INSURANCE QUESTIONS

WHAT IS A COB REQUEST (COORDINATION OF BENEFITS)?

A PROVISION IN THE CONTRACT THAT APPLIES A PERSON IS COVERED UNDER MORE THAN ONE MEDICAL PLAN; YOU NEED TO CONTACT YOUR INSURANCE COMPANY A.S.A.P.

WHAT IS A COPAYMENT?

A COST SHARING ARRANGEMENT IN WHICH AN INSURED PAYS A SET AMOUNT FOR A SPECIFIED SERVICE, SUCH AS $25 FOR AN OFFICE VISIT. COPAYMENT IS PAID AT THE TIME OF SEVICE PER YOUR CONTRACT WITH THE INSURANCE COMPANY.

WHAT IS A COINSURANCE?

THE PORTION OF COVERED HEALTH CARE COSTS FOR WHICH THE INSURED HAS A FINANCIAL RESPONSIBILITY, USUALLY A FIXED PERCENTAGE RATE AFTER THE INSURED MEETS HIS/HER DEDUCTIBLE.

WHAT IS A DEDUCTIBLE?

A DEDUCTIBLE IS A YEARLY AMOUNT A COVERED PERSON OR FAMILY PAYS EACH YEAR FROM HIS/HER OWN POCKET BEFORE THE PLAN WILL MAKE PAYMENTS FOR SERVICES RENDERED.

WHAT IS AN OUT OF POCKET MAXIMUM MET?

THE YEARLY MAXIMUM DOLLAR AMOUNT GIVEN BY YOUR INSURANCE COMPANY THAT SETS A LIMIT ON THE DOLLAR AMOUNT THE POLICY WILL PAY FOR HEALTHCARE, ANY AMOUNT OVER THE SET AMOUNT IS INSURED RESPONSIBILITY.

WHAT IS AN EXPLANATION OF BENEFITS (EOB)?

THIS IS A STATEMENT SENT TO AN INSURED BY THEIR INSURANCE COMPANY LISTING SERVICES PROVIDED, AMOUNT BILLED, ELIGIBLE EXPENSES PAID BY THE HEALTH INSURANCE COMPANY TO THE PROVIDER.

WHAT IS A PARTICIPATING PROVIDER?

A MEDICAL PROVIDER WHO HAS BEEN CONTRACTED TO RENDER MEDICAL SERVICES AT A PRE-NEGOTIATED FEE. THIS IS A CONTRACT ONLY BETWEEN INSURANCE COMPANIES AND PROVIDERS NOT SUBSCRIBERS AND PROVIDERS.

WHAT IS AN OUT OF NETWORK PROVIDER?

A HEALTH CARE PROVIDER WITH WHOM A MANAGED ORGANIZATION DOES NOT HAVE A CONTRACT TO PROVIDE HEALTH CARE SERVICES. THE INSURED MUST PAY EITHER ALL OR MOST OF THE COST, DEPENDING ON THE INSURED POLICY FOR OUT OF NETWORK PROVIDERS.

WHAT IS POINT OF SERVICE (POS) PLAN?

THIS IS SIMILAR TO THE HMO. HOWEVER, YOU CAN GO OUT OF NETWORK. BUT THE PLAN USUALLY ONLY REIMBURSES YOU 50 TO 80 PRECENT, AND YOU MAY BE REQUIRED TO PAY CO-INSURANCE AND A DEDUCTIBLE.

WHAT IS PREFERRED PROVIDER ORGANIZATION (PPO)?

THE MAIN CONCEPT BEHIND A PPO IS THE NETWORK. IF YOU OPT FOR THIS TYPE OF INSURANCE, YOU MAY CHOOSE ANY HEALTH CARE PROVIDER FROM WITHIN YOUR NETWORK, DETERMINED BY YOUR POLICY, OR ANY NON-NETWORK HEALTH CARE PROVIDER. YOU ARE USUALLY REQUIRED TO MAKE A CO-PAYMENT OR PAY CO-INSURANCE.

WHAT IS HEALTH MAINTENANCE ORGANIZATION (HMO)?

LIKE THE PPO, THE HMO REQUIRES YOU TO MAKE A CO-PAYMENT TO AN IN-NETWORK PHYSICIAN. HOWERVER, AN HMO WILL NOT PAY FOR SERVICES YOU RECEIVE OUTSIDE THE NETWORK. YOUR PRIMARY CARE PHYSICIAN ACTS AS THE GATEKEEPER TO YOUR HEALTH CARE. IN ORDER TO OBTAIN SPECIALTY CARE, YOU MUST ATTAIN A REFERRAL FROM YOUR PCP.

WHAT IS A PRIMARY CARE PROVIDER (PCP)?

A PHYSICIAN THAT IS REPONSIBLE FOR PROVIDING PRIMARY CARE, PRESCRIBING, AUTHORIZING AND COORDINATING ALL MEDICAL CARE AND TREATMENT.