Frequently Asked Questions for Rydell High School's Reference Based Pricing Plan

What is a Referenced Based Pricing Plan?

Your health plan has eliminated Preferred Provider Networks (PPO) for medical facilities and physicians, allowing you to access any provider you choose. All payments to providers are based off of Medicare pricing, plus an incentive bonus over and above the Medicare allowable amounts.

Why is my employer offering this plan instead of the previous PPO?

This plan allows your employer to manage the ballooning cost of healthcare while still continuing to provide quality benefits to employees and their families.

Can I only go to a Doctor or Hospital that is in network?

No. There is no network.

Employees enrolled in the Rydell High School health plan have the freedom to go to any doctor, hospital, or medical facility they choose.

What should I do if scheduling or billing doesn't recognize my health plan?

Please tell your provider that your health plan is an open access plan and that there are no reduced out-of-network benefits. They should collect any applicable copay and submit a claim through the Third-Party Administrator, with the information on your ID Card.

If the Provider still has questions, have them call Health Customer Service immediately at 1-888-888-8888. The phone number is also on your health plan ID card. Make sure you present your ID card at every visit or service.

Who should I contact for questions about my plan benefits or my medical coverage?

You should call the Third-Party Administrator. There is a dedicated customer service team at the Third-Party Administrator's office that is ready to assist you with any questions regarding your medical coverage or plan options. Call 1-888-888-8888.

How will I know what my health plan has paid?

After any medical service, you will receive an Explanation of Benefits (EOB) from the Third-Party Administrator. The statement that will be sent by the Third-Party Administrator is a breakdown of what medical treatments were billed and what benefits were paid, along with indicating what you, the patient, is responsible for.

What is a balance bill?

A balance bill is when a provider bills a member for the difference between what the health plan allows for a medical service versus what the provider chooses to charge. In essence, it's when the provider charges more than what the Explanation of Benefit (EOB) indicates is patient responsibility.

Example: Your hospital charges are $100 and the plan allowable at 140% of Medicare is $70.00. If the provider bills you the $30 difference between the charged amount and the plan allowable, they are balance billing.

Deductibles, copays, and coinsurance are not examples of balance billing and you are still responsible for these cost sharing items.

What should I do if I receive a balance bill?

If you receive a bill from your provider, either a physician or medical facility, you need to compare it to the EOB that you received from the Third-Party Administrator.

If you are asked to pay more money than what is shown as patient responsibility on your EOB, you need to call the Third-Party Administrator at 888-888-8888. You will likely need to send the bill via email or fax.

What happens when I contact the Third-Party Administrator about a balance bill?

The Third-Party Administrator will work on your behalf to resolve the billing dispute with the provider. A customer service representative will walk you through our process and keep you updated until a resolution is achieved.

What should I do if a facility requests payment up front?

Do not pay anything other than your copay up front. The facility should call the Third-Party Administrator Health Customer Service at 800-228-1803.

IMPORTANT: It is important for employees to open any and all mail in order to check for any balance bills. If you receive a balance bill for any medical services, it is VERY important that you call the Third-Party Administrator at 888-888-8888.