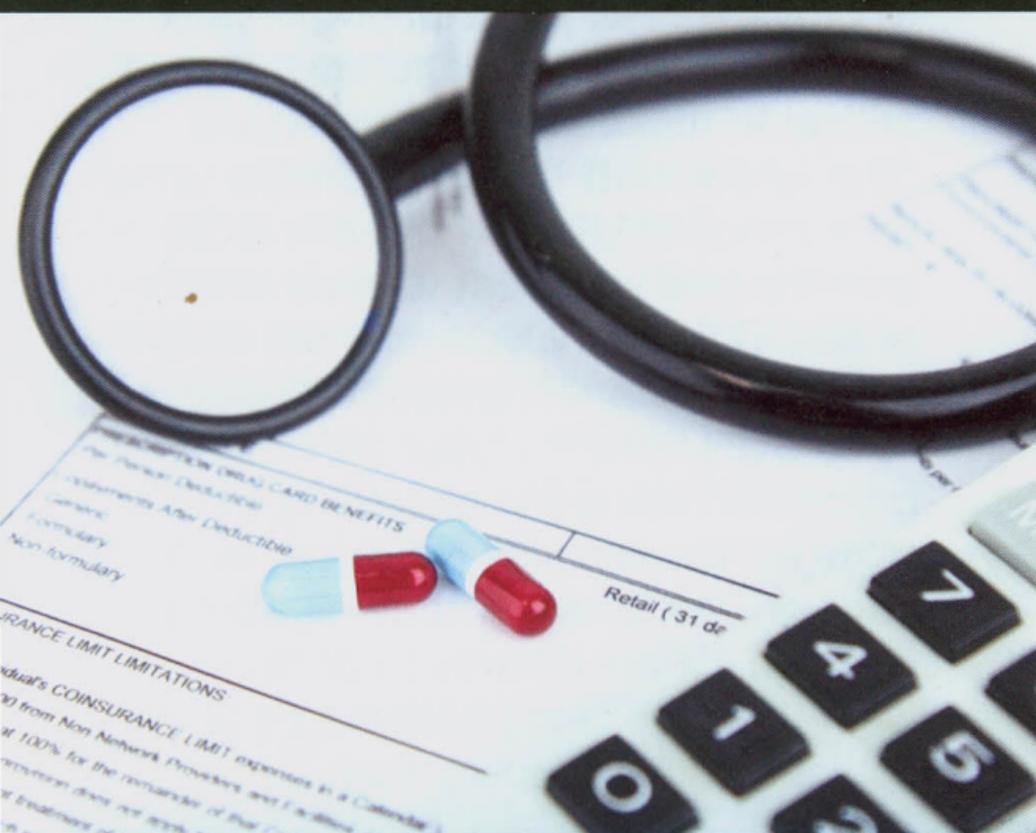


A Greater Understanding

Understanding Your Insurance Plan:

Usual, Customary and Reasonable Charges



**Patient Advocate
Foundation**

Solving Insurance and Healthcare Access Problems | since 1996

A Greater Understanding

Patient Advocate Foundation

■ MISSION STATEMENT

Patient Advocate Foundation is a national non-profit organization that serves as an active liaison between the patient and their insurer, employer and/or creditors to resolve insurance, job retention and/or debt crisis matters relative to their diagnosis through case managers, doctors and attorneys. Patient Advocate Foundation seeks to safeguard patients through effective mediation assuring access to care, maintenance of employment and preservation of their financial stability.

Editors Note:

This is the second in the series "A Greater Understanding" brochures developed by the Patient Advocate Foundation. The information contained herein is in response to frequently asked questions (FAQ's) by patients. This brochure is intended to provide a general yet informative response to these inquiries. Any incident, inquiry or issue may vary according to these specific facts and circumstances relating to the individual.

Patient Advocate Foundation is dedicated to ensuring that all Americans have access to healthcare. Professional Case Managers are available to assist patients affected by debilitating or life threatening illnesses by empowering them to be able to make informed decisions regarding their health-care options. For further information, please contact Patient Advocate Foundation at 1-800-532-5274 or visit our website www.patientadvocate.org.

Patient Advocate Foundation

■ PUBLICATIONS

- *The Managed Care Answer Guide*
Available in English & Spanish
- *Your Guide to the Appeal Process*
Available in English & Spanish
- *First My Illness...Now Job Discrimination: Steps to Resolution*
Available in English & Spanish
- *Promoting a Healthier African American Community*
- *The National Financial Resource Guide for Patients: A State-By-State Directory*
- *Too Young To Be Ill...*
A Practical Survival Guide for Caregivers of Children and Young Adults
- *Guide to Health Savings Accounts*
- *Promoting a Healthier African American community*
- *Promoting a Healthier American Indian and Alaska Native Community*
- *"A Greater Understanding" series:*
A series of pamphlets written to provide answers to the most frequently asked questions regarding health care.

If you would like further information about any of these publications, please contact our office or visit our website at www.patientadvocate.org.

When you sign up for health insurance

- just like when you sign your auto or homeowner's policies- you are entering into a contract with the insurance carrier. Regardless of whom your insurance carrier is or what type of insurance you have, you are subject to the terms of your policy. It is critical for you as the patient to understand the way your policy works so you can maximize your benefits and your coverage under your plan.

No matter what kind of health insurance plan you have, it is very important that you read your plan carefully. If you have any questions regarding any portion of your policy, refer to the phone number provided on your insurance card.

What Are UCR Charges?

Many patients are surprised to find themselves facing large out-of-pocket expenses even though they are "fully insured." Usual, Customary and Reasonable (UCR) charges are often one reason for this situation. UCR rates are established based on the geographic region in which you live and the specific service provided to you.

Terms associated with insurance billing:

Actual charges - the amounts charged by the physician for a specific service.

Allowable charges (UCR charges) - the amounts an insurance carrier is willing to pay for a specific service.

Co-payment - the amount a patient is required to pay for a visit/service to a physician/provider.

Co-insurance - the percentage a patient will be responsible to pay for a specific service as dictated by your plan document.

Network Providers and UCRs

Most health insurance policies covering Americans today use a specified "Network" of providers. Whether you have an HMO (Health Maintenance Organization), a PPO (Preferred Provider Organization), a POS (Point of Service) or another variant of one of these plans, you generally have the most extensive coverage when you visit a physician or medical facility that participates in your insurance carrier's network.

These providers may include physicians, hospitals, out-patient diagnostic facilities, radiation therapy centers, out-patient infusion centers or any other provider of medical services. When you remain within your provider network, you are not responsible for UCR rates and charges.

Example:

Doctor Visit

Actual Charge.....	\$250.00
UCR Allowable Charge	\$200.00
Contractual Write-Off	\$50.00
80/20 plan Insurance Paid ..	\$160.00
Your 20% Co-Insurance	<u>\$40.00</u>
Your Total Costs	\$40.00

When your insurance carrier receives a claim on your behalf, they process claims payment per the terms of the contract. Once the claim has been processed, the provider and the patient both receive statements more commonly referred to as “**Explanation of Benefits**” (EOB). It is important to review each EOB you receive, as they will tell you the amounts paid to the provider as well as any financial responsibility you may have.

Out-of-Network Providers and UCRs

Often, patients make the choice to go to providers not participating in their network. If you choose to do this, it is critical to make sure that you have “Out-of-Network” (OON) benefits under your policy. If you do not have OON benefits and you elect to receive care at an OON facility, you may not receive ANY insurance reimbursement. If you have OON benefits, your claim will be processed using the prevailing UCR rates for the services provided. In addition, the provider may “Balance Bill” you for the difference between what the physician charges and what the insurance company pays.

As the following example illustrates, the amount of patient financial responsibility can be much greater than originally anticipated. The application of UCR rates and balance billing can more than double the patient’s financial responsibility.

Example:

OON Facility Bills Actual	
Charge	\$1,000.00
UCR Allowable Charge.....	\$400.00
60% (OON) Insurance Paid.	\$240.00
Your 40% Co-Insurance.....	\$160.00
Balance Billing Choosing	
OON	\$600.00
Your Total Costs	\$760.00

Even if your policy has an out-of-pocket maximum, it is important to understand that ONLY your portion of the UCR amount allowed is applied towards your maximum. In the example above, only \$160.00 (your portion of the amount the insurance company deemed payable) of the \$760.00 you paid is counted toward your yearly out-of-pocket maximum. For this reason, many patients have much larger than anticipated medical bills when seeking services at an OON provider.

Medicare and UCRs

UCR charges are not regulated by state or federal agencies, but Medicare does publish their UCR fee schedule. This is commonly referred to as “Medicare Allowable” charges. Providers who participate with Medicare agree to accept the Medicare allowable charge as full payment. Bear in mind the patient will be responsible for their co-insurance and deductible.

Example:

Chemotherapy Actual Charge..	\$500.00
UCR Allowable Charge.....	\$300.00
Medicare 80/20 Insurance Paid	\$240.00
Your 20% Co-Insurance.....	\$ 60.00
Your Total Costs	\$ 60.00

(continued on back page)

Medicare providers may choose not to bill the patient for amounts above the Medicare allowable fee schedule. It is important to verify that your provider “Accepts Medicare Assignment” or is a “Medicare Provider” to avoid unexpected and potentially large out of pocket expenses.

Sometimes, a healthcare provider will notify a patient—either verbally or by written notification—that they may be subject to balance billing after the insurance carrier has paid the allowable charge or if the claim is denied completely for reimbursement. This communication constitutes a “waiver of financial responsibility.” This happens most commonly when a healthcare provider anticipates that the insurance carrier may deny a claim and the physician and patient want to proceed with the therapy regardless of the insurance coverage.

All insurers including Medicare provide an appeals process for denial of service. To understand more about these processes, please refer to Patient Advocate Foundation’s *Your Guide to the Appeals Process*.

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