Guard against the unexpected

GET SMART PLANNER

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Policy Information Worksheet

There are some significant advantages to knowing specifics of your health plan while you are preparing for an office visit or procedure. As much we don't like thinking about finances while thinking about our health, the two are closely connected. Knowing plan specifics can help you prepare for your patient responsibility and potential bills as a result of your appointment. Your out-of-network benefits may be different from your in network ones, so taking a look is worth the time.

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Know this information from your insurance plan

Being familiar with your plan details will make your calls go smoother. You can find this information on your insurer's website.

Your Insurance	(HMO, PPO, HDHP-High Deductible Health Plan)	
Plan Type		
Deductibles	In	Out
Indiviual		
Family		
Out of Pocket Maximums	In	Out
Indiviual		
Family		
Co-Pays	In	Out
Primary Care		
Office Visit		
Specialist		
Urgent Care		
ER		
Co-Insurance	In	Out
Primary Care		
Office Visit		
Specialist		
Urgent Care		
ER		

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Emergency Location Card

The purpose of knowing this information now, is so you have it when you really do need it. Don't assume the closest hospital is in-network and ask if the hospital uses employed doctors and specialists, or if they use contractors that may not have the same in-network status as the hospital under your health plan.
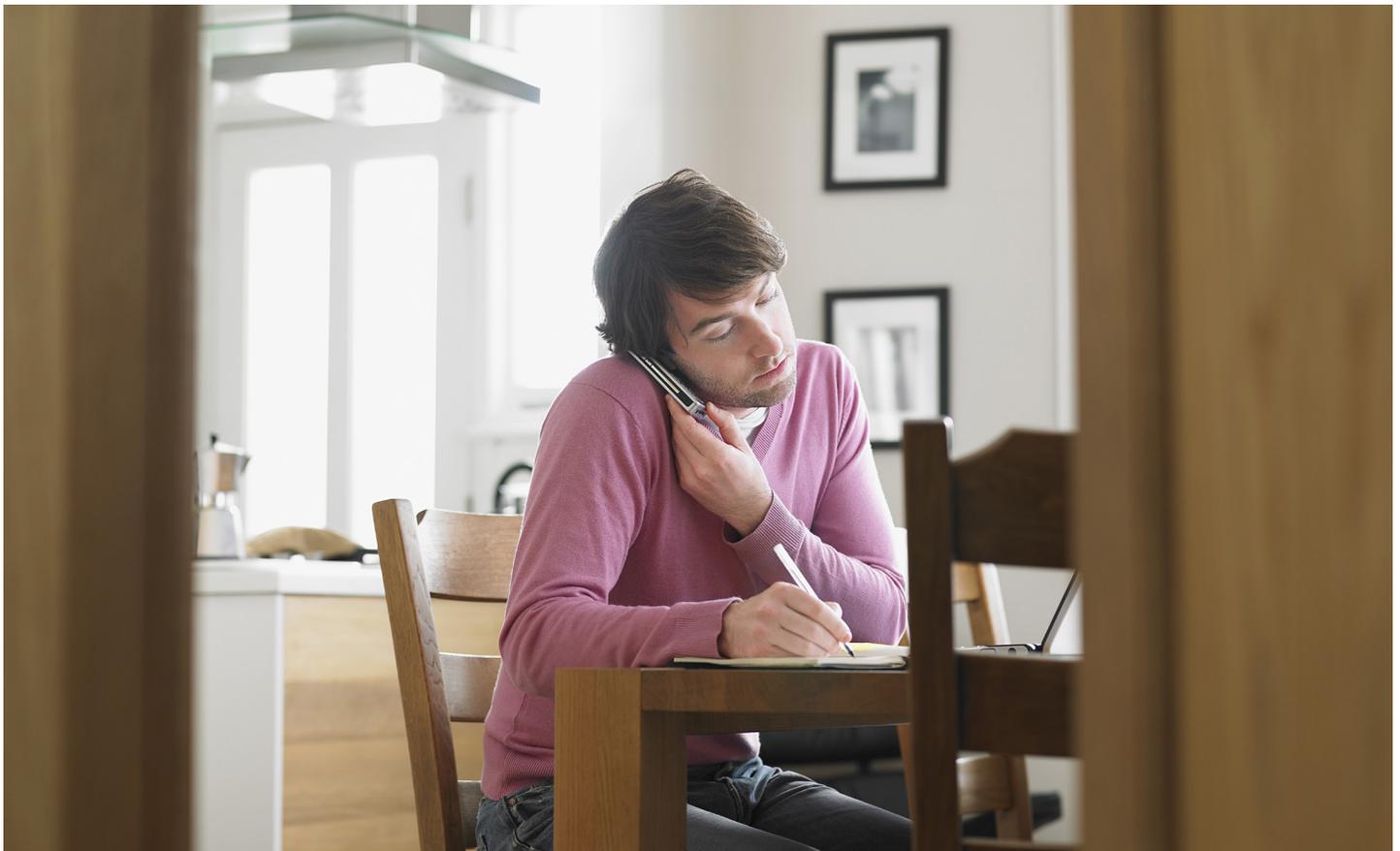
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Plan for potential ER visits so you dont unintentionally end up out-of-network

Remember to check if ER staff are considered in-network resources too!

YOUR PLAN	DESCRIPTION (NAME, ADDRESS, PHONE)	CONTRACTED STAFF	
Closest in-network ER		☐ IN	☐ OUT
Closest in-network ER to (work/school)		☐ IN	☐ OUT
Closest in-network Urgent Care		☐ IN	☐ OUT

Do you have out-of-network ER visit coverage in your health plan?

For additional support visit Naviguard.com Your fierce defender from out-of-network medical bills.

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Procedure Planning Worksheet

The purpose of this section is to help you prepare for an upcoming visit or procedure to make sure you use in-network providers and facilities if possible. Often surprise, out of network bills are generated from downstream providers, or providers you didn't schedule with directly but were necessary to your care. It is good to understand which of those might be involved in your visit or procedure and how to do some research if they are.

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Top places where out-of-network surprises can occur!

You may be a careful planner for a medical event or procedure, but often supporting providers are brought in that you might not be prepared for!

☐ **Are you going somewhere else?**

Are you being referred or scheduled for a procedure **outside of your primary care facility?**

⚠ Possible Out-of-Network Impact
Outside Facility

☐ **Are you having pain blocked?**

Local or general anesthesiology, or "put under" is common in many procedures. **Anesthesiologists** administer this part of your procedure.

⚠ Possible Out-of-Network Impact
Anesthesiology

☐ **Are you leaving a sample?**

When you leave a sample (like blood or urine) that sample is sent to a **laboratory** for analysis.

⚠ Possible Out-of-Network Impact
Laboratories

☐ **Are you getting scanned?**

MRI's, X-Rays and CT scans are all examples where a **radiologist** will be brought in to "read the scan".

⚠ Possible Out-of-Network Impact
Radiology

☐ **Is something being removed?**

Having a biopsy involving organs, tissue, bodily fluid or cells will require a **pathologist** for analysis.

⚠ Possible Out-of-Network Impact
Pathology

☐ **Is someone helping with the procedure?**

For more complicated procedures doctors and surgeons often bring in a **Physician Assistant** or **Surgical Assistant**.

⚠ Possible Out-of-Network Impact
Supporting Roles

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Be prepared before you go!

If you don't know what is involved, call your Physician. Ask who is providing the service. Then check to see if they are also an in-network provider (you can call your insurer or visit their website!

WHAT'S HAPPENING	DESCRIPTION	NETWORK RESULT	
Name & address of your Primary Physician		☐ IN	☐ OUT
Name of the Specialist performing your surgery or procedure		☐ IN	☐ OUT
What is the procedure or surgery? Get A CPT code!		N/A	
Date of the procedure or surgery		N/A	

WHAT'S INVOLVED			DESCRIPTION (PROVIDER NAME, ADDRESS)	NETWORK RESULT	
Outside Facility Where will this be happening?	☐ Yes	☐ No		☐ IN	☐ OUT
Laboratory Will I have any lab work?	☐ Yes	☐ No		☐ IN	☐ OUT
Pathology Will I be having a biopsy?	☐ Yes	☐ No		☐ IN	☐ OUT
Anesthesiology Will I need any form of anesthesiology?	☐ Yes	☐ No		☐ IN	☐ OUT
Radiology Will I be getting any type of scan?	☐ Yes	☐ No		☐ IN	☐ OUT
Physician or Surgical Assistant Is someone assisting with this procedure?	☐ Yes	☐ No		☐ IN	☐ OUT
Physical Therapy Will there be Physical Therapy?	☐ Yes	☐ No		☐ IN	☐ OUT
Rehabilitation Will there be Rehabilitation?	☐ Yes	☐ No		☐ IN	☐ OUT

If you find yourself with an out-of-network provider there are a few things to try:
1. Call you provider and see if there is an in-network option they can schedule.
2. Call the hospital or surgery center to see if they have any in-network providers that are contracted with that facility.
3. Ask if you can get an upfront estimate for their services.

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Glossary

Let's be clear about this - health care jargon is confusing—sort of like health care. We pulled these terms together since they show up often in our website, guides, and worksheets.

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Glossary

Allowed Amount	The amount your insurance company has agreed to pay a provider for a specific service. For in-network providers, this amount is the negotiated rate that insurers agree to pay for a service. For in-network situations, if the allowed amount is less than the charged amount, the provider covers the difference. For out-of-network situations, there are no negotiated rates. So for out-of-network situations, if the allowed amount (the amount your insurance company has agreed on) is less than the charged amount (the amount your provider charged), the patient may need to pay the balance.
Amount Claimed	See "Charged Amount"
Balance Bill	The difference between the amount the provider is billing and the amount insurance will pay. A Balance Bill occurs only with out-of-network providers, where there are no negotiated rates between the provider and the insurance company. If the amount your insurance company pays for a specific service is less than the amount the out-of-network provider bills for that service, the balance could be billed to you, the patient. The Balance Bill does not include any deductible, co-insurance, or co-pay that patients might owe as part of the insurance allowed amount
Charged Amount	The amount your doctor (your provider) is charging for their service. This is what your provider expects to be paid by you and your insurance company. You might also see "amount claimed."
Co-insurance	The patient must pay a certain percentage of all charges above and beyond a patient's deductible. For example, in an 80/20 co-insurance plan, the insurance pays 80% of the allowed amount (after the deductible) and the patient pays 20%.
Co-pay	A fixed dollar-amount the patient pays every time they see a doctor or specialist.
Claim	The amount the provider submits to the insurer for services provided. Claims are submitted only when the patient seen by a provider has an active insurance plan. The insurer will process the claim and apply the plan benefits, including allowed amount, deductible, co-insurance, and co-pays. Once a claim is processed your insurer will send you an Explanation of Benefits (EOBs) outlining these details.
Deductible	The out-of-pocket amount patients must pay before insurance benefit payments begin. Insurance plans may have different deductibles for in-network and out-of-network claims. A deductible is considered a normal part of your patient responsibility and is not included in a Balance Bill. Also, a Balance Bill payment made by a patient does not count against their deductible.

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Glossary

EOB or Explanation of Benefits	Provides details about services received and how those services will be charged. Scanning every EOB for discrepancies may help save significant amounts of money in healthcare costs.
Out-of-Network	When there is no contracted, negotiated rate between the provider and insurer. If you receive services from an out-of-network provider, your insurance may cover those services at a lower rate, or with greater patient responsibilities, such as higher co-insurance, higher co-pay, or a separate deductible. Out-of-network providers will not cover the difference between their charged amount and the out-of-network allowed amount, and they may bill the patient the difference.
Out-of-Pocket Maximum	The amount of out-of-pocket expenses an individual or family must meet before insurance pays 100% of in-network claims for that plan year (12-month period). This out-of-pocket limit is met through payment of deductibles, co-insurance, and co-pays. It usually does not apply to out-of-network claims, which could result in an insurance policy member paying more than their out-of-pocket maximum in a plan year. Regular premiums are not included in out-of-pocket maximum calculations.
Patient Responsibility	The amount the patient is required to pay. This amount appears on the Explanation Of Benefits (EOBs) and bills. For in-network encounters, patient responsibility typically includes the deductible, co-insurance, and any co-pays. Patient responsibility for out-of-network services may include not only the same responsibilities as in-network services but also the risk of a balance bill amount.
Payer	Typically, this is your insurance company.
Premium	The amount paid regularly (typically monthly) to your insurance company to continue health insurance coverage.
Provider	The name your insurance company uses to refer to a person or organization providing medical care (examples: your doctor, doctor's office, specialists).

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