Insurance FAQ's

Many patients have questions regarding their insurance coverage. The recent changes to healthcare laws have added even more insurance options. There are many different plans available, so even two Blue Cross Blue Shield plans might be different, and we are unable to know every patient's specific plan.

The new healthcare bill requires coverage of certain things, but will only apply to NEW plans. If your plan was in service prior to the new laws, these new coverage requirements may not apply.

Most insurance companies today share the cost with the patient. There are many cost sharing options:

Deductible: The total amount of covered medical expenses that must be paid by the patient before the insurance company begins paying benefits. After this requirement is reached the insurance company will begin paying according to the terms of the contract (70%,80%or 100%) of covered medical costs. The patient is responsible for any remaining balance. Usually a new deductible is met each calendar year.

Copayment: The patient pays a share of the covered medical costs for certain office visits as determined by your insurance company. This is required when checking in for the visit.

Co-insurance: The patient pays a percentage share of covered medical costs and the insurance company pays an amount based on the patient's policy.

Understand the fine print of your plan:

Your health insurance policy is an agreement between you and your insurance company. It is generally negotiated by your employer if it is an employee benefit. Or, it may be one of the tiers of insurance offered by the health exchange. The policy lists a package of medical benefits such as tests, medications and treatment services. The insurance company agrees to cover the cost of certain benefits listed in your policy. These are called "covered services". Coverage does not guarantee full payment and your insurance company may require partial coverage by the patient. Your policy also lists the kinds of services not covered by your insurance company. You are responsible to pay any uncovered medical care that you receive.

Be aware that a medical necessity is not the same as a medical benefit. A medical necessity is something that your provider has decided is necessary based on clinical presentation and standard of care. A medical benefit is something that your insurance plan has agreed to cover. In some cases, your provider might decide that you need medical care that is not covered by your insurance policy.

Since we are unable to know the specifics of every insurance plan, we hope patients understand their own coverage. Take time to read your insurance policy. It's better to know what your insurance company will pay for before you receive a service. If you still have questions about your coverage, call your insurance company and ask a representative to explain it.

What if something isn't covered by my plan?

Most of the things your provider recommends will be covered by your plan, but some may not. You can still obtain the treatment that is recommended, but you will have to pay for it yourself. Sometimes an insurance company denies a claim. If your company denies a claim you have a right to appeal (challenge) this decision. This process will be discussed in your plan handbook.

Why does the front desk always ask for my card?

Bring your insurance card with you to each visit. Although you may have the same plan as last year, the copay might be different. Sometimes the insurance billing address has changed. We cannot file your claim properly without the correct information.

What if I have a question about a bill?

If you do not understand a bill or Explanation of benefits (EOB), please call your benefits administrator, the customer service number on the back of your card, or our billing department.

Key Terms

Billing Statement: A summary of current activity on your account

Claim: Information billed to the insurance company for services provided.

EOB (Explanation of Benefits): A detailed explanation from the insurance company that identifies the amount due for services provided. This includes any payments made by the insurance company and any co-payment, coinsurance or deductible due from the policy holder.

Guarantor: The person responsible for paying the bill.

Payment Arrangements: A formal payment plan set up between a patient and our office when payment cannot be made in full.

Prior Authorization/Pre-Certification: A formal approval obtained from the insurance company prior to the delivery of medical services. Many insurance companies require prior authorization for specific medical services, procedures, or medications. This does not guarantee payment by the insurance company.

Subscriber: The person who holds and/or is responsible for the medical insurance policy.