Georgetown Family Dental

Relaxing.
Understanding.
Our team is **focused** on you!

Frequently Asked Questions: In-Network vs. Out-of-Network Providers

1. What does it mean when Dr. Maynard goes Out-of-Network with Aetna?

   Out of network does not mean you cannot use your insurance. It does not mean you will not get any benefits from your plan either. Your co-pay could increase if there is a large difference between what your insurance pays and what we bill. You will be responsible for whatever portion your insurance does not pay.

2. Will my co-pays for my visit increase?

   As a courtesy, our office will continue to file with Aetna. Your co-pay could increase if there is a large difference between what your insurance pays and what we bill. You will be responsible for whatever portion your insurance does not pay. We offer in house payment plans to help with your out of pocket costs if they do increase.

3. How will Georgetown Family Dental be able to accommodate me if I decide to stay?

   GFD will continue to file your claims in a timely fashion. If your insurance denies a service for any reason, we will be happy as always to file an appeal on your behalf to help recoup any monies payable to you according to your plan provisions. And we take great pride in offering in house payment plans that our Treatment/Financial Coordinator will be happy to put into place that not only work for us but fit into your budget as well. Depending on your needed treatment, we will be able to provide financial options that we could not apply because we were under contract with Aetna.

4. If I decide to transfer to a different provider, how will that process happen?

   We will be happy to assist you should you decide to change providers. We will make the process simple by having you complete and sign a records release form. Once received, we will email your x-rays to your new provider's office at no cost to you. If your new provider should need further information, such as previous placement dates, we will be happy to assist them with this information.

5. What will my check up and cleaning appointment cost?

   A 6-month checkup and cleaning appointment averages about $275. (Keep in mind that your insurance should reimburse at 90-100% of the allowed amount per procedure per your plan provisions) And don't forget the in-house payment plans that we offer to help offset your out of pocket cost.

Email: **contactus**@georgetownfamilydental.com
GeorgetownFamilyDental.com

821 King George Blvd
Savannah, Ga 31419
(Tel) 912-927-8484
(Fax) 912-927-8487

6. Why are you no longer an in-network provider for my carrier?

   Insurance companies consider Doctors as “Providers” with the exception that we provide a certain service for a certain fee, according to their policies. Being an in-network provider binds Doctors to work within the confines of the insurance contractual requirements regardless of the patients’ needs or my expertise and discretion to act in the best interest of my patient.

7. What insurance companies are Georgetown Family Dental In-Network with?

   CIGNA (NOT CIGNA ADVANTAGE)
   UNITED CONCORDIA (NOT UCCI ADVANTAGE PLUS OR UNITED CONCORDIA SELECT)
   AMERITAS
   GEHA
   UHC
   UMR
   LINCOLN
   PRINCIPAL
   HUMANA
   ANTHEM (BCBS/EMPIRE)
   MUTUAL OF OMAHA
   ASSURANT/DHA/SUN LIFE

8. What is an “In-Network” Provider?

   These are providers that have a contract with your insurance company. If you receive covered services from an in-network provider, generally you will only need to pay your deductible and any applicable copay or coinsurance. You may not be billed for the balance by the provider.

9. What is an “Allowed Amount”?

   The maximum amount the insurance company will use when deciding what to pay for a covered health care service. This is sometimes referred to as "payment allowance" or "negotiated rate." It is also the basis for calculating your coinsurance, which is a percentage of the allowed amount you are responsible for paying. The allowed amount will be described in your policy or certificate of coverage. It may be based on a fee schedule, a database, or a percentage. You may have to pay the difference if your provider charges more than the allowed amount and the provider is not an “in network” provider.

10. What is an “out-of-Network” Provider?

    These are providers that do not have a contract with your insurance company. If you receive covered services from an out of-network provider, the insurance company may pay only a part or none of the charges depending upon the terms of your policy. Also, your copay or coinsurance may be larger than if the services had been provided by an in-network provider.

11. What is “Balance Billing”?

    If you receive covered services from an out-of-network provider, and the cost of these services is more than the allowed amount, the provider may be permitted to bill you for the difference. Check your health plan’s on-line provider directory or call your health plan. Make sure that you know the type of health benefit plan that you have. If you are told that a provider is “participating” or “accepts” payment directly from your health plan, follow up by asking if the provider is “in-network” or “out-of-network.”

12. Can I see an “Out-of-Network” Provider?

    It depends on the type of health benefit plan you have. Some plans only allow you to see in-network providers unless it is an emergency, you do not have control over the provider you see such as when you receive in-patient services at a hospital, or you need a certain type of specialist and there is no specialist in the health plan’s network. If you are covered under a health maintenance organization (HMO), you may be restricted from seeing an out-of-network provider. Some plans, often called Preferred Provider Organizations or PPOs, allow you to see any provider even if the provider is out-of-network. You should review the schedule or summary of benefits for your health plan. You may also contact your employer’s human resources department or your plan for this information.

13. What will I have to pay if I see an “Out-of-Network” Provider?

    You may have to pay more if you see an out-of-network provider. If your health plan does not cover out-of-network providers at all, you will be responsible for the entire cost of services. If you have a PPO plan, the provider will be paid the allowed amount for covered services, but you may be responsible for a higher copayment, the deductible, or coinsurance. You may also be responsible for the difference between the provider’s billed charge and the PPO’s allowed amount (i.e. the balance bill).

14. How do I pay an “Out-of-Network” Provider?

    Generally, an out-of-network provider will bill you directly for services. You or the provider’s office would then need to file a claim with your health benefit plan in order to be reimbursed the allowed amount for your covered benefits. And please remember that we offer in house payment plans to help with your out of pocket cost.