GuideStone®

My Screening is 100% Covered

Why Did I Get A Bill?

It's a common and frustrating problem: After a screening that you were sure your health plan covered at 100%, you get a bill. Why?

How can you know whether or not to plan for a bill after a procedure? Here are four tips.

1 Understand Your Preventive Schedule

Preventive exams are important for maintaining health. These services generally include annual wellness exams, yearly immunizations such as pneumonia and flu vaccines, and scheduled screenings. To better understand these benefits, review your ***Preventive Schedule***. Everything you qualify for on your schedule is **covered at 100%** of the allowed amount.

However, if the preventive exam uncovers an issue that leads to a diagnosis and treatment, the treatment that follows is paid according to your medical benefits, which can include **a co-pay, deductible or co-insurance**.

Example 1: Preventive

A routine colonoscopy screening checks for issues, such as polyps, or confirms that everything is healthy. If performed as a routine preventive benefit, your GuideStone® health plan would **cover the screening at 100%**.

Example 2: Diagnostic

If a routine coloscopy revealed a potential issue that required an additional colonoscopy six months later, the second screening is considered a diagnostic procedure, which is **paid according to your plan's benefits**. Depending on your plan, you may be **responsible for a deductible, co-insurance or co-pay**.

Read this article to learn the differences between a diagnostic and a preventive screening.

2 Know More About Your Plan Than Your Doctor Does

Many people mistakenly assume their health care provider's office knows how much their health plan will pay toward a procedure. The fact is that many providers rely on the patient to understand the details of his or her own coverage. There are so many different types of health plan benefits, so it's impossible for the health care provider or the office staff to know these details for every individual. This is your health and your finances, so it's important to understand how your plan's benefits work.

If you want to know more about your costs for medical visits, tests or procedures, contact the patient advocates at Highmark® at **1-866-472-0924** to understand what's covered before receiving services. They can help you understand your coverage so you can make informed decisions.

3 Learn the Codes

What can you do to avoid the health plan equivalent of buyer's remorse? Spend time understanding your health care provider's orders and how the office will bill your health plan for the services. If your provider says something isn't urgent, you have time to call Highmark to understand potential costs and manage your budget accordingly. Ask your the health care provider's office for the procedure's billing codes so Highmark can check your benefits. Your medical providers submit two codes with each claim:

1. A procedure code — This describes what will be done and tells Highmark where to look in your benefits to see whether you have coverage and what costs you might be responsible for under your plan.

2. A diagnosis code — This describes why the procedure is being done. Some procedures are diagnostic-specific, meaning a procedure may be covered under one diagnosis code but not under another. The more information you provide, the better. This works in the other direction too — Highmark patient advocates can let you know if there are questions you should ask your doctor. For example, if you go in for a routine physical and your doctor wants to have blood work done, you may want to ask, "Is this the routine blood work like a glucose screening and lipid profile, or are you adding something with a diagnostic code, which may involve costs I need to know about?"

4 Compare Claims To Bills

If you think there's been an error, please contact Highmark right away. There are many things that can happen during the treatment process that will affect the codes used on the claim.

However, if you receive an explanation of benefits (EOB) letter with a denial of coverage, wait until you receive a bill from your provider before contacting Highmark. With the bill in hand, it's easier for Highmark to talk to the billing office on your behalf. In many cases, they'll send it back for review and put the account on hold for 30 days.

In the meantime, you may also call the health care provider's office for assistance. For example, if a provider ordered blood work and the patient went to an outside facility, the provider may simply need to contact the facility and request that the claim be resubmitted with a corrected diagnostic code. GuideStone understands that health coverage can be challenging sometimes — that's why it's our goal to make sure you have a complete understanding of your coverage before you receive treatment.

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