

Frequently Asked Questions

Q: I am losing my insurance coverage, am I eligible for cobra?

A: You are eligible for COBRA only if your company employs 20 or more people 50% of the year. You have 60 days from the time your coverage terminates and/or you receive your COBRA notice to choose COBRA. You may also have State continuation coverage available to you. Read your Summary Plan Description or Health Insurance Policy for details. If you should need short term medical coverage (for up to six months), or an individual insurance policy, contact our office to see if you qualify.

Q: I want to drop my insurance and be added to my spouse's policy. Is this allowed?

A: There must be a qualifying event in order to be eligible for coverage outside of the open enrollment period. Check with your human resource department or your carrier for your specific open enrollment period. A few examples of qualifying events are birth, adoption, marriage, and loss of job. There is generally always a specific time period that you must apply for coverage if you or one of your family members has a qualifying event.

Q: Can the company raise my health insurance premium even if I didn't have a claim?

A: Yes, so health insurance plans allow the carrier to renew at a month other than your traditional renewal date as long as the increase is across the board – that is, as long as the company raises the rates for everyone in the same health insurance pool (Risk group) that you are in.

Q: What is medical underwriting?

A: Underwriting is an insurance company's process for deciding how [risky] much premium it will [be] need to insure you. The company is trying to predict the likelihood that you will become sick or injured and file claims against the policy. Each company has its own underwriting standards, insurance companies expect a predictable number of claims based on your gender, age, height, weight, residence, they will add to these factors your known health risks.

Q: What is a preferred drug list (also called a formulary)?

A: A preferred drug list, or formulary, is a list of prescription medications generally covered under your pharmacy benefit plans, subject to applicable limits and conditions. Your formulary includes brand name and generic drugs that have been approved by the FDA as safe and effective. Most drugs listed on the preferred drug list are subject to manufacturer volume discount arrangements under which your carrier receives financial consideration. Some medications on your formulary, for instance oral contraceptives, may not be covered unless optional coverage is purchased or unless required by law. Please refer to your plan documents for details. Formularies are subject to change, and generally do change annually.

Q. What are the differences between brand name and generic drugs?

A. The Food and Drug Administration (FDA) has deemed that generic drugs are therapeutically equivalent to brand name drugs. Generic drugs must contain the same active ingredients in the same amounts as their brand-name counterparts. Additionally, the same rigorous FDA quality and safety reviews apply to generic drugs and brand-name drugs. Furthermore, generic drugs may help lower your health care expenses. Under some prescription drug benefit plans, members pay a lower co-payment if they choose generic drugs over brand-name medications. Always remember to ask your Physician if a generic might be a good option for you.

Q: What portion of my health insurance premium goes into my Health Savings Account (HSA)?

A: In a HSA, a qualified High Deductible Health Plan (HDHP) is paired with a savings account, which is available to cover qualified medical expenses not covered by the insurance policy. The premium paid is strictly for the plan component. Any funding would be from additional dollars either by the employer or employee, or in combination of both.

Q: I need to make a change with the company health insurance plan. The premium increases have been double digit for the past two years and I just can't afford to provide this comprehensive coverage anymore at this cost. I've heard of Health Savings Accounts, but don't want my employees burdened with the structure of a qualified high deductible plan. I'm not in a position to fund the accounts either. Are there any other consumer driven concepts I could consider?

A: Yes! A Health Reimbursement Arrangement (HRA) might be something to consider! A HRA is a redefined Section 105 plan, which have been available for years. HRAs can be implemented with any plan. Any premium savings are employer owned and you design the funding structure, to meet your needs. Another significant difference between the HSA and HRA are copays. HRAs allow copays for office visits, emergency room, and prescriptions, so exposure to the plan deductible and/or coinsurance is offset substantially!

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