



Medicare Maximum Allowable Charge

As announced in *Benefits Highlights*, starting January 1, 2012, the reimbursement for out-of-network services in the healthcare plans will be indexed to the Medicare Maximum Allowable Charge. Out-of-network services will be reimbursed at 150% of the Medicare Maximum Allowable Charge. This replaces the Reasonable & Customary (R&C) reimbursement and will result in significantly lower reimbursement for out-of-network services. As with the R&C, the Medicare Maximum Allowable Charge is adjusted by location.

Here's an example: Your out-of-network doctor charges you \$200 for an office visit. The claim that goes to the medical carrier (Aetna, CIGNA or UHC) has a billing code of 99212 (office visit for an established patient). 150% of the Medicare Maximum Allowable Charge for this code is \$73.38. Therefore, \$73.38 (not \$200) is the basis for the out-of-network reimbursement.

- **If you had not met the out-of-network deductible**, you would be responsible to pay the full \$200, and \$73.38 would be applied to the deductible.
- **If you had already met the out-of-network deductible**, the plan would pay the coinsurance of 60% of \$73.38, which is \$44.03. Your share of the coinsurance is 40% of \$73.38, which is \$29.35. You are also responsible to pay the amount in excess of the 150% of the Medicare Maximum Allowable Charge; that is: $\$200 - \$73.38 = \$126.62$. In total, therefore, you would pay \$29.35 plus \$126.62, which is \$155.97. The amount counted toward your out-of-network out-of-pocket maximum would be \$73.38.
- **If you had met the out-of-network out-of-pocket maximum**, the medical carrier would pay the 150% of the Medicare Maximum Allowable Charge (\$73.38), and you would be responsible for the balance (\$126.62).

*Please note that the charges in excess of 150% of the Medicare Maximum Allowable Charge (in this example, \$126.62) do **not** count toward the out-of-network out-of-pocket maximum, and you are responsible for this payment to the healthcare provider or facility.*

The chart on the next page includes the current values of the 150% of the Medicare Maximum Allowable Charge for the New York metro area associated with some common billing codes. For information on specific Medicare Maximum Allowable Charge(s) relevant to your personal situation, talk to your doctor or his/her office staff.



Procedure Code	Literal Description	150% of Medicare Maximum Allowable Charge
12020	CLOSURE OF SPLIT WOUND	\$472.16
19125	EXCISION, BREAST LESION	\$908.18
24620	TREAT ELBOW FRACTURE	\$945.63
29873	KNEE ARTHROSCOPY/SURGERY	\$900.53
33750	MAJOR VESSEL SHUNT	\$2,444.40
70551	MAGNETIC RESONANCE (EG, PROTON) IMAGING, BRAIN (INCLUDING BRAIN STEM); WITHOUT CONTRAST MATERIAL	\$967.89
99212	OFFICE VISIT - ESTABLISHED PATIENT	\$73.38
92507	TREATMENT OF SPEECH, LANGUAGE, VOICE, COMMUNICATION, AND/OR AUDITORY PROCESSING DISORDER; INDIVIDUAL	\$142.07
97530	OCCUPATIONAL THERAPY - THERAPEUTIC ACTIVITIES TO IMPROVE FUNCTIONAL PERFORMANCE	\$56.60
97110	PHYSICAL THERAPY - THERAPEUTIC PROCEDURE(S) (TO IMPROVE FUNCTION)	\$51.35
71250	CAT SCAN - CHEST - COMPUTED TOMOGRAPHY, THORAX; WITHOUT CONTRAST MATERIAL	\$466.40
77056	MAMMOGRAPHY - DIAGNOSTIC - BILATERAL	\$200.58
95950	EEG - MONITORING FOR IDENTIFICATION AND LATERALIZATION OF CEREBRAL SEIZURE FOCUS, ELECTROENCEPHALOGRAPHIC (EG, 8 CHANNEL EEG) RECORDING AND INTERPRETATION, EACH 24 HOURS	\$496.34
38570	LAPAROSCOPY, LYMPH NODE	\$916.88
44140	PARTIAL REMOVAL OF COLON	\$2,241.95
44389	COLONOSCOPY WITH BIOPSY	\$721.92
45333	SIGMOIDOSCOPY & POLYPECT	\$528.32
50075	REMOVAL OF KIDNEY STONE	\$2,567.51
72126	CT NECK SPINE W/DYE	\$577.31
59400	VAGINAL DELIVERY	\$3,261.00
27130	TOTAL HIP REPLACEMENT	\$2,479.00
90806	BEHAVIORAL HEALTH	\$148.60
90805	PSYCHOPHARMACOLOGY	\$128.28