Understanding Your Group Insurance Benefits

Need assistance understanding your Group Health Benefits Coverage? Every benefit plan can be different – so always refer to your Group Benefits Booklet for the details specific to your plan. Coverage under most plans is subject to certain rules, limits, and maximums which govern how much of your claim is eligible for reimbursement. Just remember, when you make a claim, all of the following items apply to each and every claim.

Reasonable & Customary

Refers to the maximum allowable amount that an insurer will reimburse for a particular service or item. It reflects the typical fees and/or costs associated with a particular service or product, in a specific geographical region. Your provider may choose to charge an amount which exceeds the reasonable and customary amount allowed by your insurer. In such a case any reimbursement for your eligible claim would be limited to the maximum reasonable and customary limit imposed by the insurer.

Deductibles

Refers to the amount of a covered expense that you pay before your insurance company makes any payments. The deductibles apply both to you and to any dependents covered under the plan. Examples might be $50 per person per year or $5 for each drug prescription.

Co-Insurance

An arrangement in a health or dental insurance plan where you and the insurance company share the cost of the items covered. You usually pay a set percentage, and the insurer pays the balance (e.g., 20% paid by you and 80% paid by the plan). Your plan might list a co-insurance value of 100% for some benefits – meaning the plan will pay 100% of the eligible claim after all other factors (e.g. reasonable & customary, deductibles, maximums) have been applied.

Maximums

Your plan may provide for specific dollar maximums for certain benefits. The amounts may be per visit, per calendar year (January 1st to December 31st) or a lifetime maximum. Plans often utilize more than one maximum applicable to a particular benefit. For example, chiropractic coverage might be listed as a maximum of $30 per visit up to $300 per year.

Referral required

Most plans do not require a doctor's referral for services rendered by a Chiropractor, Naturopath, Osteopath, Podiatrist, Chiropodist, clinical Psychologist, licensed Physiotherapist, Speech Therapist or Acupuncturist. However, some plans require a doctor's written referral for registered Massage Therapy to be sent in with the claim. If you are unsure of your group's requirements, you should review your Employee Benefits Booklet first for coverage and any claim requirements specific to your plan.

Pre-determination

For large expenses, such as major dental restorations, your plan may ask you to obtain a pre-determination or estimate of the benefits payable from the insurer before you receive treatment. The pre-determination of benefits will tell you how much the plan will pay and how much of the expense of a specific course of treatment you will be responsible for. It will allow you to budget for your share of the expenses, and to see if you can cover more of the cost by coordinating your benefits with those of your spouse/partner.

Check your Employee booklet carefully for the specific details of your coverage or contact RWAM directly.

Avoid surprises by calling us if you're unsure.
RWAM Insurance Administrators Inc. at 1-877-888-RWAM (7926) or 519-669-1632