Basic Insurance FAQ

Question	Answer
What is a health insurance policy	Your health insurance policy is a contract between you and your health insurance company. It is an agreement that your health insurance company will pay for covered medical care as long as your premium is paid. The health insurance company may not pay for every bill. This is why it is important for you to know which medical treatments the health insurance company will pay for and which expenses it will not cover. You are responsible for paying any medical costs that the health insurance company does not pay for.
What is a Co-payment/co-pay?	The part of your medical bill you must pay each time you visit the doctor. This is a pre-set fee determined by your health insurance policy.
What is Co-insurance?	The part of your bill, in addition to a co-pay, that you must pay. Co-insurance is usually a percentage of the total medical bill – for example, 20%.
What is deductible?	The amount of money you must pay before your health insurance company starts to pay – for example $500 per individual or $1,500 per family. In most cases, a new deductible must be satisfied each calendar year.
What are non-covered (excluded) services?	Cost for treatment that your health insurance company does not pay. You may wish to determine if your treatment is covered by your health insurance policy before your appointment.
What is an HSA account?	A health **SAVINGS** account, which allows you to set aside pre-taxed money (normally from your paycheck), until you need it, even if you don't need it until many years later.
What is an FSA account?	A flex **SPENDING** account, allows you to set aside pre-taxed money (normally from your paycheck), which you plan to use during the year for qualified expenses. This money normally has to be used within the plan year or you lose it.
How is my doctor's office paid?	You should pay your co-payment and deductible, if required, during your visit to the doctor. While you are responsible for your medical treatment, your doctor's office will make every effort to seek payment from your health insurance company for the amount owed under your policy. The process by which the office seeks payment is very complicated, which is why the doctor's office needs correct information from you.
What is coordination of benefits?	Many health insurance companies require you to fill out a form that tells the company whether you or a family member have other health insurance. Your health insurance company needs this information to work with other insurers to determine which company pays for what services. It is important that you fill out this form and return it to the health insurance company or call them directly to give them this information. Otherwise, your medical bills may not get paid or payment may be delayed.
What is an EOB?	**Explanation of benefits** is the documents which indicates how health care services were paid by your health insurance company and the reasoning if no payment or only partial payments were made. It will also indicate the amount which is patient responsible. This documents is normally mailed to your home or available online with your health insurance company.

What is an allowed amount?	It is the maximum amount which payment from your insurance company will pay for covered health care services.
What is out-of-pocket limit?	The most you pay during a policy period (Usually a year) before your health insurance or plan begins to pay 100% of the allowed amount.
What if the health insurance company does not pay or pays only a portion of my medical bill?	The doctor's office will inform you as to why the claim is not covered. It may be necessary to contact the insurance company to resolve any disputes.
What are some reasons a health insurance company may not pay for medical treatment?	The treatment may not be a covered service under your plan; Your health insurance company may require a coordination of benefits form to be completed (see coordination of benefits); The health insurance premium has not been paid by either you or your employer; A spouse, child and/or newborn is not covered under your policy, since he/she was not added during the appropriate time frame; The doctor was "out of network"; Any other health insurance policy requirement, such as prior authorization, was not obtained.
What steps should be followed if I am expecting a baby?	Make sure you contact the health insurance company and ask them how to enroll the newborn prior to birth. Once the baby is born, it is imperative that the newborn be added to the policy within the first 30 days.