

# **Florida Consumers' Notice of Rights Health Insurance**

## **Introduction**

The Office of the Insurance Consumer Advocate has created this guide to inform consumers of some of their rights under Florida law in order to help consumers get the health care services they have a right to under their insurance policy or HMO plan. The office would like to remind consumers that insurance plans and laws are constantly changing. Consumers should conduct an annual review of their policy or plan to be aware of any change in benefits or costs.

In preparing this document our office selected topics that generate most of the confusion among consumers. This is not an exhaustive list of rights. Consumers who have questions or disputes concerning the application of rights should contact the Division of Consumer Services within the Department of Financial Services on-line at <http://www.myfloridacfo.com/Consumers/> or by phone at 1-877-MY-FL-CFO (1-877-693-5236), toll-free in Florida, and (850) 413-3089 from out of state.

Consumers are encouraged, prior to purchasing health insurance coverage, to read the Consumer Guides published by the Division of Consumer Services. The guides are located on the website at: [http://www.myfloridacfo.com/Consumers/Guides/Health/docs/health\\_2008.pdf](http://www.myfloridacfo.com/Consumers/Guides/Health/docs/health_2008.pdf)

Upon purchasing health insurance, the coverage, rights and obligations are located in the policy or Certificate of Coverage. Failure to meet these obligations may affect the status of the policy. Consumers should read their policy; ask questions of their agent, employer, and contracted servicer. Consumers should keep their policy updated with any changes that are sent from the company, employer, and agent.

Our review of rights will also define some commonly used health insurance terms to facilitate better communication among consumers, doctors, and health insurance companies. These definitions begin on page 11.

## **Health Insurance Overview**

Health insurance is an important coverage that helps protect you and your family from the devastating financial effects of unexpected health problems or catastrophic illness.

Health coverage can be issued to individuals, to employees of an employer offering health coverage, or to individuals that are members of association groups. Some health coverage is provided by self insured funds that are not

regulated by the State of Florida. Although there are other forms of health insurance, the three main categories of health insurance are:

- Policies that offer comprehensive or “major medical” coverage;
- Policies that provide managed care services;
- Policies that provide limited benefits.

Most group health policies fall under the category of major medical policies. Major medical policies are more expensive because they provide more benefits than basic policies. A major medical policy pays a percentage of covered expenses (normally 80%), after you pay the deductible. Maximum out-of-pocket limitations restrict the amount of coinsurance you pay. Not all policies include such limits, but those that do pay 100 percent of remaining covered expenses after the insured pays a stated amount of coinsurance.

Most major medical policies contain annual and lifetime limits on the amount that the policy will pay. Under the new Federal health insurance reforms, the use of lifetime limits on the amount of coverage is prohibited in all health plans and insurance policies issued or renewed on or after September 23, 2010. Annual limits will be phased out over the next three years.

Managed care systems combine the delivery and financing of health care services. They limit the choice of doctors and hospitals. In return for this limited choice, you usually pay less for medical care (i.e., doctor visits, prescriptions, surgery and other covered benefits) than you would with traditional health insurance. The managed care network controls the use of health care services by its member.

The types of managed care are:

- **Preferred Provider Organizations (PPOs)** - PPOs offer a provider network to meet the health care needs of their insureds. A traditional insurance carrier provides the health benefits. An insurer contracts with a group of health care providers to control the cost of providing benefits to their insureds. These providers charge lower than usual fees in return for receiving prompt payment from the insurer and access to serve a greater number of patients. Insureds usually can still choose who will provide their health care, but pay less in coinsurance with a preferred provider than with a non-preferred provider.

- **Health Maintenance Organization (HMO)** - HMO members pay a monthly fixed dollar amount (similar to an insurance premium), which gives them access to a wide range of health care services. In many cases, members also pay a copayment for each doctor or emergency room visit and for prescription drugs. Members must use the HMO’s network of providers, which include the doctors, pharmacies and hospitals under contract with that particular HMO. Some HMOs offer a point of service rider that allows a participant to receive care

from a physician outside of the network. This option provides less coverage for health care expenses provided outside the network and will usually require pay of deductibles and coinsurance costs.

- **Exclusive Provider Organizations (EPOs)** - In an EPO arrangement, an insurance company contracts with hospitals or specific providers. Insured members must use the contracted hospitals or providers to receive benefits from these plans.

**Limited Benefit Plans.** Although there are others, the most popular policies that provide limited benefits are:

- Basic Hospital Expense;
- Basic Surgical Expense;
- Specified diseases such as cancer; and
- Hospital Indemnity plans

Limited benefit plans provide just what the name implies. They are insurance policies that cover only certain specified expenses or illnesses. They do not provide comprehensive coverage like major medical insurance policies or HMOs. Limited benefit plans do cost less than major medical insurance policies or HMOs because they provide much less coverage.

There are other types of health-related services that are NOT health insurance plans, including Medical Discount Plans, Prescription Discount Plans, Dental Discount Plans, and Vision Discount Plans. These are programs where a consumer pays a fee to join a plan in return for discounts on products and services from participating vendors and providers. Often, members who join these plans are issued a card similar to an insurance card identifying them as a member. However, these plans are NOT insurance.

## **Consumer Rights**

### **Patient's Bill of Rights**

Florida law contains rights granted to patients under Section 381.026, Florida Statutes. These include the right to:

- ✓ Be treated courteously, with respect and dignity by your providers,
- ✓ Have candid discussions about all treatment options regardless of cost and benefit coverage; and
- ✓ Refuse treatment provided the consumer is willing to accept the responsibility and consequences of that decision.

## Evidence of Coverage

Consumers have the right to receive a copy of an Outline of Coverage and a copy of the policy when purchasing an individual insurance policy covering themselves and dependents. You can call the plan's customer service department at any point during your coverage and ask for a written copy of your certificate of coverage. This should be provided free of charge.

This document explains the health benefits you and your dependents have under the plan. It details the services that will and will not be covered. Services that are not covered are called *exclusions*. The actions you have to take to receive the health benefits—such as paying a copayment, meeting a deductible, or using particular health care providers—are called *conditions*.

The outline explains:

- ✓ when you will be required to make copayments and pay deductibles and how much you will have to pay;
- ✓ when you will need to obtain a referral from one provider to another; and
- ✓ when you will need to call the insurance company to obtain approval before you receive a service.

These limitations and exclusions are important to review because these are items or conditions that the carrier will NOT cover. Coverage may change each time the policy is renewed. You are entitled to receive notice of the updates and changes. One area of particular concern is for pharmaceutical coverage (formulary) as the particular drugs that are or are not covered may change during the year and should be verified often.

The certificate also details the process for appealing decisions made by the plan. It is important to keep the certificate available, because it should be the first place you look when you have a question about coverage. It includes the phone numbers to call if you have any questions, including the number for the insurance customer representative.

For group insurance plans, the insurer must furnish to the policyholder, for delivery to each employee or member of the insured group, a Certificate of Coverage containing the group number and setting forth the essential features of the coverage for the employee or member and those to whom benefits are payable. If dependents are included in the coverage, only one certificate needs to be issued for each family.

Each member of a plan must also receive an identification card that contains, at a minimum:

- ✓ The name of the organization issuing the policy or name of the organization administering the policy, whichever applies.
- ✓ The name of the certificateholder.
- ✓ The member identification number, contract number, and policy or group number, if applicable.
- ✓ A contact phone number or electronic address for authorizations and admission certifications.
- ✓ A phone number or electronic address whereby the covered person or hospital, physician, or other person rendering services covered by the policy may obtain benefits verification and information in order to estimate patient financial responsibility, in compliance with privacy rules under the Health Insurance Portability and Accountability Act.

Reference: Individual policies, Section 627.642, Florida Statutes; Group policies, Section 627.657, Florida Statutes.

HMO subscribers must be given a copy of the applicable health maintenance contract, certificate, or member handbook specifying all the provisions, disclosures, and limitations, the covered services and where and in what manner services may be obtained. The HMO contract, certificate or member's handbook must be delivered to the subscriber within ten working days after approval of the enrollment by the HMO.

Reference: Section [641.3107](#), Florida Statutes.

### **Preferred Providers and HMO Providers**

Consumers have the right to receive or have access to a current list of contracted physicians, facilities and hospitals in a PPO, EPO or HMO.

This list will assist you in selecting care from a medical provider that has entered into a payment agreement with the insurance issuing entity. This will ensure that whether you are covered under a health maintenance organization (HMO) or a preferred provider organization (PPO) or an exclusive provider organization (EPO), the consumer has the ability to easily identify preferred providers in order to avoid paying the extra costs involved with being treated by non-network providers.

This list may change during the contract year and should be checked each time prior to using a service (going to a physician, going for a medical test, or being admitted to a hospital).

People who are insured under a policy that utilizes a PPO also have the right to:

- ✓ Expect that the contracted or participating providers in a PPO have had their credentials verified by the health plan.

- ✓ Expect to be treated courteously, with respect and dignity by the plan's participating providers.
- ✓ Expect to have candid discussions about all treatment options regardless of cost and benefit coverage and participate in the decision making process of their health care.
- ✓ Refuse treatment provided the consumer is willing to accept the responsibility and consequences of that decision.

References: Small Group Health: [627.6471](#), Florida Statutes; Large Group Health: [627.6471](#), Florida Statutes; Individual Health: [627.6471](#), Florida Statutes.

### **Balance Billing**

Neither a contracted or nor a non-contracted Florida licensed medical provider or facility can balance bill a subscriber or bill a subscriber if the HMO fails to pay a claim for a covered service. Florida Law prohibits providers from billing HMO members for covered services except for applicable co-payments, co-insurance or deductibles. A medical provider or facility may bill the subscriber for services received that are not covered by the HMO contract.

Reference: Section [641.3154](#), Florida Statutes.

However, the same is not necessarily true for health insurance policies that provide services through a PPO. While PPO contracts with an insurer generally prohibit providers from billing insureds any amount in addition to what the provider has agreed to accept from the insurer, there are no statutory provisions to prevent balance billing. Additionally, if a consumer uses non-network medical provider, these providers will general balance billing them for charges in excess of what the plan determines it will pay for services or procedures. The only protection for PPO members is to use network providers.

A major risk of being billed for the balance of an out-of-network provider's fee occurs when a PPO plan member goes to an in-network provider hospital, especially under emergency circumstances, and is treated by a subcontractor of the hospital such as a Radiologist, Anesthesiologist, Pathologist or ER physician. In most cases, these specialists are not participants in the PPO network. Therefore, the patient may be balance billed for the amount that exceeds how much the insurance company customarily pays for the services rendered. The remaining amount that is not covered may be significant. If at all possible, patients with coverage through a health plan that uses a PPO should discuss this issue with the hospital prior to treatment.

## **Utilization Review**

Consumers have the right to request the criteria or medical guidelines that the health care plan uses to determine if a test, procedure, treatment, provider, drug or referral to a specialist is “medically necessary” and will thereby be covered by the carrier.

Even when these things are generally covered under the contract, most health care plan contracts still provide that coverage can be denied if the plan determines that particular treatment is not medically necessary for the patient’s condition. The plan contract will define medical necessity and definitions vary among plans. The simple fact that a physician has determined that a service is medically necessary does not mean that the health plan will automatically cover that service.

If a service is denied authorization based on “lack of medical necessity,” ask the carrier for a copy of the guidelines used to make this determination and speak with your physician about the details of your medical situation, these guidelines, and possible options or alternatives.

## **Appealing a Denial of Coverage**

Consumers have the right to appeal the denial of coverage for a service. Each policy will set forth an appeals process for requesting that the carrier reexamine the denial. Usually the appeal must be requested in writing. Consumers should review the policy or certificate of coverage and contact the member service line for more information.

As an HMO or EPO member you have additional appeal rights by Florida law beyond that of the carrier’s appeal procedures. Once you complete the carrier’s appeal process, you may file an appeal through the Statewide Subscriber Assistance Panel, described in Section 408.7056, Florida Statutes, which is administered through the Agency for Health Care Administration and the Department of Financial Services. The information is available on line at: <http://ahca.myflorida.com/MCHQ/Consumer/SPSAP/index.shtml>.

In addition, HMO and EPO participants may then appeal the decision of the Subscriber Assistance Program to the Florida Office of Insurance Regulation.

Under the new federal health care program, all new health plans issued after September 23, 2010, are required to have an external appeals process monitored by the state.

## **Preexisting Conditions**

Consumers have the right to coverage for the treatment of pre-existing medical conditions but only after a waiting period. Insurance policies will often exclude coverage for treatment of diseases or conditions which existed prior to purchase of an insurance policy. However, Florida law limits the length of time that the exclusion can be in effect. The exclusion periods, if any, are different depending on the type coverage purchased. Individual and one man group plans have 24 month limitations. Small and large group plans generally have 12 month waiting periods before they will cover treatment for preexisting conditions. There can be differences for late entrants into group plans. The specifics are in the Certificate of Coverage.

References: HMO (Individual and Group): [641.31071\(8\)](#), Florida Statutes; Small Group Health: [627.6699\(5\)\(f\)](#), Florida Statutes; Large Group Health: [627.6561\(8\)\(9\)\(10\)\(11\)](#), Florida Statutes; Individual Health: [627.64871](#), Florida Statutes.

Under certain circumstances, a plan may not have preexisting condition limitations. Under Federal health care reform, new plans issued after September 23, 2010, cannot deny coverage or apply preexisting condition limitations to insureds 19 years of age and below. Eventually, under Federal health care reform, health plans will no longer be able to deny coverage, limit coverage or exclude coverage based on a person's preexisting conditions.

## **Certificate of Creditable Coverage**

Consumers have the right to receive a "certificate of creditable coverage" when coverage with a health care plan is terminated for any reason.

This certificate of creditable coverage is important because it allows you to obtain new coverage without having to again go through a waiting period for coverage of preexisting conditions as long as you obtain new coverage with 63 days of termination of the prior plan. However, not all health policies will satisfy the requirement for creditable coverage.

If a person has met the waiting period for coverage of preexisting conditions but then loses coverage or terminates coverage, a consumer will not have to satisfy another preexisting condition exclusion period if new coverage is obtained with no more than a 63 day break in coverage and the consumer has a certificate of creditable coverage.

References: HMO (individual and group) [641.31071\(5\)](#), Florida Statutes; Small Group Health: [627.6561](#) Florida Statutes; Individual Health: [627.6045](#), Florida Statutes; Large Group Health: [627.6561](#), Florida Statutes.

## Obtaining New Coverage after Termination of Prior Coverage

Consumers have a number of options to extend existing group health plan coverage when the consumer is no longer a member of the group. The typical situation involves employees who lose or terminate their job and are no longer eligible for coverage under the employer's group health insurance policy. If you were covered under a group policy, you may have access to coverage through a federal law known as "COBRA," through a Florida law known as "mini-COBRA" and, after expiration of coverage extensions under these laws, then through either a HIPAA guarantee issue policy or a conversion policy under Florida law.

COBRA applies to employees who work for employers with 20 or more employees (commonly known as a large group). The carrier or its administrator must provide you notice of your right to choose to continue benefits provided by the group upon being terminated from an employer's group for any reason. You will have **60 days** to accept this coverage or lose all rights to the benefits. If you elect COBRA coverage, you pay the entire cost of the health insurance premium plus a 2 percent processing fee. COBRA coverage lasts from a minimum of 18 months to a maximum of 36 months, depending upon your individual situation.

To obtain a free publication that explains COBRA in more detail, call the Employee Benefits Security Administration at **1-866-444-3272**.

If you are covered under an employer group with fewer than 20 employees (commonly known as a small group), Florida law provides access to continued coverage under the mini-COBRA law found in section 627.6692, Florida Statutes. The primary difference between COBRA and mini-COBRA is that to obtain information about your right to mini-COBRA benefits, **YOU** must notify the health carrier of your termination and request the necessary forms to continue coverage. **YOU** must do this **within 63 days** of losing group eligibility to continue coverage.

Cobra and mini-COBRA rights also extend to dependents who lose coverage because of divorce or legal separation; death of the covered employee; the covered employee qualifying for Medicare; or a loss of dependent status under the health plan's provisions.

After you exhaust COBRA coverage, you may have access to a conversion policy. It is important to understand that this policy may NOT have the same benefit structure as your prior coverage and the premium will also be different. You should request information regarding the benefits and premium from your carrier. REMEMBER that strict time lines exist for taking advantage of this option.

Additional information about conversion policies for persons previously covered in a group plan may be found at section 627.6675, Florida Statutes. section 627.646, Florida Statutes, for individuals.

If for some reason you do not have access to a conversion policy upon exhaustion of a COBRA extension, you may be eligible for a guaranteed issue health plan under HIPAA. To obtain information about HIPAA policies, see <http://www.dol.gov/ebsa/publications/yhphipaa.html>.

If you were covered under an individual policy, you may have access to either a HIPAA guarantee issue policy or a conversion policy. Additional information about conversion policies for persons previously covered by an individual plan may be found at section 627.646, Florida Statutes.

However, if you do not, then you may be eligible for a guaranteed issue health plan under HIPAA. To obtain information about HIPAA policies, see <http://www.dol.gov/ebsa/publications/yhphipaa.html>.

### **Help in Understanding and Dealing with Health Care Coverage**

Consumers have the right to contact and consult with knowledgeable state employees at the Department of Financial Services, Division of Consumer Services Division, for assistance at any time. The toll-free number in Florida is **1-877-MY-FL-CFO (1-877-693-5236)**. The toll-free number from outside of the state is (850) 413-3089. You may also request assistance online at <http://www.myfloridacfo.com/Consumers/>.

### **Responsibilities of Consumers**

Each person covered under a health insurance policy or HMO contract has the responsibility to:

- ✓ Be courteous and respect the rights, needs and privacy of other patients, office staff and providers.
- ✓ Supply accurate, honest and complete information (to the extent possible) to the plan and providers.
- ✓ Follow the providers agreed upon instructions for care.
- ✓ Pay copayments, deductibles, coinsurance as provided in the COC.
- ✓ Follow the plans established procedures for changing providers, requesting referrals, or prior authorizations, or for filing a grievance.
- ✓ Read, review and understand the plans benefit structure, coverages, limitations and exclusions – including changes that may occur.
- ✓ Follow the plans requirements for referrals and prior authorizations.

## Conclusion

Consumers should review the benefits of their health plans. This should be done annually, paying specific attention to possible changes to the plan benefits, restrictions or requirements. If there are questions as to how to access a benefit, contact the health plan first. It is a good idea to read and review the instructions (or call the plan) prior to incurring a service to be assured that the service will be covered. Know the language of the plan (definitions). Know the appeal rights.

### Health Care and Health Insurance Definitions

**Annual limit** – a maximum dollar limit on the amount the plan will pay over the course of a plan year. The new federal health care legislation prohibits lifetime limits for *essential benefits* for plan years beginning after Sept. 23, 2010 and phrases out annual limits over the next three years.

**Balance Billing** – the practice of out-of-network providers billing consumers for the amount of their charges that exceed the amount an insurer pays for the services.

**Certificateholder** – the consumer covered under a group insurance policy or HMO contract that covers a group.

**Certificate of Coverage (COC)** – a document issued by the insurance company or HMO to the consumer that outlines the benefits, exclusions, limitations and coverage for a specific health care plan.

**Certificate of Creditable Coverage** – a document, provided by the previous insurer, indicating the beginning and ending dates of creditable coverage a person has accrued.

**COBRA** – the federal **C**onsolidated **O**mnibus **B**udget **R**econciliation **A**ct (COBRA) allows employees, or those who lose coverage due to termination of a job or reduced work hours, to continue group coverage for a limited period of time.

**Mini-COBRA** – Florida's mini-COBRA law extends similar continuation of coverage protection for employees who work for employers with fewer than 20 employees.

**Co-insurance** – an amount of liability that the insurance company or HMO shares with the consumer of the covered services. Usually the insurance pays or shares the higher percentage such as 80 percent; the consumer pays or shares the balance or 20 percent of the covered charges.

**Conversion Policy** – the opportunity to obtain a health insurance policy without evidence of insurability after a person who was covered under a Florida-regulated individual health insurance policy is no longer eligible for the plan and has exhausted continuation of coverage pursuant to COBRA. Conversion policies must offer the same benefits as the group policy but may offer higher deductibles as a cost savings to the consumer.

**Copayment** – a fixed amount that the consumer pays for a stated service such as a physician visit, diagnostic test or drug purchase.

**Creditable Coverage** – the period of time a consumer has spent under a prior health plan. This time period is used to determine what conditions are exempt from the pre-existing condition clauses in a new policy. This time period is also used to determine if a consumer qualifies for a guaranteed issue policy under the Health Insurance Portability and Accountability Act (HIPAA).

**Deductible** – a stated dollar amount that the consumer must pay before insurance benefits are paid. There may be individual deductibles and family deductibles. Family deductibles can be applied per person, or for the entire family. Deductibles are set forth in the policy, COC or the Summary of Benefits. Deductibles can apply to different providers and facilities.

**Health benefit plan**- any hospital or medical insurance policy or certificate, hospital or medical service plan contract, or health maintenance organization subscriber contract. The term does not include accident-only, specified disease, individual hospital indemnity, credit, dental-only, vision-only, Medicare supplement, long-term care, or disability income insurance.

**Group Health Plan** – a group health plan covers groups of persons under a policy issued to employee groups, labor unions, associations, debtor groups and teacher and student groups.

**Health Insurance Portability and Accountability Act (HIPAA)** – a federal law that provides protection for patient medical records; limits the ability of a new employer plan to exclude coverage for preexisting conditions; provides additional opportunities to enroll in a group health plan if you lose other coverage or experience certain life events; prohibits discrimination against employees and their dependent family members based on any health factors they may have, including prior medical conditions, previous claims experience, and genetic information; and guarantees that certain individuals will have access to, and can renew, individual health insurance policies.

**Health Maintenance Organization (HMO)** – a managed care plan that provides health care services to their members through networks of doctors, hospitals, and other health care providers.

**Insured** – the person or persons covered under the insurance policy.

**Medical Necessity** – a health care service or product that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease or its symptoms in a manner that is: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site and duration; and (c) not primarily for the convenience of the patient, physician, or other health care provider.

**Network** – a group of providers who have agreed to discount their fees for treatment of patients covered by a particular insurance company or HMO/EPO.

**In-Network Provider** – a health care provider (such as a hospital or doctor) that is contracted to be part of the network for a managed care organization (such as an *HMO* or *PPO*).

**Out of Network Provider** – a health care provider (such as a hospital or doctor) that is not contracted to be part of a managed care organization's network (such as an *HMO* or *PPO*).

**Open Enrollment Period** – a specified period during which individuals may enroll in a health insurance plan each year. In certain situations, such as if one has had a birth, death or divorce in their family, individuals may be allowed to enroll in a plan outside of the open enrollment period. Plans may apply special open enrollment periods to insureds 19 and under to prevent adverse selection on new plans issued after September 23, 2010.

**Patient Protection and Affordable Care Act (PPACA)** – This is the title of the federal health care reform law that became effective on March 23, 2010. Note: The Insurance Consumer Advocate's website contains articles that explain various provisions of the act that are currently in effect. Other provisions will be phased in over the course of the next few years.

**Pre-existing condition**– a condition that manifested itself in such a manner that would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care, or treatment has been recommended or received; or a pregnancy existing on the effective date of coverage.

**Preventive Benefits** – covered services that are intended to prevent disease or to identify disease while it is more easily treatable. The federal health care reform legislation requires insurers to provide coverage for preventive benefits without *deductibles, co-payments* or *coinsurance*.

**Primary Care Physician (PCP) or Gatekeeper** – the physician to which consumers are assigned who is primarily responsible for the consumer's health

care. Consumers who desire to see a specialist must obtain a referral from their PCP.

**Small Group Market** – the market for health insurance coverage offered to small businesses – those with between 2 and 50 employees in most states. PPACA will broaden the market to those with between 1 and 100 employees.

**Stop Loss** – a feature that limits consumer’s out-of-pocket expenses. For example; once the consumer has paid a specified amount for deductible, copayment and coinsurance costs - usually \$2,000 to \$10,000 - the company pays 100 percent of covered expenses after that point. Consumer stop-loss amounts vary by policy and are contained in either the COC or the policy.

**Subscriber** – an individual who has contracted, or on whose behalf a contract has been entered into, with a health maintenance organization for health care coverage and the individual’s dependants who are covered under the contract.

**Summary of Benefits** – the document that provides an overview of the benefits provided and the insureds’ responsibilities under a health care plan, including deductibles, copayment and coinsurance schedules, limitations on coverage and coverage exclusions.

**Usual, Customary & Reasonable Fee** – the amount an insurance company determines is the appropriate fee to pay out-of-network providers for specific medical services. It represents an average amount that local medical providers charge for specific services.