the insurance company has determined is fair compensation for the service rendered and they base their reimbursement on this amount. *You may be responsible to pay for all, or a portion of, fees for services that may be considered, "over usual and customary."*

Types of Insurance Companies

1. HMO, Managed Health Care, and Medicaid. This type only covers in network or participating providers. A participating provider is someone who has a contract with an insurance company for his/her services.
2. PPO/POS or Indemnity Plans. PPO or POS plans allow you to choose your provider by going "out of network" and possibly paying a bit more for the services out of pocket. An indemnity plan is a traditional old-fashioned insurance plan, pre-HMO days. You pay your deductible and co-insurance and you can choose your provider without the restrictions of an HMO provider list.

Scenario for PPO/POS or Indemnity Plans

Many people who have insurance are surprised when they have a balance due to their midwife even after claims have been paid by their insurance company. It is difficult to determine how much an insurance company will actually pay for services rendered (even after obtaining verification of benefits), and many times there will be an outstanding balance due in spite of the upfront deposit payment and payments from the insurance company. Below are examples of possible scenarios to help explain why this might happen. These are EXAMPLES only and do not necessarily reflect what your midwife charges, nor what your benefit level is.

- Let's say your benefit level is 70%, your deductible is \$500.00, and the fee for service is \$4000.00. Assuming that the insurance company accepts the full \$4000.00 fee, the benefit paid would be \$4000.00 MINUS your \$500.00 deductible = \$3500.00, MULTIPLIED by .70 (70% benefit level), resulting in a \$2450.00 payment by the insurance company. This leaves you, the client, with a \$1550.00 (\$500.00 deductible and \$1050 co-insurance) remaining balance to pay your Midwife.
- If the insurance company did not accept the full bill of \$4000.00 and decided that \$400.00 was over usual and customary, then the benefit paid would be \$4000.00 MINUS the \$400.00 over usual and customary and MINUS your \$500.00 deductible = \$3100.00, MULTIPLIED by .70 (70%). This would result in a \$2170.00 payment by the insurance company and leaves you, the client, with an \$1830.00 (\$500.00 deductible, \$400.00 usual and customary and \$930.00 co-insurance) remaining balance to pay your Midwife.

Please remember that if an insurance company chooses not to accept your midwife's full fee, it does not mean she charges too much. By agreeing to work with her, you understand that you may still have a balance due after your baby is born and that you may or may not be reimbursed your full prepaid deposit. Accepting these terms and employing your Midwife's services, or those of the birth center, are a binding financial agreement.

You may receive a reimbursement from your Midwife if you have paid all, or a portion of, your deposit upfront. There is no way of knowing this until your claims have processed.