Got Billed?

By Ed Gaelick CLU, ChFC

So your company decided to switch insurance carriers and your current doctor is not in your new plan's network. Since the new policy has out-of-network coverage, you decide to keep going to him or her.

Flu season comes and you are now sick. You visit your favorite doctor and she writes you a prescription. A couple of days later, you are feeling better and go back to work. Ahhh, the magic of medicine!

About a month later you get a bill in the mail: Please pay Dr. Wonderful $200. What? That can't be right. Under the old plan, it only cost you $50. You call the doctor's office as well as the insurance company and they both assure you that there was no mistake. You owe $200.

So what happened? When a patient has an in-network office visit, they are usually responsible for a fixed amount known as a copayment. It is paid when you are at the office and then you never really think about it again. However, out-of-network services are handled quite differently. First, there is the deductible. This is the amount you owe before your health plan begins to pay. Once your deductible has been met, costs are split between you and your insurance company. This cost-sharing portion of the policy is called coinsurance.

But on the Explanation of Benefits you received it lists the deductible as $100 and $0 for coinsurance. So why do you owe an extra $100?

When a doctor participates with an insurance carrier's network, they agree upon a discounted rate for their services. If there is no agreement, there is no discount. Non-participating providers are free to charge whatever they feel they are worth and the insurance company has no say in the matter. As such, out-of-network charges are controlled in another way. There are several methods available, but the most commonly used approach today is based on a percentage of Medicare allowed charges. Eligible expenses are determined by the type of service as well as the geographic area.

Excluded amounts for out-of-network claims are not applied towards your deductible nor your out of pocket maximum. Your policy may require you to satisfy a $1,000 out-of-network deductible. It may also state that you cannot pay more than $5,000 for out-of network expenses in a year. These figures may or may not hold true. If the out-of-network cost is less than the allowed amount, the entire claim will be applied to the deductible and out of pocket maximum. However, if the out-of-network cost is more than the allowed amount, the excluded portion will not be included in either.

Maybe you are willing to pay a little extra to keep seeing your favorite doctor. But what happens when you need to go to the hospital? The difference between the total charge and the allowed amount may be shocking.

Bottom line is that when you visit in-network providers, you get maximum benefits at lower costs. Using out-of-network providers results in standard benefits and higher costs. Make sure to understand all of your options and financial responsibilities before scheduling your appointment.

Since 1985, Ed Gaelick, CLU, ChFC, has helped people protect their families, their assets, their businesses and their employees. He specializes in life, disability and long term care insurance, employee and executive benefits. Ed has exceptional knowledge, integrity and a commitment to being relevant to his clients. Throughout his career, he has received many of the highest professional honors awarded in the insurance industry and is the go to insurance expert for various organizations. www.psi-consultants.com