Allowable Charges and What They Mean for Your Wallet

When you enroll in health insurance, just like when you sign up for auto or homeowner's policies, you are entering into a contract with the insurance company. Regardless of your insurance carrier or the type of coverage you have, you are subject to the terms of your policy. It's important for you to understand how your policy works so you can maximize your benefits and coverage under the plan.

No matter what kind of health insurance plan you have, you should read your plan carefully. If you have any questions or don't understand any portion of your policy, call the Customer Service number listed on your insurance card.

In-Network Providers and Allowable Charges

Most health insurance policies available 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, outpatient diagnostic facilities, radiation therapy centers, outpatient infusion centers, or any other provider of medical services. You are not responsible for allowable charges when you remain within your provider network.

Actual Charge for Specialist's Visit	$250
Allowable Charge	$200
Contractural Write-Off	$50
80/20 Plan Paid	$160
Your 20% Coinsurance	$40
Your Total Costs	**$40**

When your insurance company receives a claim on your behalf from your treating provider, they process payment for the services you received 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.

What are Allowable Charges?

Many patients are surprised to find themselves facing large out-of-pocket expenses even though they have comprehensive insurance. Allowable charges (often called UCR charges, payment allowance, or negotiated rate) are often one reason for this situation. Allowable charges are established based on the geographic region in which you live and the specific service provided to you.

Billing Terms to Know

Actual charges - the amount charged by the physician for a specific service

Allowable charges (UCR charges) - the amount 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

Out-of-Network Providers and Allowable Charges

Sometimes patients decide 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 will likely not have any insurance reimbursement. If you have OON benefits, your claim will be processed using the prevailing allowable charges 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 allowable rates and balance billing can more than double the patient's financial responsibility.

Actual Charge for OON Facility	$1000
Allowable Charge	$400
60% (OON) Insurance Paid	$240
Your 40% Co-Insurance	$160
Balance Billing due to OON	$600
Your Total Costs	**$760**

Even if your policy has an out-of-pocket maximum, it is important to understand that **ONLY** your portion of the allowable amount allowed is applied toward 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.

The good news is that most insurance plans, such as HMOs or PPOs, come with a large network of providers, including doctors, hospitals, labs, and therapists. You won't pay anything over the allowable amount if you stay in that network. There may be a circumstance when you seek emergency services at an in-network facility and receive care (and a bill!) from an out-of-network provider. This is called Surprise Billing and is illegal. **Find out more here about surprise billing.**

Medicare and Allowable Charges

Medicare has its own way of handling allowable amounts. They publish their allowable fees, commonly referred to as "Medicare Allowable" charges. Providers who participate with Medicare agree to accept the Medicare allowable charge as full payment and will not bill more than that amount. However, you will still be responsible for any out-of-pocket expenses related to these charges. For example:

Infusion Actual Charge	$500
Allowable Charge	$300
Medicare 80/20 Insurance Paid	$240
Your 20% Co-Insurance	$60
Your Total Costs	**$60**

Medicare providers may not bill you for more than what Medicare will pay. 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. For Medicare, this process is called an Advance Beneficiary Notice (ABN).

All insurers including Medicare provide an appeals process for denial of service. **To understand more about these processes, click here.**