

Health Insurance FAQs

Who is a participating provider?

A participating provider is a health care provider/physician who has an agreement with the health insurance company to provide benefits to members at a discount rate.

What are in-network benefits?

In-network benefits are covered services that are provided by a participating provider/physician.

What are out-of-network benefits?

Out-of-network benefits are covered services that are provided by a non-participating provider/physician.

What is a deductible?

A deductible is the part of eligible expenses you may be required to pay out-of-pocket before the health insurance plan begins to pay benefits for eligible expenses.

What is coinsurance?

Coinsurance is a cost-sharing method by which a health insurance plan pays a percentage of the provider's covered expense (often after a deductible is met) and the participant pays the rest. For example, the plan may pay 70% and the participant may pay 30%. In this case, the 30% is the participant's coinsurance.

What is a copay?

A copay (or copayment) is flat dollar amount that you pay for a certain medical services (such as an office visit). Copayments may apply in addition to deductibles and coinsurance and generally apply to the in-network benefits.

What are covered services?

Covered services are eligible expenses that meet all the requirements according to your health insurance plan. Health insurance plans are not designed to cover everything and if you obtain services that are not covered services, you pay the full cost for those services.

What is an out-of-pocket maximum?

An out-of-pocket maximum refers to the covered expenses for which you are not reimbursed through insurance. This maximum represents the most you would have to pay out of your own pocket for covered services. This out-of-pocket maximum may

include such items as deductibles, copays and your coinsurance amounts. Charges that exceed what is reasonable and customary are excluded from your total out-of-pocket maximums. Once you reach the out-of-pocket maximum for a given calendar year, the plan would pay all eligible expenses for the remainder of the calendar year or until any lifetime maximum benefit is reached.

What is a lifetime maximum?

A lifetime maximum is a cap on the benefits paid for the duration of a health insurance policy for a given member. Once you reach the lifetime maximum, no additional benefits are payable under the health insurance plan.

What is an explanation of benefits (EOB)?

A statement sent by a health insurance carrier to persons who have experienced a claim under their health plan. The explanation of benefits (EOB) details the charges for health care provider services, the amount the health insurance company will pay for those services, and the amount the insured person will be responsible for paying

What is Usual and Customary (U&C) or Reasonable and Customary (R&C)?

These are terms used to refer to the commonly charged or prevailing fees for health services within a geographic area. A fee is generally considered to be reasonable if it falls within the parameters of the average or commonly charged fee for the particular service within that specific community. "Usual and Customary (R&C)" essentially means the same thing as "Reasonable and Customary (R&C) Charge." You as the member will most commonly see these terms when utilizing out-of-network providers. Since, out-of-network providers do not have a negotiated agreement with the insurance carrier they are free to charge whatever fee they choose. When you visit an out-of-network provider, the provider will be reimbursed by the insurance carrier based on what is "*reasonable and customary.*" You are responsible for any differences between the provider's bill and what the insurance carrier reimbursed the provider/physician based on what is deemed reasonable and customary.