

How does reimbursement work when you see an out-of-network provider?

Essentially, the process goes like this: You pay me directly for the office visit at the end of the appointment. I give you an invoice stating you've paid your bill in full. You submit the invoice to your insurance plan, and they send you a reimbursement check in the mail.

Reimbursement for out-of-network providers varies among insurances and even between different plans for the same insurer. Some don't reimburse at all and others reimburse 75% or even 90% of your visit. Check your member handbook or insurance website for information about reimbursement rates for your particular plan. When you see an out-of-network provider, there's no need to pay your typical office copay, so you may save money there. (In fact, some plans reimburse so well that it may be *less* expensive to see an out-of-network doctor with a waived copay.)

For example, let's say the cost for the office visit is \$100 and your plan reimburses at 75%. Although you'd pay \$100 up front on the day of the visit, your insurance company would send you a check for \$75, making the total cost of your office visit \$25. Let's also say you normally have a \$20 copay when you see an in-network doctor. Since you didn't need to pay your copay (\$20), you only paid \$5 more to see an out-of-network doctor.

Also, realize that the only expenses subject to the reimbursement rate are my office charges. Labs, imaging studies, specialty referrals, physical therapy, prescription medications, hospital costs, etc. can all be billed in-network with no up-front costs to you.