Health insurance: follow the money

Keep this reference beside your EOB, provider bill and receipts. The numbers below are fictional, not a price quote or plan recommendation.

01 Know what each number does

Premium	Regular payment for coverage; separate from the deductible and out-of-pocket limit.
Allowed amount	The contract price used for this covered, in-network example. A price reduction is not an insurance payment.
Deductible	Eligible care builds toward a threshold. It is not a separate invoice. Some benefits apply before it is met.
Copay / coinsurance	A copay is a fixed amount; coinsurance is a percentage of the allowed amount. Check the rules for the particular benefit.
Out-of-pocket limit	Caps eligible in-network cost-sharing for the plan year. Premiums, uncovered care and charges above allowed amounts do not count.

02 Work the episode's one-visit example

One person, one covered in-network claim, no other insurer or copay. In this plan year, $1,500 already counts toward both the $2,000 deductible and the out-of-pocket limit. Coinsurance: 20% after the deductible.

Provider charge less contractual adjustment	**$3,000 - $1,500 = $1,500 allowed**
Remaining deductible	**$2,000 - $1,500 = $500**
Amount left after this visit's deductible	**$1,500 - $500 = $1,000**
Penny's coinsurance / plan's share	**Penny: $200 (20%); plan: $800 (80%)**
Penny's total share	**$500 + $200 = $700**
Provider balance after her $100 advance	**$700 - $100 = $600 still due**

The Explanation of Benefits (EOB) is not a bill. It explains the claim. The provider's statement tracks what is still unpaid. For this same claim, do not add the $700 share and the $600 balance together.

Annual limit example: this visit adds $700, including the $100 already paid: $1,500 + $700 = $2,200 counted. A $4,500 limit leaves $2,300. Later in the same plan year, a covered in-network claim with a $20,000 allowed amount and 20% coinsurance costs Penny $2,300 (the remaining limit), and the plan $17,700.

Check your own paperwork

Fill in what the documents say. A mismatch is a question to investigate, not automatic proof of an error or fraud. Keep this sheet private.

03 Match the same claim

Patient: **Provider:**

Service date: **Claim / service reference:**

Claim processed? Yes / No / Unsure

Same services on both papers? Yes / No

04 Reconcile the balance

EOB: allowed amount	$
EOB: plan paid	$
EOB: patient share	$
Provider: patient payments / credits	$
Provider: balance still requested	$

For a matching claim, compare patient share minus posted patient payments/credits with the requested balance. Confirm partial claims, adjustments and other balances before treating a difference as an error.

05 Ask the right office. Keep the dates.

Provider billing: Are all payments and credits posted? Which services make up this balance? What is the due date, and what happens while this question is reviewed?
Health plan: How was the claim processed? If denied, what is the reason, appeal route and deadline?

Who I spoke with / date / reference / next step:

Comparing plans: check the Summary of Benefits and Coverage, network directory, covered-drug list, premiums, cost-sharing and plan-year dates. Certain preventive benefits may have no cost-sharing; not every checkup service is free. Surprise-billing protections have specific coverage rules and do not make all care free.

Sources: CMS: bills Terms Preventive care Appeals Surprise bills