



## Health Care

Health insurance is one of your most important needs. Medical expenses can be extremely costly and health insurance protects both you and your family from financial hardship. Most employers offer Health Care coverage as a benefit of employment with some required employee contribution.

The information provided below will help you better understand the Health/Medical system in the United States

There are 3 major types of Health Care plans:

- Traditional Plans/Indemnity (fee for service)
- Health Maintenance Organization (HMO)
- Preferred Provider Organization (PPO)

### Traditional Plans

This is the type of health care coverage that has been traditionally offered in the U.S. Insurance companies pay a portion of medical fees for the medical services provided to those insured under the policy (known as a fee-for-service plan). 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 insurance company pays for part of your doctor and hospital bills. The insured is responsible for the following:



- A monthly fee, called a premium
- A certain amount of money each year, known as the deductible, before the insurance company begins paying the medical fees
- In a typical plan, the deductible might be \$250 for each person in your family, with a total family deductible of \$500. The deductible requirement applies each year of the policy. Also, not all health expenses you incur count toward your deductible; only those covered by the policy do. You need to check the insurance policy to find out which expenses are covered
- After you have paid your deductible amount for the year, you share the bill with the insurance company. For example, you might pay 20 percent while the insurer pays 80 percent. Your portion is called coinsurance

To receive payment for fee-for-service claims, you may have to fill out forms and send them to your insurer. Sometimes your doctor's office will do this for you. You also need to keep receipts

for drugs and other medical costs. You are responsible for keeping track of your medical expenses.

### **Health Maintenance Organization**

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.



There may be a small co-payment for each office visit, such as \$20 - \$30 for a doctor's visit or \$50 for hospital emergency room treatment. Your total medical costs will likely be lower and more predictable in an HMO than with fee-for-service insurance.

Many people like HMOs because they do not require claim forms for office visits or hospital stays. Instead, members present a card, like a credit card, at the doctor's office or hospital. However, in an HMO you may have to wait longer for an appointment than you would with a fee-for-service plan.

In almost all HMOs, you either are assigned or you choose one doctor to serve as your primary care physician (PCP). This doctor monitors your health and provides most of your medical care, referring you to specialists and other health care professionals as needed. You usually cannot see a specialist without a referral from your primary care doctor who is expected to manage the care you receive. This is one way that HMOs can limit your choice.

### **Preferred Provider Organization**

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

When you go to doctors in the PPO, you present a card and do not have to fill out forms. Usually there is a small co-payment for each visit. For some services, you may have to pay a deductible and coinsurance.

As with an HMO, a PPO requires that you choose a primary care physician to monitor your health care. Most PPOs cover preventive care. This usually includes visits to the doctor, well-baby care, immunizations, and mammograms.

In a PPO, you can use doctors who are not part of the plan and still receive some coverage. At these times, you will pay a larger portion of the bill yourself (and also fill out the claim forms). Some people like this option because even if their doctor is not a part of the network, it means they don't have to change doctors to join a PPO.

### **What Plan Benefits Are Offered?**

Most plans provide basic medical coverage, but the details are what count. The best plan for someone else may not be the best plan for you. For each plan you are considering, find out how it addresses:

- Physical exams and health screenings
- Care by specialists
- Hospitalization and emergency care
- Prescription drugs
- Vision care
- Dental services

### **Tips on Choosing a Doctor**

Your doctor will be your partner in care, so it is important to choose carefully from the doctors available to you. In some managed care plans, you will generally be limited to choosing from only certain doctors; in other plans, some doctors may be "preferred," which means they are part of a network and you will pay less if you use them. Ask your plan for a list or directory of providers. The plan may also offer other help in choosing the right physician for you.



### **How Do I Obtain Care?**

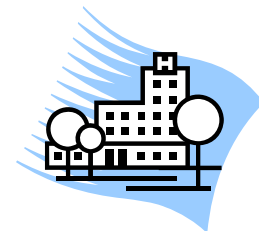
Learning what you can expect from your health plan and how it works are key steps to getting the care you need.

Ask these questions:

- When are the offices open? What if I need care after hours?
- How do I make appointments? How quickly can I expect to be seen for illness or for routine care?
- If I need lab tests, are they done in the doctor's office or will I be sent to a laboratory?
- Will most of my appointments be with the primary care doctor? Will nurse practitioners or physician's assistants sometimes give care as well?
- Is there an advice hotline? (Some plans have toll-free phone services that help members decide how to handle a problem that may not require a doctor's visit.)

### **Planned Hospitalizations**

Unless it is a medical emergency, your health plan or primary care doctor will probably have to give advance approval (preadmission certification) for you to go to the hospital. Otherwise, the cost of your hospital care may not be covered.



Ask these questions:

- Which hospitals come under the plan network?
- Is there a limit on how long I can stay in the hospital?
- Who decides when I am to be discharged?
- Will I need follow-up care, such as nursing home or home health care, and will it be covered by the plan?
- If I have a serious medical problem, will the plan provide someone to oversee care and make sure my needs are met?

### **Emergency or Urgent Care**



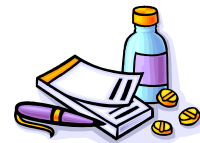
If you have a true medical emergency, you should go to the nearest hospital as fast as possible. It is important for you to know what kinds of medical problems are defined as emergencies and how to arrange for ambulance service, if needed. Most plans must require notification within a certain time after emergency admission to a hospital. If the hospital is not part of the plan network, you may be transferred to a network hospital when your condition is stable.

Ask these questions:

- How does the plan define "emergency care"? What conditions or injuries are considered emergencies?
- How does the plan handle "urgent care" after normal business hours? (Urgent care is for problems that are not true emergencies but still need quick medical attention. Check with your plan to find out what it considers to be urgent care. Examples may include sore throats with fever, ear infections, and serious sprains. Call your primary care physician or the plan's hotline for advice about what to do. The plan may also have urgent care centers for members)
- How do I get urgent care or hospital care if I am out of the area? How must I tell the plan and how soon after notification, will I get the care?

### **Prescription Plan**

From time to time, your physician will treat you with drugs that are not available for you to buy "over the counter" at pharmacies or stores. "Over the Counter" drugs are products that you can obtain just by walking into a store and selecting the product from the store shelf. Your physician will then write a prescription for the drug you need. You will then bring the prescription to your local pharmacy and give it to the pharmacist. The pharmacist will then give you your medication. At times, your doctor can phone the pharmacy and provide them with your prescription. Ask your doctor if you must take the brand name drug, because in some cases a generic drug will work just as effectively and be less costly.



Try to use one pharmacy for all your medicinal needs. Some pharmacies are open 24 hours a day. Look for any in your area, and keep their phone numbers handy, along with the number of your regular pharmacy.

## **Understanding Health Insurance Terms**

**Coinsurance** is 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. For example, if the insurance company pays 80 percent of the claim, you pay 20 percent.

**Coordination of Benefits** is 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.

**Co-payment** is another way of sharing medical costs. You pay a flat fee every time you receive a medical service (for example, \$30 for every visit to the doctor). 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. Some may not pay for prescription drugs. Others may not pay for mental health care. Covered services are those medical procedures the insurer agrees to pay for. They are listed in the policy.

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

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

**HMO (Health Maintenance Organization)** - Prepaid health plans. You pay a monthly premium and the HMO covers your doctors' visits, hospital stays, emergency care, surgery, checkups, lab tests, x-rays, and therapy. You must use the doctors and hospitals designated by the HMO.

**Managed Care** - Ways to manage costs, use, and quality of the health care system. All HMOs and PPOs, and many fee-for-service plans, have managed care.

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

**Non-Cancelable Policy** - A policy that guarantees you can receive insurance, as long as you pay the premium. It is also called a guaranteed renewable policy.

**PPO (Preferred Provider Organization)** - A combination of traditional fee-for-service and an HMO. When you use the doctors and hospitals that are part of the PPO, you can have a larger part of your medical bills covered. You can use other doctors, but at a higher cost.

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

**Premium** is the amount you or your employer pays in exchange for insurance coverage.

**Primary Care Physician (PCP)** is usually, your first healthcare contact. This is often a family physician or internist, but some women use their gynecologist (if the plan allows). 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. This can be an insurance company, an HMO, a PPO, or the Federal Government.