Frequently Asked Questions

Health Insurance

Why do you need health insurance?

Today, health care costs are high and getting higher. Who will pay your bills if you have a serious accident or a major illness? You buy health insurance for the same reason you buy other kinds of insurance, to protect yourself financially.

Where do people get health insurance coverage?

Most Americans get health insurance through their jobs or are covered because a family member has insurance at work. This is called group insurance. Group insurance is generally the least expensive kind. In many cases, the employer pays part or all of the cost.

If your employer does not offer group insurance, or if the insurance offered is very limited, you can buy an individual policy. Individual plans may not offer benefits as broad as those in group plans.

What are your choices?

There are many different types of health insurance. Each has pros and cons. There is no "best" plan. Choosing a health insurance plan is like making any other major purchase: you choose the plan that meets both your needs and your budget. Cost isn't the only thing to consider when buying health insurance. You also need to consider what benefits are covered. You need to compare plans carefully for both cost and coverage.

Although there are many names for health insurance plans, the information here groups them as three main types:

- Fee-for-Service (or Traditional Health Insurance)
- Health Maintenance Organizations (or HMOs)
- Preferred Provider Organizations (or PPOs)

Fee-For-Service

This is a traditional kind of health care policy. Insurance companies pay fees for the services provided to the insured people covered by the policy. This type of health insurance offers the most choices of doctors and hospitals. You can choose any doctor you wish and change doctors at any time. You can go to any hospital in any part of the country.

With fee-for-service, the insurer only pays for part of your doctor and hospital bills. This is what you pay:

- A monthly fee, called a premium
- A certain amount of money each year, known as the deductible, before the insurance payments begin
- After you have paid your deductible amount for the year, you share the bill with the insurance company. Your portion is called coinsurance

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Health Maintenance Organizations (HMO)

Health maintenance organizations are prepaid health plans. As an HMO member, you pay a monthly premium. In exchange, the HMO provides comprehensive care for you and your family including doctors' visits, hospital stays, emergency care, surgery, lab tests, x-rays, and therapy.

The HMO arranges for this care either directly in its own group practice and/or through doctors and other health care professionals under contract. Usually, your choices of doctors and hospitals are limited to those that have agreements with the HMO to provide care.

Preferred Provider Organizations (PPO)

The preferred provider organization is a combination of traditional fee-for-service and an HMO. Like an HMO, there are a limited number of doctors and hospitals to choose from. When you use these providers (sometimes called "network" providers), most of your medical bills are covered.

Understanding Health Insurance Terms

Coinsurance: the amount you are required to pay for medical care in a fee-for-service plan after you have met your deductible. The coinsurance rate is usually expressed as a percentage.

Coordination of Benefits: a system to eliminate duplication of benefits when you are covered under more than one group plan. Benefits under the two plans usually are limited to no more than 100 percent of the claim.

Copayment: another way of sharing medical costs. You pay a flat fee every time you receive a medical service. The insurance company pays the rest.

Covered Expenses: most insurance plans, whether they are fee-for-service, HMOs, or PPOs, do not pay for all services. Covered services are those medical procedures the insurer agrees to pay for.

Deductible: the amount of money you must pay each year to cover your medical care expenses before your insurance policy starts paying.

Exclusions: specific conditions or circumstances for which the policy will not provide benefits.

Managed Care: ways to manage costs, use, and quality of the health care system.

Maximum Out-of-Pocket: the most money you will be required to pay in a year for deductibles and coinsurance. It is a stated dollar amount set by the insurance company, in addition to regular premiums

Preexisting Condition: a health problem that existed before the date your insurance became effective.

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Premium: the amount you or your employer pays in exchange for insurance coverage

Primary Care Doctor: usually your first contact for health care. This is often a family physician or internist. A primary care doctor monitors your health and diagnoses and treats minor health problems, and refers you to specialists if another level of care is needed.

Provider: any person (doctor, nurse, dentist) or institution (hospital or clinic) that provides medical care

Third-Party Payer: any payer for health care services other than you.