



Your Health Insurance  
Information Guide

# What You Should Know About Your Insurance



Thank you for choosing Sutter Health for your health care needs.

We know that it can be challenging to understand how most health insurance works. We are providing you with this health insurance information to help you. All insurance plans are different, so we encourage you to call your insurance company and speak with a customer service representative. He or she should be able to answer your questions and give you the most current information about your specific plan and coverage.



## Understanding Your Medical Bill

First, we want to help you understand how your medical services are billed. When you receive medical services from a Sutter Health care provider, we put all financial transactions related to your care in an account under your name. According to the law, medical providers like Sutter Health must correctly specify the type of services they provide to you, whether they are practices that help keep you well, or if they are intended to help deal with a health problem. We will submit a claim for you to your insurance company according to the insurance information that you provide. Health insurance companies determine what they will cover according to the services you receive and the correct diagnosis code(s) submitted for claims processing.

Your provider may charge for both a preventive service (practices that help keep you well) and a visit to treat a health problem when both services are performed during the same appointment and correctly noted in your medical record. The quality of care you receive will not be affected no matter what.

You may receive separate billing statements from other doctors or medical staff that helped in your medical care. (For example, if you have laboratory tests or radiology services performed by a non-Sutter Health provider.) The providers may have different arrangements with your insurance company and will need to send you separate bills.

## Financial Assistance

At Sutter Health, it is important to us to provide medical services to everyone in the communities we serve, including those who cannot afford to pay for health care. There are many programs that may be able to help people in need pay for medical services. Our Customer Service Representatives can help you get more information about government sponsored programs like Medicare, Medi-Cal (Medicaid), Healthy Families, or to get a Sutter Health financial assistance application.

For those patients who have received medical treatment from a Sutter Health clinician, we have a financial assistance program that may be able to help:

- Provide care to uninsured patients earning up to 200% of the FPIG (Federal Poverty Income Guideline).\*
- Provide catastrophic protection to uninsured, low income patients by limiting their liability to 30% of their annual household income.

\*FPIG is updated each year and can be found on the Internet at: [aspe.hhs.gov/poverty/index.shtml](http://aspe.hhs.gov/poverty/index.shtml)



## Commonly Asked Questions

**I was told my procedure/test was authorized, why do I have to pay?**

### Authorization

Authorization does not guarantee that your insurance will pay for everything. “Authorization” simply means that your insurance company approves the service to be medically necessary. Your insurance plan determines how much you’ll have to pay for services. Please call your insurance company with any questions about your specific plan and what it will pay for.

**What is the difference between a referral and an authorization?**

**Referral:** A request to transfer your care from one provider to another (usually for specialty services).

**Authorization:** Approval from your insurance company to pay for specific services before they are provided.

**Who can I contact to find out what my out-of-pocket expenses will be for an upcoming test/procedure my provider has ordered?**

### Related to your service or visit

You will need to contact your provider’s office for the billing code for the test or procedure he/she has ordered. You can then call the customer service phone number on your insurance card, tell the representative your billing code, and ask what your out-of-pocket costs will be.

**Does my co-payment have to be paid at every visit?**

Yes. This amount is determined according to the insurance plan you chose.

**What is the difference between diagnostic and preventive services?**

***Preventive Services are those that help keep you well.***

Examples of Preventive Services: When a physician performs services to prevent disease or injuries; screening mammogram; screening pap smear; screening colonoscopy; screening cholesterol panel; age and gender appropriate history, examination, counseling.

***Diagnostic Services are those that help you find out the cause or identify a disease or illness.***

Examples of Diagnostic Services: When a physician performs services to determine the identity of a disease or illness; diagnostic blood test; diagnostic radiology test; a diagnostic procedure such as examination, counseling, and ordering of laboratory/procedures like colonoscopy to evaluate the problem of bloody stools.

There may be times during a preventive visit when a health problem is discovered. There may be an additional charge for dealing with this health problem.

NOTE: To know what your plan covers, call the member service number located on your insurance card.



**Why might my physician charge for two services at one appointment?**

Federal guidelines specify that a provider may charge for preventive care, such as an annual physical exam, separately from problem-related care, for example, a sprained ankle or high blood pressure, when both services are performed at the same visit. Therefore, if you receive treatment for a specific health problem during your physical exam your physician is bound by established coding regulations to submit a separate charge for this service.

**I am a Medicare patient and I received a bill after I had my Medicare welcome visit (or annual wellness exam)?**

If you are a Medicare patient and you schedule an appointment for either a Medicare Welcome Visit or Annual Wellness Exam make sure your provider knows the reason for your visit. If you choose to discuss and deal with any specific health issues during these types of visits it may result in an additional charge and you may receive a bill for those services.

**Why can't these two services be combined if they occur during one appointment?**

According to the regulations, these services cannot be combined because they are not the same service and are not considered related. Most health insurers also follow these same regulations and consider preventive care and problem-related treatment to be different services. Therefore, they are willing to pay for these services separately. However, it is important for you to check with your insurance carrier prior to your visit to find out specifically what your insurance covers. Some insurance carriers, especially Medicare, have strict limitations regarding coverage for preventive services. You, your employer, and your health insurance company are the only ones who know or can verify insurance coverage. Sutter Health providers and their business office staff do not have access to this information.

**Is charging for two services at one appointment a standard, ethical and legal practice in health care?**

Yes. It is defined as a correct physician billing practice by The Centers for Medicare & Medicaid Services (CMS), which was established by the U.S. Department of Health and Human Services (HHS). The American Medical Association (AMA) guidelines also define this as a correct billing practice. Providing both services during one appointment uses your time and your provider's time effectively and generally means that the problem-related office visit may be charged at a lower fee than if it were provided at a separate visit. It can also be a cost-saver for you since often only a single office-visit co-payment would be necessary as opposed to the two office-visit co-payments that would apply if the services were provided at different appointments.



**Why didn't the doctor tell me the cost during my visit? Shouldn't he/she let me know what is covered?**

Our providers are required to bill only for the service they provide, not according to what a patient's insurance plan covers. Also, it would be impossible for your doctor and their staff to know the benefits of every insurance plan considering the large amount of different types of plans available. If you feel your provider has recommended a service or procedure, and you are unsure if you are covered for that service, we encourage you to contact your insurance and ask about your coverage before that service is scheduled.

**My insurance company told me you can change the billing code so they can pay for the service. Why can't you?**

Physicians are required by law to accurately document each office visit and procedure. Changing a code in order to have the service covered by a patient's insurance plan could be considered fraud according to the American Medical Association (AMA) Standards for Ethical Coding.

### **Payment**

**Is there a way I can make payments?**

You can call the phone number found on your billing statement to set up a payment plan with a customer service representative. You may also make a payment online if you have an online patient services account by logging in to My Health Online at: [www.myhealthonline.sutterhealth.org](http://www.myhealthonline.sutterhealth.org). If you were referred to a provider outside of the Sutter Health network contact the office that is billing you.

## Glossary of Terms

- **Authorization:** Approval from your insurance company to pay for specific services before they are provided.  
NOTE: Authorization does not guarantee full payment.
- **Contracted provider:** A provider who has agreed to the terms of the insurance you have chosen.
- **Co-payment:** The co-payment (or co-pay) is a predetermined (flat) fee that you pay for medical services, in addition to what the insurance covers. For example, some plans require a \$10 co-payment for each office visit regardless of the type or level of services provided during the visit.
- **Referral:** A request to transfer your care from one provider to another (usually for specialty services).

## Call your customer service number on your insurance card for the following information:

- How much your yearly deductible is, and how much has been met.
- Why the co-payment for your primary care physician is different from a specialist.
- To find out if a Sutter Health provider is contracted under your insurance.
- To find out what your covered benefits are.
- To find out what hospital and/or lab facility is contracted by your insurance. Insurance benefits change frequently and can be confusing. At Sutter Health we want to partner with you and provide information and guidance which will help us work together as a team to provide the very best service and health care available.

It is equally important that you take the time to learn about your plan benefits through the resources your insurance company provides such as customer service representatives, materials about your plan, and your insurance company website.





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