Frequently Asked Health Insurance Questions

Benefit Questions

Below you will find the most frequently asked health insurance questions and their answers.

What is the Accidental Medical Expense (AME) rider? The Accident Medical Expense rider provides benefits for injury due to a covered accident. AME benefits are administered per injury/accident, instead of per calendar year. After AME benefits are paid, your annual health insurance deductible, coinsurance and emergency room copayment (if appropriate) will apply.

What is the Doctor's Office Copayment (DOC) option? The Doctor's Office Copayment Option is an optional benefit that provides 100% coverage for all covered reasonable and customary charges for an office visit to any physician after a copayment. Copayments do not apply toward satisfying the deductible or out-of-pocket maximums.

Am I covered when I go out of the United States? Unless specifically excluded by your contract, you are covered for the benefits listed in your health insurance policy. All health insurance policy provisions apply, including medical necessity and reasonable and customary.

What is a non-smoker discount? A non-smoker discount is a reduction in the health insurance premium amount for our policyholders who lead a healthier lifestyle by not using tobacco products.

What is a deductible? A health insurance deductible is the amount of covered expense you must incur and pay each calendar year before we will pay for covered medical expenses. This is for each individual, each calendar year. Expenses that are not covered by your health insurance policy will not be applied to your deductible.

When does my calendar year deductible start over? The calendar year begins January 1st and ends December 31st each year.

What is coinsurance? Coinsurance (also known as Rate of Payment) is the percentage of covered expense you are responsible for after you have met your deductible. For example, if your coinsurance is 20% up to $5000, the carrier will pay benefits at 80% of covered expenses up to $5000. Then the carrier will pay 100% of your covered charges, up to the policy maximum. You are responsible for the 20% amount that the carrier does not pay.

What is a copayment? A copayment is the amount you pay for each prescription drug or PPO physician office visit.

What is individual out-of-pocket expense? Individual out-of-pocket expense is your deductible and coinsurance added together. In other words, it is the maximum you will have to pay — per person, per calendar year — in deductibles and coinsurance.

What is family out-of-pocket expense? Family out-of-pocket expense is your deductible and coinsurance added together, for your whole family. In other words, it is the maximum you will have to pay per person, per calendar year, no matter how many members of your family need health insurance benefits.

What is reasonable and customary? Reasonable and customary (R&C) is the dollar amount allowed for a particular service. The reasonable and customary amount for charges is determined by the carrier using your geographic area.

What do I do if my physician or hospital is billing me for the amount not covered as over the reasonable and customary amount? There is a specific reasonable and customary amount allowed in your geographic area, and this is the amount allowed by your policy. Anything over the reasonable and customary amount would be your responsibility.

What is preauthorization? Preauthorization is when we are notified in advance of a surgery or hospital stay, and is required for most policies. The requirements can differ from policy to policy, but the purpose of preauthorization is to determine if a hospitalization or surgery is medically necessary, and how many days of hospitalization are warranted. Your health insurance ID card shows the preauthorization telephone number, and a full listing of which services require preauthorization can be found in your health insurance policy. Please follow the preauthorization procedure in order to maximize your benefits.

What is a predetermination? A predetermination of benefits is a written request for verification of benefits. We review these requests based on policy provisions, and send an explanation of your potential health insurance benefits. You may request a predetermination before your medical procedure, although a predetermination of benefits is generally not necessary.

Does my surgery/hospital stay need preauthorization? In most cases, preauthorization is a requirement for services listed in your health insurance policy. Please review your health insurance policy for details.

How do I get my surgery/hospital stay preauthorized? Your health insurance ID card shows the preauthorization telephone number, and a full listing of which services require preauthorization can be found in your health insurance policy. Please follow the preauthorization procedure in order to maximize your benefits.

How long do I have to submit a bill/claim? Please submit the claim as soon as you can. Carriers typically cannot consider any claim received more than 15 months after the date of service.

How do I get a claim form for my prescriptions? Usually, the pharmacy will submit prescription claims for you.

Where do I send claims? Refer to the back of your health insurance ID card for claims submission information.

How long does it take to process a claim? The amount of time it takes to process a claim depends on the information submitted. In general, you should receive an Explanation of Benefits within 3-4 weeks. If additional information is required to process a claim, we will notify you, and the claim could take longer to process.

How do I appeal a claim denial? If you believe your claim has been processed incorrectly, please contact our Customer Services Department.

My physical therapy/chiropractic claim was denied as maintenance care. What does that mean? Maintenance care means that the care that you are receiving is no longer improving your medical condition.

Network Questions

Below you will find the most frequently asked health insurance questions in regard to provider networks.

What is the Network Option? This option utilizes a network, which is comprised of a large number of participating hospitals and physicians. The providers in this network have agreed to reduce the amount they charge for services provided to our policyholders. Network availability may vary depending on the area in which you live.

Who is my vendor? What is the name of my Network? This information is printed on your health insurance ID card, along with a telephone number for you to contact the network vendor for your policy.

Which physicians and hospitals are members of my Network? How can I find out if my physician is a member of my Network? At the time you received your health insurance policy, you may have received a directory of physicians and hospitals in your network. If you would like an updated list, please contact your network vendor. You may also contact your provider's office and ask if the physician is a member of the network (listed on your ID card). Always verify whether your provider is a member of the network in order to maximize your health insurance benefits.

Why are my claims sent to the Network vendor first? The network vendor determines the discounts that are applied to your bills, and then forwards them to carrier.

My Network physician wasn't in the office. I saw the "on call" physician. Will this be paid as a Network claim? If the physician you saw is a member of your network, we will consider the charges at the network rate of payment. If the physician you saw is not a member of your network, we will consider the charges at the non-participating provider rate of payment.

The clinic was a Network provider. Why wasn't the physician paid as a Network provider? Each physician contracts individually with the network. If the physician you saw is not a member of your network, we will consider the charges at the non-participating provider rate of payment.

I was on vacation and had to see a physician. Will you pay my claim at the Network rate? If the physician you saw is a member of your network, we will consider the charges at the network rate of payment. If the physician you saw is not a member of your network, we will consider the charges at the non-participating provider rate of payment.