

## Insurance at a Glance

### What is Health Insurance?

The term refers to a variety of insurance policies, ranging from those that cover the costs of doctors and hospitals to those that meet a specific need — like long-term care or dental coverage. When most of us talk about health insurance, however, we refer to the kind of plan that covers doctor bills, surgery and hospital costs.

You may have heard terms like "Managed Care," "Fee-for-Service" and "Indemnity." These words define different types of coverage or health plans widely used by today's consumers. Confused? Don't worry. We'll help you make sense of the lingo.

#### In a nutshell

- **Fee-for-Service** (also known as indemnity or traditional) plans generally offer complete freedom to choose your own doctors (including specialists) and hospitals. These plans, however, tend to be more expensive to the consumer.
- **Managed care plans**, on the other hand, have agreements with certain doctors, hospitals and health care providers to give a range of quality health services at a reduced cost. The secret? Patients must stay within the plan's network of providers and health facilities to get the best benefits. HMOs, PPOs and POS plans are all types of managed care.

### Understanding Health Insurance

No single plan will cover all costs associated with medical care, but some cover more than others. Use the guide below to explore the various types of coverage available to you.

#### Types of Coverage:

- **Fee-for-Service (or Indemnity) Plans:**  
With this traditional plan, you can make an appointment with almost any medical provider. After your visit, you or your provider sends your claim to the insurance company. If you have met your deductible for the year, then the Fee-for-Service plan will pay a percentage of the bill - usually 80%. You pay for the other 20%, known as coinsurance. Few purchase this traditional type of plan. Why? Because it's expensive.
- **Managed Care**  
This term refers to types of health insurance plans that provide health care services at a lower cost. The key to these lower costs? Members of managed care plans must adhere to certain rules designed to lower the cost of medical care.

### Choosing Wisely

If you have a choice from more than one plan, compare how each plan handles the following:

- Coverages
- Co-payments
- Coinsurance
- Deductibles
- Pre-existing conditions
- Exclusions
- Limitations on devices, drugs, and access to specialists

## **A Closer Look**

Take a closer look at how various plans operate in normal practice

### **Fee-for-Service**

Under a typical Fee-for-Service plan, the doctor or hospital will be paid a fee for each service rendered to the patient. In other words: You go to the doctor or hospital of your choice and you (or your doctor or hospital) submit a claim to your insurance company for reimbursement. You will only receive reimbursement for the “covered” medical expenses listed in your policy.

#### **More about reimbursement**

When a service is covered under your policy guidelines, you will be reimbursed for some - but rarely all – of the cost. How much you get depends on the specific policy provisions, on coinsurance and on deductibles.

#### **How does it work?**

The portion of the covered medical expenses you pay is called “coinsurance.” There are some deviations, but usually Fee-for-Service plans reimburse doctor bills at 80% if “reasonable and customary charges” – in other words, the prevailing cost of a medical service in any given geographic area. Who pays the other 20%? You do, that amount is your coinsurance.

- What if charges are higher than “reasonable and customary”?
  - If you are covered by a Fee-for-Service plan and your medical provider charges more than the reasonable and customary fee, you will have to pay the difference.
- What about hospitalization?
  - Some Fee-for-service plans pay hospital expenses in full. Most, however, reimburse at the 80% level as described above. Read your policy carefully

#### **All about deductibles**

A deductible refers to the amount of covered expenses you must pay each year before the insurer starts to reimburse you.

Deductibles vary. A typical deductible is \$250 per person, but it can be lower or much higher. As a rule, the higher the deductible, the lower the premiums.

Premiums are the monthly or quarterly payments paid for insurance. They do not count toward the deductible amount.

#### **A few things to keep in mind about Fee-for-Service plans:**

- Fee-for-Service policies typically have an out-of-pocket maximum. This means that once your covered expenses reach a certain amount in a given calendar year, the reasonable and customary fee for covered benefits will be paid in full by the insurer. If your provider bills you more than the reasonable and customary charge, however, you may still have to pay a portion of the bill.
- You may have lifetime limits on the benefits paid under your Fee-for-Service policy. Look for a policy whose lifetime limit is at least \$1 million. One major illness or extended hospital stay could easily use up a smaller lifetime limit, and nothing is worse for your healthy recovery than worrying about medical bills.

## Managed Care

The term “managed care” has become a buzzword – and not everyone knows what it means. Simply stated, managed care refers to the health care insurance plans designed to provide care at the lowest possible cost. In order to make coverage affordable, managed care plans require that patients follow certain rules.

### Types of Managed Care

- Preferred Provider Organizations (PPOs)
- Health Maintenance Organization (HMOs)
- Point-of-Service (POS) plans

### Preferred Provider Organization (PPO)

This plan type closely resembles a Fee-for-Service plan. A PPO has arrangements with a network of doctors, hospitals and other providers who have agreed to accept lower fees from the insurer for their services. As a result, your cost sharing should be lower than if you go outside of the network. In addition to the PPO doctors making referrals, plan members can refer themselves to other doctors, including ones outside the plan. This makes it a best-of-both-worlds option for many patients: lower costs in the network, but flexibility to leave the network if necessary.

If you go to a doctor within the PPO network, you will probably pay a copay. Your coinsurance will be based on lower charges for PPO members.

If you choose to go outside the network, you will have to meet the deductible and pay coinsurance based on higher charges. You might also have to pay the difference between what the provider charges and what the plan will pay.

### Health Maintenance Organizations (or HMOs)

With an HMO, you receive a range of health benefits for a set fee. Generally, there are no deductibles - and most plans require a small copay per office visit (around \$10-\$25). Some require no payment when you visit doctors. You must also choose a primary care physician from the plan's list. This doctor then becomes the "gatekeeper" for all of your medical needs. This is the doctor you call or see when you are sick, and when necessary, he or she will refer you to a specialist or other providers within the HMO network. With most HMOs you will not receive benefits if you go out-of-network, except for emergency care.

HMOs generally provide preventative care like annual check-up, flu shots, hearing tests, etc., at lower out-of-pocket costs to you. This makes them preferred for many people who don't want to pay huge fees for an annual physical, a cholesterol check or other necessary tests.

### Types of HMOs

- **Staff Model HMO** - A form of HMO in which doctors are employees of the HMO and visits are at a central medical facility.
- **Individual Practice Associations (IPAs)** - The HMO contracts with outside physician groups or individual doctors who have private practices. This means the HMO network will include doctors in various locations rather than only at a central facility.

### Point of Service (POS)

A hybrid of the HMO and PPO is known as a POS plan. Like a standard HMO, your primary care doctor makes referrals to other providers within the plan. However if you choose to see a physician outside of the network without consulting your primary care doctor, the POS plan will still pay a predetermined amount of the bill, while your share of the bill will be higher than if you stay in-network. These plans usually cost more in monthly premiums, but they give you the flexibility to call any doctor - within the plan or not.

### HMOs & Primary Care Physicians - A partnership with your doctor

An HMO will typically provide you with a list of physicians. From that list, you choose a "primary care physician." This doctor will serve as your chief medical officer. He or she will coordinate your care, see you when you are sick, and make any decisions about whether you should see a specialist.

What kind of doctors are primary care physicians? Usually, they fall into one of the following specialties:

- **Family practice doctors or general practitioners**
  - These doctors are trained to diagnose and treat a variety of health conditions. If you are young and in good health, a general practitioner is your best bet. Many HMO members select the same general practitioner for their entire family.
- **Internists**
  - Specializing in internal medicine, these physicians are trained to treat health conditions like diabetes and cardiovascular disease. If you are managing high blood pressure, heart disease, or diabetes, an internist is a wise choice
- **Pediatricians**
  - The doctors only treat children, usually under the age of 12.
- **OB/GYN**
  - Some plans allow women of childbearing age to select an OB/GYN as their primary care physician
- **Other types of doctors**
  - Some plans may allow a specialist to be selected as a primary care physician. For example, a diabetic may elect to have an endocrinologist (in the HMO plan) as his primary care physician.

How do you pick a primary care physician? Most HMOs only offer a list of doctors' name. How can you find out more about them?

- If you know others in the plan, ask for recommendations.
- Make appointments to meet with your doctors in your area to find one who is right for you.
- If the plan's doctors are located in the same facility, ask the staff nurse for recommendations.
- Some ratings and reviews of offices and physicians can be found online.

### Fee-for-Service vs. Managed Care

While Fee-for-Service and managed care plans are different, the difference can get a little fuzzy. Many managed care plans now contain Fee-for-Service elements. Conversely, almost all Fee-for-Service plans apply managed care techniques to contain costs and guarantee suitable patient care. Be sure to read the different plan descriptions carefully.

### Utilization Review

Utilization review is a fancy term for the process used by plans to determine whether a specific medical or surgical service is appropriate or medically warranted.

## **Other Types of Coverage**

### **Hospital-surgical policies**

Also known as “basic” health insurance policies, these plans provide benefits when you have a specified condition that requires hospitalization. Benefits usually include room and board and other hospital services; surgery; physicians’ non-surgical services performed in the hospital; and diagnostic X-ray and lab expenses, as well as room and board in an extended care facility. Some policies contain a small deductible, but most provide “first-dollar” coverage. These policies are NOT a substitute for broad medical coverage, because the benefits are limited in amount and relegated to specific illnesses. This type of policy may not be available in all areas.

The majority of hospital-surgical policies do not cover lengthy hospitalization and costly medical care. If you find that you need these types of service, you may rack up huge medical bills unless you have other insurance.

### **Catastrophic Coverage**

This type of policy pays hospital and medical expenses above a certain deductible and provides additional protection if you have either a hospital-surgical policy or a comprehensive policy with a lower-than-adequate lifetime limit. Catastrophic plans usually have extremely high deductibles -- \$10,000 and beyond – and a maximum lifetime limit that may be high enough to cover the costs of major catastrophic illness. The bad news is, you foot the first \$15,000 of a disastrous illness. The good news is you may save yourself from owing the millions in medical bills you would accumulate without any insurance. These policies are NOT a substitute for broad medical coverage because the benefits are limited in amount and relegated to specific illnesses. This type of policy may not be available in all areas.

### **Specified or dread-disease policies**

These policies provide benefits only if you get the specified disease or group of diseases named in the policy. These policies are NOT a substitute for broad medical coverage because the benefits are limited in amount and relegated to specific illnesses. This type of policy may not be available in all areas.

### **Hospital Indemnity Insurance**

This type of policy pays you a specified amount of cash benefits for each day you are hospitalized, up to a designated number of days. These cash benefits are paid directly to you, and can be used for any purpose you choose. This is useful for meeting out-of-pocket expenses not covered by the other insurance. Some contain limitations on pre-existing medical conditions that you may have had before your insurance takes effect. Others contain an elimination period, which means that benefits will not be paid until after you have been hospitalized for a specified number of days. These policies are NOT a substitute for broad medical coverage because the benefits are limited in amount and relegated to specific illnesses. This type of policy may not be available in all areas.

### **Long-term Care Policies**

These plans cover the medical care, nursing care and certain in-home care that you might need if you ever are unable to care for yourself due to an extended illness or disability. Most long-term care policies pay a fixed dollar amount, typically from \$40 to \$200 a day, for each day you receive covered care in a nursing home. The daily benefit for at-home care is usually half the benefit of nursing home care.

Keep in mind that some state insurance departments may require a face-to-face meeting with an agent who has received special certification to sell individual long-term care plans.

**Dental Insurance**

Paying out-of-pocket for yearly dental checkups probably won't break your bank. But what happens if you need more serious dental work? A root canal or crown can easily cost over \$1000. Some health insurance plans include dental coverage as part of your benefits package. If not, you have the option of purchasing separate dental insurance. Dental indemnity or Fee-For-Service plans allow plan participants to visit any credentialed dentist or dental specialist they wish. The participant pays the dentist at the time of service and gets reimbursed according to the plan's coverage. This is the plan for those who enjoy the freedom of provider selection and don't mind a higher monthly premium and greater out-of-pocket expense. Dental Maintenance Organization (DMO) plans require members to seek all services through their assigned dentist. These affordable plans offer preventive services at little or no cost to the member. (The plans differ in premium and copay levels.) Dental PPO (Preferred Provider Organization) plans offer patients the choice of an indemnity plan and the affordability of a managed care plan.

**Vision Insurance**

Vision coverage also might be included in a health insurance benefits package. If not, it may be purchased separately -- and is usually provided in the form of a Vision Maintenance Organization (VMO) or PPO network. Coverage generally includes yearly eye exams and a percentage of the cost of eyeglasses and contact lenses. Some plans cover all or a part of the cost of laser corrective surgery as well.

## **Limitations**

### **What's Not Covered?**

This section does not address StudentResources Ltd. policies specifically (each one of these has its own list of exclusions and limitations). However, this is a generic overview of items typically not covered.

Remember, HMO benefits are generally more comprehensive than those of traditional Fee-for-Service plans. No health plan, however, will cover every single medical expense. Here are some common exclusions in coverage:

- No matter how much you want that nose job, very few plans will cover it -- or any other elective cosmetic surgery, for that matter. Exceptions occur when the procedure is needed to correct damage caused by accidental injury, but check your plan to make sure!
- Some Fee-for-Service plans do not cover routine medical checkups. Women should take careful note of which plans cover annual gynecological exams -- pap smears and mammograms, for example.
- Women should also note that some individual plans will cover complications of pregnancy but won't cover normal pregnancy or childbirth.
- Want to try acupuncture for your hypertension? Your plan might not cover it. Procedures that are considered experimental or non-traditional are usually not covered.
- Believe it or not, mental health coverage is not offered in many health plans. Others offer limited coverage for acute conditions only.
- Procedures the health plan determines are not medically necessary.

### **Other exclusions**

Insurers will definitely not pay duplicate benefits. You and your spouse may be covered under different health insurance plans, but under what is called a "coordination of benefits" provision, the total you can receive under both plans for a covered medical expense can never exceed 100% of the allowable cost. So while you won't be able to pull a fast one, you can be rest assured that this provision benefits everyone in the long run. How? By helping to keep overall insurance costs down.

## **Getting the Most from your Health Coverage**

How can you utilize your healthcare benefits most effectively? Be an active participant in your own health and health care by:

- **Remembering the importance of preventive care**
  - Find out about health screenings and see that you get them.
- **Eating well**
  - There's a shred of truth in the old adage, "an apple a day keeps the doctor away." A healthy, balanced diet can help you avoid a multitude of health problems (like obesity, heart disease and adult-onset diabetes), and helps with many pre-existing conditions (like high blood pressure and depression).
- **Exercising NOW, not later**
  - Studies show that even moderate exercise three times per week can offset an adult's risk for heart attack, stroke and certain cancers.
- **Always asking your doctor questions, and listening for clear answers**
  - Know what prescriptions you are taking, when to take them and what not to mix with them. Ask about the risks and benefits of each test and treatment. Make certain that you understand your doctor's responses. Go ahead and take notes, if necessary.
- **When in doubt, writing it down**
  - While we're on the subject of taking notes, remember to keep a log or diary of symptoms, concerns or unusual problems that occur. That way, you have a clear record when it comes time to meet with the doctor. Also, make sure to keep a record of treatments, vaccinations, lab tests, drug reactions and side effects.
- **Knowing your policy**
  - Read your coverage policy and member handbook -- particularly the information on benefits, coverage, exclusions and limitations. If your plan has a newsletter or magazine, make sure to read it as well. You can keep abreast of policy changes and new services that may affect your care.
- **Knowing how to obtain care**
  - Don't wait until it's 4 a.m. and you are having a bizarre reaction to the shellfish you had for dinner -- learn coverage specifics like urgent-care hours and how to schedule appointments now, while you feel good. Don't forget to find out how (and where) to get lab tests, as well as what number to call in an emergency.
- **When you're unhappy with the treatment you received**
  - If you have a bad experience with your managed health care provider, you have the right to complain. Contact the member services division of your plan immediately for more information on how to register a complaint. Health insurance plans have grievance or appeal processes. While in the complaint process, be sure to save records of all correspondence, claim forms and copies of bills. Also keep a log of phone conversations and names of the people you speak with.