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Dear Health Insurance Holder,

This letter is a general explanation of health insurance as it applies to physical therapy. Please check your plan for specifics so that you understand who is a provider with your insurance and what services are covered or not covered by your plan.

Insurance can be complicated, so here is an explanation of general terms:

Member: This is the person who holds the insurance policy and is directly responsible for paying the premium.

Patient: The patient is the person receiving the medical care and may be the same as the member if they hold the insurance policy, or it may be someone else who also receives coverage under the plan such as a dependent child or spouse.

Covered services: Health insurance will assist in paying for these type of services. Not every medical treatment available is a covered service. The services your insurance covers are outlined in your plan.

Medical necessity: Insurance decides which services are covered by reviewing research for evidence of a treatment being proven effective. If a treatment is not proven effective, it will not be considered medically necessary for your care. Also, if a treatment IS considered effective, but insurance doesn't think you need the treatment, they will claim your care is not medically necessary and will not pay for the service.

Premium: The monthly fee paid to the health insurance company for health coverage. It can vary with the type of plan you have.

Out-of-pocket expenses: Any additional money you pay beyond the premium (monthly fee). This includes the deductible, the copayment, and the co-insurance. Some companies have what is called an out-of-pocket maximum which may include deductible, copay, and co-insurance or may only be copay/co-insurance separate from the deductible.

Deductible: This is an out-of-pocket expense paid by the member for medical fees. Each plan has a limit to the amount that must be paid by the member. For example, a plan may require that the member pay $1000.00 on medical expenses BEFORE the insurance company will pay anything additionally. Once that amount has been paid by the member, then the insurance company will pay their portion of the bill, but only for covered services according to your specific plan.

Copayment (Copay): This is another out-of-pocket expense paid by the member. Copays are typically listed on your insurance card, though not always. Copays are paid at the time of the office visit with the provider. The amount you pay goes toward the overall cost of the medical expenses, but you will have to check with your plan to see if copays go toward the deductible or not.

Co-insurance: Sometimes the insurance company will only cover a portion of the medical fee. The remaining portion is paid by the patient and is called the "co-insurance." Most commonly, insurance will pay for 80% of the medical fee while 20% is paid by the patient, but check with your plan to know for sure. Again, this is for covered services only.

In-network provider: When a health care provider agrees to accept insurance payments, it is after the provider has applied to the insurance company and entered into a contract with them. Typically, the contract states that the provider agrees to accept a predetermined amount for a given service and will not require more than that of the patient.

Allowed amount: This is the amount a provider agrees to accept from an insurance company. It is often a lesser amount than the usual and customary fee that the provider charges for services.

Out-of-network provider: A provider who DOES NOT enter into a contract with an insurance company and is NOT required to accept the allowed amount. SOME insurance plans will pay a portion of the fee to an out-of-network provider, but it is typically not as much coverage as would be given for an in-network provider. An example would be insurance paying 80% of the fee for in-network providers, but only 50% for out-of-network providers - if they cover anything at all.

Medicare participating provider, non-participating provider, and opt-out provider:

- **Participating provider**: a health care provider who has entered into a contract with Medicare to accept Medicare's allowed amount for covered services. There may be deductibles, co-pays and co-insurances for members.
- **Non-participating provider**: They accept Medicare PATIENTS, but don't accept the Medicare ALLOWED AMOUNT. Medicare may cover some of the medical fees, but you may have to pay more than you would if you went to a participating provider.
- **Opt-out provider**: Medicare will NOT pay for ANY of the medical fees. You and the opt-out provider are required by law to sign a contract before care is given that outlines what the cost of the service will be and that you, the patient, are completely responsible for paying it.

*If a provider has not distinguished which type of provider they are with Medicare, then it is illegal for that provider to see Medicare patients.

Self-pay: When a patient decides to pay the medical bill without the assistance of insurance or any federal/state organization (such as Medicare or Medicaid).

Discounts: Discounts may be offered under certain circumstances related to financial need. It must be determined on a case-by-case basis and requires the review of state laws and insurance contracts. Basically, a provider can't just be a "nice person" and grant discounts freely. Providers are required by law and by their contracts with insurance to follow very specific stipulations if they wish to grant a discount to a patient. Often this requires the patient making a case for the discount by providing evidence of financial need based on the patient's income and expenses.

Surprise billing: It's what it sounds like. The patient gets a bill they didn't expect to have to pay. Usually, it is in reference to the portion of the medical fee that insurance did not cover. It is also referred to as "balance billing" and is more likely to occur with out-of-network providers who are not bound by your insurance contract. This is more of an issue for emergency care if you happen to receive care from a provider who is out-of-network unbeknownst to you. There are specifics on when

something is or is not surprise billing (general sticker shock over the cost of medical care doesn't count). To better understand the No Surprises Act, go to CMS.gov.

Good Faith Estimate: If you are choosing to pay with cash, you will be offered a good faith estimate. This will be an invoice that estimates the cost of medical care before you receive care so that you can decide before any medical care has occurred whether or not you want to pay for it. The final amount charged cannot exceed $400.00 over the original estimate.

Pre-Authorization: It is also called prior authorization, prior approval, and precertification. Providers are required to apply for pre-authorization through the insurance company before delivery of medical services if they want the service to be covered. Insurance determines if they think a medical service is medically necessary, safe, and effective. Pre-authorization should be determined before the first visit.

Facilities Fee: This is when a hospital, or hospital-owned clinic, charges the patient/insurance an additional fee above and beyond the fee of the medical service you receive. The facility fee covers the "overhead" of the hospital or hospital-owned clinic. On your insurance bill you may see it listed separately from the charge the providers listed for the medical service. Unfortunately, private practices cannot charge a facilities fee to your insurance. Your insurance may pay some or all of this added fee. What insurance does not pay, then the patient pays.

Health care costs are covered a variety of ways between you and your insurance company. It's easiest to explain through an example. Let's say you have already paid all of your deductible so your health insurance will now assist in covering additional medical expenses. A health care provider like myself charges $110.00 for a service. The insurance plan requires the member to pay a copay of $10.00 that is paid upfront at the time of the visit. That brings the cost down to $100.00. Then the insurance says they will pay some percentage of the remaining bill. In this example, let's say it is 80%. Eighty percent of $100.00 is $80.00 covered by insurance. That brings the total down to $20.00. The remainder of $20.00 is the co-insurance and is paid by the patient/member.

If you are using insurance to pay for medical fees, then your exact medical expense can only be calculated after a provider has submitted a claim to the insurance company. This is for a few reasons. One reason is every physical therapist will charge slightly different fees for their services. Additionally, every insurance company will reimburse the providers slightly different amounts. Finally, every session may have a slightly different fee charged by the provider because we are asked to bill according to the service and the amount of time we spent on the service. For example, one session may include 20 minutes of manual therapy and 20 minutes of therapeutic exercise while a second session might have 45 minutes of only therapeutic exercise. The type of treatment and amount of time spent on that treatment result in different fees per session. I can only tell you ahead of time what your copay is and generally what the cost for therapy will be. The exact price is returned to both the provider and the patient after the claim has been submitted to the insurance company with details about what was done and for how long it took. Insurance plans and reimbursement rates can change frequently adding to the difficulty of knowing up front what the exact cost will be. I will do my best to give you a fair estimate of your medical costs so that you can budget your money and time in therapy.

Please feel free to contact me with any further questions. You will also find a customer service number on your insurance card that you can call with any question about your plan. Additionally, insurance companies will have websites with information. Good luck!

~Eleanora Phillips-Burdge, MSPT Updated: 06/04/2026