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What You Need to Know about Your Health Plan Coverage and Our Financial Policies

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Contents

Introduction

We are privileged to have you as our patient, and if you are a new patient, please allow us to take this opportunity to welcome you to our medical practice.

Today there are hundreds of healthcare insurance companies, and each has dozens of plans. We participate with many of them and each plan has its own restrictions and its own rules and payment policies for physicians, both of which are constantly changing. In addition, employer and individual plans may vary depending upon the benefit package purchased, and whether the employer is 'self-funded' or 'fully insured', and there are variations between insured members that may even be on the same plan!

It's complicated and so this guide has been written to help explain what you need to know about your insurance, as well as our clinical and financial policies that support effective and high quality health care for your child.

That said, we can only explain so much in a short guide. For information on your specific benefits – such as what is covered, what is not, and why – please refer to the benefits guide provided by your employer or plan at the time of enrollment, call the member number usually located on the back of your insurance card, or log in online if your insurer has that option available.

We encourage you to keep and store this guide as a reference whenever you may need it.

Our goal is to provide nothing less than the highest quality medical care for your child.

** Please note: if you are a member of a Medicaid plan, some of these policies do not apply to you. Please do not hesitate to ask our staff if you have any questions.*

Insurance and Payment Policies

Being 'financially responsible' for incurred charges:

As the child's parent or guardian, you are responsible for all care rendered regardless of the level of your insurance coverage. Following are the most common varieties of 'financial responsibility'. As mentioned, there are simply hundreds of different insurance plans and understanding the coverage details is the responsibility of the patient/member in advance of each appointment.

Most plans require that you pay a **copayment** at the time of your visit, which is a fee paid at most visits. Copayment is collected upon checking in or out. Even though the Patient Protection and Affordable Care Act (or PPACA, also known as the 'Health Care Reform Act') has resulted in many plans being required to waive copays for well care, there are 'grandfathered' plans that require the continuation of copay collection at well visits. Also, in cases where a plan waives the copay for the well visit, it may require that we collect a copay on any other services rendered along with a well visit, such as a vision or hearing screening.

Some plans have a **coinsurance** provision, which means that the member shares in the total payment for services by paying a percentage of the total allowable (allowed payment or fee schedule) due to the practice. You will usually be balance-billed by us for that amount once your insurance company has processed the bill.

Many plans (and/or employers) now require that you meet a deductible amount, where the plan does not pay for any billed charges until the member pays a certain amount out-of-pocket for services within a given time period. For example, you may have an annual $2,000 deductible for your family, in which case your insurer will only start paying bills once you have paid $2,000 yourself for medical services.

Some insurers allow **deductibles** to be calculated in real-time, meaning that your insurer makes the remaining deductible amount available for look up online. In these cases, a portion of, or the remaining amount of that deductible (if equal or less than your visits charges), may be collected by us at the time of service.

What you may not know:

In order for a provider to participate in an insurance plan, contracts are signed between the plan and the provider or group. These contracts legally require that we HAVE TO COLLECT your portion of the costs (that is, copay, coinsurance and deductible amounts). If we do not, federal and state law, as well as the insurer, can hold our practice liable for insurance fraud. If you have difficulty meeting your payment obligations, please let us know and we can make alternative payment arrangements with you.

If you do not have insurance:

We will work with you to make sure that your child receives the care they need. Often this starts with a 40% discount for payment at the time of service. Your child may also qualify for free vaccines under the State's Vaccines For Children (VFC) program. And you will only ever be charged the mandated medical fee for vaccine administration costs.

Please do not hesitate to call our billing team at 201-252-8700 if you need to set up a payment plan to pay charges over time.

If you have insurance but we do not participate with your plan:

We expect that you will make payment at the time of service, at which time we will provide you with a receipt that can be submitted by you to your insurer for direct reimbursement. Many insurers will pay only up to their 'allowable' amount for any given service, and as such, it may be less than what our charges are for those services. We therefore offer a 40% time of service payment discount to help offset some of that cost for you. In the event that a reimbursement payment comes directly to us, we will forward that payment to you promptly.

If you are in an HMO plan:

Many HMO plans require you to select a Primary Care Provider (or PCP). You must do so in order for services rendered by us to be covered by your insurer. If your dependent's insurance card does not list a PCP, or lists a PCP other than a provider here at our practice, you must call your insurer and ask them to assign your child to one of our providers BEFORE your visit. This will ensure that you avoid liability for charges for that visit.

Referrals to specialists:

Insurance regulations prevent us from making referrals to specialists unless your child has been seen by us for the specific problem. We cannot make 'retroactive' referrals (meaning dating them prior to your request for one). For any new referral requests, please call our office and schedule an appointment so that we may evaluate the issue and make recommendations from there. You may not need to be seen for follow-up referrals (for example, if the specialist is providing on-going care and another X number of visits need to be authorized). In those cases, please call our office with details and allow at least 3 business days for processing.

If you have primary and secondary insurance:

Sometimes the primary insurer submits the balance to a secondary insurer after they have processed their part of the bill. If your insurer does not provide that service, and we only participate with the primary insurer, you will need to make prompt payment to us on any portion of the charges that your primary carrier does

not pay. We will provide you with a bill which can be submitted to your secondary carrier along with the explanation of benefits that you receive directly from the primary carrier, in order for you to be reimbursed by the secondary for any benefits due to you.

Questions about statements and explanation of benefits:

As part of **BCD Health Partners, LLC**, we have a centralized billing team that can handle all of your questions. Please call **201-252-8700** during normal business hours for assistance. If you receive a statement or explanation of benefits from your insurer, please refer those inquiries directly to member services at your plan.

Billing patient's non-custodial parent:

Our policy is that the parent or guardian who brings the patient in for his/her care is financially responsible for the charges incurred at that visit. Divorce agreements and arrangements are strictly between the parents and we are unable to split bills or have two different financially responsible parties on the patient's account.

Sending accounts out for collection:

We understand that sometimes it can be difficult to meet financial obligations. We will hold accounts for 120 days before sending them out for collection by an outside agency. If you are unable to pay your bill within that time period, please help us to help you and call us to set up a payment plan. We will work with you to set up a reasonable plan and prevent your account from being turned over. There is a 40% collection fee added to your balance once account is turned over to collection agency.

About Vaccine Coverage

If a vaccine is given to your child and your insurance company processes the claim as 'not a covered benefit', then you are responsible for the payment in full.

About After Hours / Weekend / Emergency Visits / Holidays

Additional charges for emergency visits, and visits on evenings, weekends, and holidays may be incurred.

About In-Hospital Newborn Care, Emergency Room Visits and Hospitalizations

If you have a newborn, you must add your new child to your insurance policy as soon as possible to avoid any newborn claims to be permanently denied. The Insurer may deny any claims submitted after **day 30** for in-hospital and pediatric follow

up visits. Payment for these service dates would then become your responsibility until your new child is enrolled into a plan. Please, notify us as soon as your child is enrolled so we can begin billing our service to your insurer.

If you need to access emergency room care or your child is hospitalized, please make sure to call both your insurer and our practice to let us know about it. Coverage will often be denied if proper notification is not made.

About Well care versus Sick visits

You may have insurance that does not cover you and your dependents for 'well care'. However, under no circumstances can we list well visits as sick care. It is fraudulent for us to do so and at no time will we undertake to commit fraud for any reason whatsoever.

Office fees that are NOT covered by your insurer

Following are details about services and fees that are not part of your plan benefits:

Copay billing fee

- Often the cost of billing a copayment is equal to the amount of that copayment (once labor, materials and postage is factored in). Therefore, if we need to bill you for a copayment, we need to charge you $20.00 for that service. Please avoid these charges by making sure that you have your copayment amount on hand at the time of your visit.

Missed appointment fee

- Life happens and we understand that sometimes you may need to reschedule a visit. All we ask is that you provide us with 24 hours notice, otherwise we will need to bill you a 'missed appointment' fee.

Recurring billing fee

- Similar to our copay billing fee, there is expense involved in sending monthly statements. Personal balances that remain unpaid for 30 days or more will be charged a recurring billing fee per month for each month that the bill is outstanding. This fee is waived for patients on a recurring payment plan.

Record Release Fee

- We charge a fee to cover costs associated with copying / printing records. Per New Jersey regulations, these fees cannot be greater than $1.00 per page or $100.00 for the entire record, whichever is less. If the record is less than 10 pages, we may charge $10. Please allow up to 30 days for us to prepare your records.

Returned Check Fee

- We will assess a bounced check fee if your check is returned by the bank.

School, Camp and Athletic Forms

- There are fees associated with form requests. Please see our separate handout on form requests and related fees, which can be obtained from our front desk.

About in-office tests, screenings and other services

We pride ourselves on providing only the **highest quality care** for your child and do this by following many of the American Academy of Pediatrics clinical guidelines and other trusted sources for evidenced-based clinical outcome information. However, insurers rarely keep pace with guidelines, or want to cover services related to meeting these clinical recommendations. In fact, insurance company rules and policies change all the time.

For example, your child's hearing and vision screening may have been covered at your last visit, but that is no guarantee that your insurer will cover the same screening at this visit. Frustrating, isn't it? And often we only find out that a plan is no longer paying for something when they send us a payment denial for a bill.

So why do these policies change anyway? Well, your insurer is constantly looking to improve their profits, and making changes such as what to pay for and what to deny really helps their bottom line, quarter-to-quarter. It's unfortunate for both of us, as we waste time and effort having to find out why payment was denied and then have the expense of billing you for it, while you, in addition to your copay / coinsurance / deductible cost sharing, may now have a 'non-covered service' to pay for too.

Your insurer may already have a policy in place whereby it does not cover things like in-office strep testing and urinalysis, to name a few. You can verify with your insurer which services it covers and which it does not. Performing tests in-office is faster and more efficient than sending tests out to labs, and performing screenings such as hearing and vision tests avoids incurring the inconvenience and expense on your part to refer you to a specialist for these things.

As prompt and appropriate treatment of your child is of primary importance to us, we ask that you sign a 'waiver' (at the back of this guide) giving us permission to perform screenings and tests as we, your trusted providers of care, deem necessary.

Following is a list of the most frequently provided services for which we request a signed waiver and that you can use to determine coverage with your insurer.

Waivers

As mentioned, some insures do not pay for tests and screenings. In particular, at the time of publication, these services include:

Vision Screening

- **Snellen, Go Check, Suresight testing**. This is a simple examination performed to measure visual acuity

- **Photoscreening** is a pediatric vision screening technique wherein a camera and flash are used to determine refractive errors and identify risk factors for amblyopia. A photoscreener detects amblyopic risk factors such as hyperopia, myopia, and anisometropia and estimates their severity. We consider this an important screening and will routinely perform them at well visits. Unfortunately, some insurers no not cover this test at this time.

- **Visual Evoked Potential testing** (or VEP). This is an important test for early detection of eye and vision problems in infants and young children. Amblyopia (or "lazy eye") occurs when the brain does not receive proper images from the eye. If it is not diagnosed in early childhood, there may be a permanent loss of vision in the affected eye. We perform this test yearly in the first 6 years of life. Unfortunately, some insures do not cover this test at this time.

As we consider these to be important tests for your child, and will routinely perform them at annual well visits, if your insurer does not cover the charge, we will significantly discount the amount.

Hearing Screening

- **Otoacoustic Emissions testing** (or OAE). This is an important hearing test and can be used on newborns through adulthood. It does not require a soundproof room or the ability of the child to understand instructions or respond to sounds, which makes it a much more accurate screening tool for picking up on hearing issues at any age.

As we consider this to be an important test for your child, and will routinely perform it at annual well visits, if your insurer does not cover the charge, we will significantly discount the amount per test.

- **Audiogram**. This is a hearing screen for verbal children. If your insurer does nt cover the charge you will be billed.

  Not only do we believe that hearing screens should be performed every year, but testing is required for most preschools, public and private schools, and for sports.

Development Screening

- **Development Testing**. Developmental screening (including standard pediatric developmental screening done at well-visits, Connors forms, Edinburgh post-partum depression screening, etc) are very important in the assessment of any delays or potential problems.

As we consider these to be important tests for your child, and will routinely perform them at annual well visits, if your insurer does not cover the charge, we will significantly discount the amount per test.

In-Office Lab Tests

Often, patients want to know as soon as possible if their child has the flu, strep, mono etc. We can effectively and efficiently determine accurate results by performing in-office testing. Many insurers do not pay for in office testing. However, sending tests out to external labs results in waiting days for results that we can provide to you with expedited results (in some cases within minutes or overnight). We believe that it is important to treat your child as quickly as possible and therefore these services are offered in-office.

- **In-office labs performed in office:**

CBC	Hematocrit	Throat Culture	Flu Test
Cholesterol	Hemoglobin	Urinalysis	Strep Test
Lead Test	Lipid Panel	Urine Culture	Covid Test
Mono Test			

If you do not wish for your child to have any of the above tests or screening exams please inform the staff at the beginning of your visit. Please realize that in doing so it may be necessary to send a test to an outside lab, refer you to a drawing station, or schedule a visit with a specialist in order to obtain the necessary information. This may significantly delay diagnosis and treatment, return to school or activities, or the provision of requested forms.

I acknowledge that, **unless specified otherwise at the time of the visit**, I request that recommended procedures which otherwise would need to be sent or performed elsewhere be done here for my convenience in order to obtain expedited results.

We appreciate you taking the time to read this guide and familiarize yourself with important insurance matters that affect your family, and the policies we have in place at our practice. If you have any questions about the information contained here, please do not hesitate to contact our billing department at:

BCD Health Partners, LLC
160 Pehle Avenue, Suite 302
Saddle Brook, NJ 07663

Tel: 201-252-8700 Fax: 201-252-8701
www.bcdhealth.com

Waiver Form and Acknowledgement of Receipt of Policies

I acknowledge receipt of the Guide and have been informed of, and hereby attest that I fully understand, my financial responsibility for any balance resulting from non-covered services, or services not covered in-office, by my insurer. I agree to pay the allowed amount of the charge per my insurance company, in the event that my insurer does not pay for these services.

Further, I agree to pay the office fees set out in the Guide and comply with office policies.

Patient(s) Name [please list all in family]: _____
_____
_____
_____

Guarantor / Responsible Party's Name:

_____

Guarantor / Responsible Party's Signature:

_____

Date: _____ / _____ / _____

Please separate this signed form from the Guide and give it to one of our staff at the front desk.

Thank you!

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