

# Health Insurance Basics

## What is the Role of Health Insurance?

Health insurance protects you from the high cost of medical care by providing coverage for specific health care services. Although you generally pay a monthly [premium](#) and either [co-payments](#) or [co-insurance](#), the cost for insurance is far less than medical care would be if paid fully [out-of-pocket](#).

## What are the different types of Health Insurance policies?

There are three umbrella types of health insurance - [consumer-directed](#), [fee for service](#) (often known as "traditional" or "indemnity" plans) and [managed care](#). These types of plans cover medical, surgical and hospital expenses and depending on the plan, may cover [prescription drugs](#), dental and behavioral/mental health coverage.

**Fee for service plans** mean the doctor or other health care professional will be paid a fee for each health care service provided to the patient. Patients can see the doctor of their choice and the claim is filed by either the health care professional or the patient.

**Managed care plans** provide coverage for comprehensive health services to their members and offer financial incentives in the form of lower out-of-pocket costs to patients who use doctors participating in a [network](#). More than half of all Americans have some kind of managed care plan - the three types include [health maintenance organizations](#) (HMOs), [preferred provider organizations](#) (PPOs) and [point-of-service](#) (POS) plans.

## What is an HMO?

An [HMO](#) is a type of managed care health insurance plan that allows you to receive care through a network of participating doctors and hospitals. Generally, you select a [primary care physician](#) who coordinates your care and refers you to [specialists](#) when needed. Out-of-network care is generally not covered under an HMO plan, unless the member requires care that is not available in the existing network.

## What is a PPO?

A [PPO](#) is a type of managed care health insurance plan that combines features of a fee-for-service plan and an HMO. In a PPO, members who seek care within the network of participating doctors and hospitals pay lower out-of-pocket costs. Members can also seek care from nonparticipating doctors and hospitals, but pay a higher portion of the cost of care.

## What is a consumer-directed Health Insurance plan?

Also referred to as "consumer-driven," or "consumer choice," this type of health plan gives members more choice and flexibility in making health [benefits](#) decisions and more control over their health benefits dollars. These plans often include a health fund or account for covered medical expenses. Depending on the type of fund or account, unused dollars may be rolled over annually to cover medical expenses in subsequent years for the duration of the members' enrollment in the plan. There are several types of consumer-directed plans, including [Health Savings Accounts](#) (HSAs), [Health Reimbursement Arrangements](#) (HRAs) and [Flexible Spending Accounts](#) (FSAs).

## **Tell me more about HSA's.....**

An HSA is a tax-advantaged savings account that allows individuals to pay current health care costs or save for anticipated future expenses. To be eligible, an individual must be covered by a high-deductible health plan and not be eligible for coverage under any other health plan. Contributions to the HSA can be made by the employer, the employee or both. Contributions are tax deductible and earn interest tax free. The accounts are portable, meaning you can take them with you when you leave your employer. And balances accumulate from year to year. HSA funds can be used to pay for qualified medical expenses or withdrawn in cash, although cash withdrawals become taxable and may be subject to an additional withdrawal penalty.

### **What is a Health Insurance premium?**

A premium is the fee you and/or your employer pay to your insurance company to purchase a health insurance plan. This can be paid on a monthly, quarterly or annual basis.

### **How does a Health Insurance deductible work?**

A deductible is the amount that you must pay for [covered services](#) in a specified time period in accordance with your plan before the plan will pay benefits. A member of a high-deductible health plan, for example, might be required to pay for the first \$1,000 of medical care prior to receiving coverage under the terms of his/her benefits plan.

### **What is a co-payment?**

A co-payment is the specified dollar amount or percentage required to be paid by you or on your behalf in connection with benefits. For example, most HMO plans have co-payments in place for certain services such as doctor's visits, prescription drugs, hospital stays, etc.

### **What are out-of-pocket costs?**

Out-of-pocket costs include premiums, [co-payments](#), deductibles, [co-insurance](#) or other fees that you are required to pay outside of your health benefits plan.

### **How do I pick a Health Insurance plan?**

If you have a choice of plans through your employer or you are purchasing your own coverage, it's important to understand your choices and pick the plan that is right for you and your family. There are several questions to ask yourself when reviewing health insurance plan options:

- How affordable is the cost of care?
- How much are monthly [premiums](#)?
- How much are the [deductibles](#)?
- Are the [co-payments](#) or co-insurance flat fees or percentages of service fees?
- What [out-of-pocket](#) expenses have to be paid before the plan begins [reimbursement](#)?
- How does the reimbursement process work?
- What is the cost of out-of-network care?

Does the plan cover the services that I may use? For example:

- Doctors, hospitals, laboratories and other health care professionals in the network
- Out-of-network care
- Treatments for pre-existing medical conditions or chronic conditions
- [Prescription drugs](#)

What is the quality of the health insurance plan? Research factors of the plan such as:

- Ratings of the plan by independent government and non-government organizations
- Accreditation from groups like the [National Committee for Quality Assurance](#) (NCQA) or the [Joint Commission on Accreditation of Healthcare Organizations](#) (JCAHO)
- Patient complaints
- Member drop-out rates for the plan
- Other patient experiences with the plan
- Doctor experiences with the plan

### **What if my employer doesn't offer Health Insurance?**

Employer-**subsidized** group coverage is **generally** less expensive than anything you can get on your own. But, if your employer doesn't offer health insurance, or if you are unemployed, you should consider purchasing an individual health insurance policy.