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Our story:

Our story started with my pregnancy in summer of 2011. I was 37 years old at that time and even though I was in good health and physically very fit (I did yoga up until the last day of my pregnancy) I was still considered high risk because of my age. I also worked in a chemical plant and my work often involved lifting heavy objects. Since my OB/GYN did not say anything otherwise (she was aware of my job description) I continued with my daily work during the entire term of my pregnancy. I had United Healthcare as my healthcare provider through work. However, in the second and third trimester I started having occasional intense pain, especially after if I had to lift or push a heavy object. Because of that I had to go for multiple tests at my OB/GYN's office (3533 Southern Boulevard, Kettering, OH 45429). Tests to determine the level of amniotic fluid were done in a different office and because the service provider was out of network, I had to pay a hefty sum every time I availed their service at the request of my OB/GYN.

On February 5th 2012, 2 weeks before my due date, I was in active labor and was admitted to the maternity ward of Kettering Medical Center (3535 Southern Boulevard, Kettering, OH 45429). Pretty soon it was evident that every time I was having a contraction, my baby's heart rate was drastically dropping. The resident doctor decided to run a few tests on me before making the executive decision to carry out an emergency c-section to save my baby. Since I was only dilated to 2cm and my water had not broken yet, the doctor ruptured my amniotic sac to access the baby and put probes on her head and chest to monitor her heart better. Before this procedure was done, I was asked to give consent. I, along with my husband was very worried about our baby who was in fact in mortal danger since her heart beat was steadily dropping as my labor pains were intensifying. My husband who had lost his first child, a baby daughter years ago in a similar situation felt as if he was having a déjà vu. So when the doctor asked us to give consent to the above mentioned procedure we agreed right away- at that time our first priority was to save our baby's life, the thought that we need to check with our insurance first, DID NOT even occur to us.

To make a long story short, a different specialist stepped in, the procedure got done, my baby who was still in my womb got hooked up to various monitors and eventually the doctor decided that I need emergency c-section. My OB/GYN got called in. She asked for epidural to relieve some of my labor pain. Attempts were then made to give me epidural by puncturing and putting a catheter in my epidural space around my spinal cord. Unfortunately, I started to bleed because it punctured my blood vessel instead. So the catheter had to be pulled out. There was no epidural for me!

After an emergency c-section and 72 hours in the hospital I brought home a beautiful healthy baby. A month later I got a medical bill. At that time we had medical insurance through Aetna. In addition to the $3000/- I have already paid the OB/GYN, and the hospital bill of approximately $2000/- I was charged about $4000/- for the emergency procedure with the probes on my baby. And I was charged additional for the epidural that I never got! When I called Aetna, I was told all these procedures were optional and I should have consulted them before giving my consent. And I should have made sure that the doctors doing these procedures were in network! So according to Aetna, while in the middle of labor and my baby in a life-threatening situation, I should have called and verified my coverage with Aetna before saying yes! So I ended up in paying about $10,000 to have my baby. Thankfully I was working a decent paying full-time job and had savings to cover this sudden expense. But there are many many families out there who would have been in serious debt because of such a medical emergency!

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My second fight with health insurance provider was when my daughter was diagnosed with severe speech language delay at 22 months. She had ear infections as a baby and had very limited vocabulary as a toddler. Concerned, that she may have other developmental delays/disabilities, I consulted a developmental pediatrician (she was highly recommended, but she was out of network- so I had to pay a higher medical bill to get her opinion) who recommended immediate speech therapy. When I tried to get approval for coverage for speech therapy ($100/- per session without insurance) I was turned down because my daughter did not have speech impairment due to a birth defect or severe medical condition such as meningitis! I was clearly told that developmental delay did not count as a valid reason for insurance coverage for speech therapy! Thankfully it was time to switch insurance companies and I finally found a healthcare provider that charged us a higher premium but agreed to partially pay for my daughter's speech therapy which we had to continue for more than 3 years, once a week- a total of about 160 sessions (an expense of $16,000 if I had to pay out of pocket!) Today she talks, sings, recites poems and is a very confident child which probably would not have been the case if she had not gone for speech therapy. She would have been socially awkward, unsure of herself and a loner- we have a similar example in our own family where the parents could not afford therapy because of its high cost and their child who had very similar speech problems like my daughter, suffers from anxiety, depression, gets bullied and is a social pariah.