



The GoHealth Insurance Buyer's Guide

Everything you need to know about buying individual coverage

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What is individual health insurance?

Individual health insurance is any health plan purchased through a private insurance company not through an employer, group, or association. It also includes plans purchased by self-employed people who have no additional employees.

Quick facts about individual health insurance:

- As of 2010, 10 million Americans utilize high deductible health plans with Health Savings Accounts (<http://www.ahipresearch.org/pdfs/hsa2010.pdf>)
- As of 2010, around 14 million Americans were covered with an individual health insurance plan (<http://www.kff.org/kaiserpolls/8077.cfm>)
- The most common types of health insurance include:
 - o Health maintenance organization plans (HMOs)
 - o Preferred provider organization plans (PPOs)
 - o Point-of-Service plans (POS)
 - o Fee-For-Service (FFS) indemnity coverage

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Foreward

What is health insurance? The most basic definition is “health insurance helps protect us against the high costs of medical care.” Through a health insurance plan, we can share the costs of health care services with an insurance company and maintain access to care when we need it.

For many of us, our best option for keeping our health insured is with an individual health plan offered through a private insurer such as Aetna, the Blue Cross and Blue Shield companies, UnitedHealthOne, Humana, CIGNA, and more.

Before you’re ready to purchase a health plan, you’ll ask yourself questions such as: Which plan should I choose? What are the differences between each plan? How do I find affordable coverage?

In this Health Insurance Buyer’s Guide, we want to give you the resources and the tools to obtain the right health insurance for your needs. The Guide is designed to help you navigate through the much-unknown world of buying individual health insurance and emerge with a fundamental understanding of how insurance coverage works.

Even though we’ll give you a full tour of the health insurance world, we wouldn’t expect you to be an expert after reading this Guide. That’s why you shouldn’t hesitate to get in touch with a licensed health insurance agent/broker to add personal service to your health plan shopping experience.

An agent can be an invaluable partner as you shop. Because they’re experts when it comes to buying coverage, many times agents can be the difference between finding the right plan and getting lost in the often confusing world of health insurance.

The bottom line is we want to make sure that you obtain the best health insurance plan for your needs.

Introduction

First off, don't panic.

For just about all of us, buying individual health insurance coverage isn't something you do often — if ever. But shopping and purchasing a health plan for yourself doesn't have to be an impossible task.

It's also very important that you fully understand what kind of health plan suits your needs — and you know exactly what you're getting when you decide to buy a particular plan.

After you read this Buyer's Guide, you'll be equipped to start comparing health plans and you'll be able to buy the right one with confidence.

What will I learn?

We'll run through the basics of health insurance such as defining PPOs, HMOs, and HSAs, we'll explain how to read a plan's benefits, and we'll go over important insurance terminology you should know.

Among many other things, you'll learn 3 basic keys to finding the right coverage:

1. Become an informed shopper by gaining a better understanding of how health insurance works.
2. Leverage easy-to-use tools to view quotes online, compare rates, and apply for coverage.
3. Partner with a licensed agent for personal service and advice whenever you need it.

We'll also weave in tips on how to use our free tools at GoHealthInsurance.com.

We hope this Guide helps you find your health plan!

Part I.

Getting Started

Let's first take a look at the most common kinds of health insurance plans, define each, then look at the costs you'll be responsible for.

Kinds of Health Insurance Plans

There are a lot of health plans available. And the acronyms that insurance companies use can be confusing — how is a POS plan different from a PPO plan? This short overview of plan types will help you sort it all out.

Health Maintenance Organizations (HMOs) are a form of managed care. In an HMO, you get care from a “network” of doctors, hospitals, and other care providers. The network provides their services at a discount. That means lower operating costs for your insurance company — and lower premiums for you. Most HMOs have no deductible, so your coverage kicks in right away.

In an HMO, you'll choose a primary care physician. The physician is usually a general practitioner, a pediatrician, or an OB/GYN. Your primary care physician will be your main contact with the health care system, and will give you referrals to see specialists when needed. If you have a health condition that requires constant attention, some HMOs will let you choose a specialist as your primary care physician.

The downside to an HMO is that your health care costs are only covered if you receive care within the HMO provider network. But most HMOs are so large that finding a convenient doctor or hospital in your area is no problem.

***Buyer Tip! If you're looking to find a lower cost plan, but still want comprehensive coverage, consider an HMO plan.*

Preferred Provider Organizations (PPOs) are also a form of managed care. Many people choose PPO plans because they offer the most flexibility you'll find in a managed care plan.

While PPO plans are similar to HMO plans, you don't have to choose a primary care physician with a PPO. You also don't need a referral to see a specialist. And you can see any doctor you choose and stay covered. Though, typically your insurance company will cover more of the cost if you stay inside your provider network.

***Buyer Tip! If you don't mind paying a little extra to ensure health care services are covered with any doctor or hospital, consider a PPO plan.*

Fee-For-Service plans — also sometimes called indemnity plans — are the traditional form of health insurance. With an FFS plan, your doctor is paid for each service that he or she provides. It's common for FFS plans to require you to pay your doctor when you receive care, and then file a claim for reimbursement.

FFS plans can provide some of the most comprehensive coverage available. But be careful when you look at an FFS plan. Some are designed to pay only for serious (and expensive) medical care, and won't pay for routine care.

FFS plans are less common than they used to be. These days, it's more common to have a managed care plan.

Point-Of-Service plans are another kind of managed care plan. Like an HMO, in a POS plan you'll choose a primary care physician. But unlike an HMO, you can choose to see any doctor or specialist you want — without a referral. This added flexibility gives you more control over your health care.

Like any managed care plan, a POS plan will have a network of care providers. You'll save the most money by visiting doctors and hospitals within the plan network. But if you choose to see a health care provider outside the network, you'll still receive some coverage.

What about Health Savings Accounts?

What about Health Savings Accounts?

Health Savings Accounts (HSAs) have been called the “future of health insurance” by many experts. But they aren't health insurance plans. They're a way to save money to help pay for your health insurance and health care.

With a health savings account you save money without paying taxes on it. The money you deposit in your HSA is either:

Taken out of your paycheck before you pay income tax on it, or

Claimed as a deduction when you file your taxes.

Either way, the end result is getting extra money from the government to help pay for health care. You can use that money to pay for almost anything related to health care: your insurance deductible, your copayments, prescription drugs, and even cold medicine.

You can't use your HSA money to pay your insurance premium. But as you save more money in your account, you can afford to raise your deductible — so your premium goes down.

Before you set up an HSA you have to enroll in a high-deductible health plan, or HDHP. To qualify, your plan needs to have a deductible of at least \$1,100 (\$2,200 if it's a family plan). PPOs are the most common HDHP you'll run into.

***Buyer Tip! Plans compatible with HSAs are best suited for people who don't visit the doctor often, who don't have chronic health conditions, and individuals without families or children.*

You can learn more at the U.S. Department of the Treasury's Health Savings Accounts and other tax-favored Health Plans.

Overview of Your Health Insurance Costs

With most health insurance plans, you'll be responsible for several different costs. These costs include:

Your premium. This is an ongoing payment — usually monthly — to keep your health policy in effect. Your premiums are determined by a variety of factors, including your age, your health status, your lifestyle, and where you live.

Your deductible. This is the amount of money you'll have to pay toward medical expenses before your coverage starts. Most health plans let you choose from a range of annual deductibles, often starting as low as \$500 and going as high as \$10,000.

***Buyer Tip! Why would anyone choose a higher deductible? To get a lower premium. The higher your deductible, the lower the monthly cost of keeping your plan in effect will be.*

Copayments. A copayment is a fixed-dollar amount that are due when you receive care. For example, you may have to make a \$20 copayment when you visit your doctor.

Coinsurance. This is a percentage-based amount that is due when you receive care. For example, you may be responsible for 20% of the cost of a hospital visit — your insurance company will pay the remaining 80%.

Out-of-Pocket Maximum. This is the most you need to pay out of your pocket for your health care services in one year. When you reach this maximum, your health insurance will cover the rest of your medical expenses for that year.

Part II.

Weighing Your Options

Even though there are distinct types of health plans as illustrated above, there's no such thing as a "one-size-fits-all" health insurance policy. One HMO can differ from insurer to insurer, and just one insurance company might offer a dozen different types of HMO, PPO, and POS plans.

But it's a good thing you have so many options to choose from. Why? Because everyone has different health needs. You could almost compare it to buying a pair of pants. We're all different shapes and sizes — and we all have to shop around a bit to find the best fit.

And just like a good pair of pants, health insurance plans can be tailored just for you.

What Do I Want Out of My Health Insurance Plan?

Every health plan is different. And it's easy to apply for a plan without knowing what you're actually getting. That can lead to nasty surprises when you file a claim — like finding out that trip to the emergency room is going to cost a lot more than you thought.

When you look at plans, the first thing to consider is the how much the policy will cost.

After that, you'll want to know what **services are covered**. Some plans will cover everything from dental care to acupuncture. Other plans will cover expensive hospital care, but leave paying for routine doctor's visits up to you. Every plan you look at should have two sections:

- The Summary of Benefits lists what services are covered, and how much of the cost of that service will be paid for by the plan.
- The Limitations and Exclusions will detail what the plan does not cover.

If you're thinking of enrolling in a managed care plan, you'll want to look at the **size of the plan network**. And if you already have a doctor, make sure you know which networks he or she participates in.

When thinking about a health plan's network, you should also ask:

- Where is the nearest in-network hospital located?
- Are referrals required for specialist care?
- Does the network have the kind of specialists you need?

If you need a plan that provides coverage for prescription drugs, you'll want to look at the plan's **formulary**. A plan formulary is a list of medications that have been approved for coverage by an insurance provider. If you currently rely on a certain medication, you'll want to make sure it's covered by any plan you consider.

***Buyer Tip! Many companies offer the same plan with 3 levels of drug coverage: no coverage, coverage for generic drugs, and coverage for brand-name drugs. If you depend on brand name medications, you'll have the option to get coverage for them. If you're open to taking generics — or don't need drug coverage — you'll save money on your health plan.*

What If I Have a Pre-Existing Health Condition?

A common hurdle in getting individual health insurance is if you have a pre-existing health condition such as asthma, diabetes, or even a recent broken bone.

If an insurance company accepts your application they might not cover any care related to your pre-existing condition, or they might impose a waiting period before they start. In the worst cases, an insurer could turn down your application altogether.

Having a serious pre-existing condition does make it more difficult to find health insurance, but licensed agents can help you explore your options and point you in the right direction.

You might also be able to find coverage through a public health insurance program where coverage is partly or wholly paid by the state or federal government. If you live on a low-income or are disabled, you could be eligible for subsidized health insurance programs such as Medicaid or Medicare.

Balancing Premiums and Deductibles

When you start comparing health plans, there are two numbers that are going to jump out at you — the premium and deductible.

A typical individual PPO health insurance premium for a woman in her forties who is single and in good health can run anywhere from \$100 to \$600* per month. If she is married, and has an individual PPO health plan that also covers her husband and two children, the premium may run \$250 to \$1,100* per month.

Your deductible is the amount you must pay for medical expenses out of your own pocket before your insurance coverage begins paying. Deductibles are usually quoted on a yearly basis.

An individual health plan's annual deductible can range from \$250 to several thousand dollars.

*These estimated premiums are preferred PPO rates for a single woman living in California.

Health Insurance Premiums: What You Get For Your Money

Your premium is a good measure of how much health insurance coverage you actually have. The more you pay for your premiums, the more coverage you have. It works the other way too — paying less for your health plan means less coverage.

For example, let's look at the premium difference between an HMO and a PPO health plan. The PPO plan has more expensive premiums, but provides a broader range of coverage. With a PPO plan, you'll be able to go to any doctor or hospital and be guaranteed some coverage.

On the other hand, you'll pay less per month for an HMO plan. But your coverage is restricted to a specific health care provider network. If you get care from a doctor outside the network, you won't have any coverage at all.

Spending a bit more to get preventive care coverage is usually worth the extra money, also. Take the example of the women in her forties from the first section of this article. If she paid \$200 per month she'll likely have preventive care coverage for routine doctor's check-ups, physicals, and visits to her OB/GYN.

But if she chooses a catastrophic, major medical plan that charges premiums at \$100 or lower, that plan might omit preventive care coverage because of the low monthly cost.

Generally speaking, once you are accepted into a health insurance plan, you keep your coverage as long as you pay your premiums. In fact, most states have laws that prohibit health insurance companies from canceling your coverage as long as you keep sending in premiums.

*****Buyer Tip! Health insurance rates are fixed by law, so you can't find a lower rate for the same plan anywhere else — not through another service or even an insurance company — guaranteed.***

Health Insurance Deductibles: Is Lower Always Better?

It's tempting to think so, but opting for a plan with the lowest deductible is not necessarily the wisest choice.

Another way to think of your deductible is as an amount of risk you're willing to assume — that is, how much you're willing to pay out of your own pocket for your medical costs. The more risk

you can afford to take on by paying a higher deductible, the less risk your insurance company assumes in insuring you, so naturally they will charge you less for your health insurance plan.

This is why health plans with high deductibles have lower premiums. Using the hypothetical woman as an example again, let's say she buys an individual health plan with a low, \$250 annual deductible. This means she wants to assume very little risk and pay very little out of her own pocket for health expenses — but her monthly premium will easily be more (and most likely a lot more) than \$100.

If she purchases an individual HMO health plan with a high \$2,000 deductible, she's willing and financially able to accept a much higher degree of risk. She'll pay all her medical expenses up to \$2,000, but she'll have much lower premiums than with the \$250 deductible.

In choosing your health plan, ask yourself: Would you rather pay more each month in premiums? Or would you rather pay more when you receive medical care?

For some people, this is an easy question to answer. If you're in reasonably good health, and have some money saved that you could tap in a medical emergency, you may be better off getting a high deductible plan and paying lower monthly premiums.

And since some health plans “waive the deductible” for certain forms of routine care, such as vaccinations and annual physicals, you may be able to see your doctor regularly for check-ups for just a small copayment (say, \$15).

In the high deductible scenario, you're basically betting that you won't need any expensive medical care in the coming year. But if a serious accident or injury strikes, you know you can afford to meet your deductible and let your plan start paying a majority of your bills.

For other people, having a health plan with low deductible makes more sense. If you have a chronic medical condition that requires you to have frequent treatment, or work in a profession with a high risk of injury, it may be financially wiser for you to pay a higher monthly premium.

Simply, you know (or have a good reason to predict) that you'll need quite a bit of costly medical care during the upcoming year, so you want your medical insurance plan to pay for as much of it as possible. Having a high deductible could leave you on the hook to pay some steep medical bills.

Ultimately, choosing a deductible comes down to deciding how much you can spend every month to stay covered, and how much you can spend when you get medical care. It can be a tricky balancing act, but with some careful budgeting you can make it work.

What Kinds of Plans Do People Like Me Buy?

Well, it depends on what kind of plan you're looking for. Which of the following sounds most like you?

I want a plan that gives me the best value for my money.

"I'm proactive about my health and believe in regular medical exams are part of a healthy lifestyle, and I want coverage for it. But I am also on a budget and would rather cover some of the cost of care myself than pay too much for my health insurance plan."

Consider...

- A plan with an affordable copayment for doctor visits
- A deductible between \$1,000 and \$3,000
- A health care provider network with your preferred physicians and hospitals
- Prescription drug benefits with some upfront coverage for generics and standard formulary brands

I want a plan with the lowest possible cost.

"The most important thing to me when it comes to my health insurance plan is the monthly bill. I tend to go to the doctor only if I become very ill and I try to avoid doctor visits, but I'm willing to cover the first few thousand dollars of cost myself. I'm also very concerned about wasting money on unnecessary care and expensive insurance coverage."

Consider...

- A deductible of \$2,500 or higher
- Major medical coverage - permanent or temporary
- Opening a Health Savings Account
- Limited benefit options, limited doctor visits
- Discount prescription drug cards

I want a plan that provides the most complete and comprehensive coverage possible.

"Health insurance is something you shouldn't try to save money on. For me, I want to make sure I have full coverage for doctor visits and prescription drugs. I want full access to the latest and best care available — and I want the complete coverage when I need it."

Consider...

- A deductible \$1,000 or less
- A plan with a low copayment for doctor visits
- The broadest available network of health care providers
- Full prescription drug benefits

***Buyer Tip! Want to compare rates and apply online for a plan with the recommendations above? Use the [GoHealth Insurance Plan Finder](#).*

Part III.

How To Find Your Health Plan

So now that we've covered a lot about health insurance, where do you start if you're ready to shop?

Not every insurance company will offer the same kind of health coverage and rates. That's why it's a good idea to compare benefits and rates from multiple companies before you decide on a plan.

There are few different ways to shop, compare, and apply for coverage that you might not know of. Let's look at each:

Apply for a plan directly with an insurance company

If you have a preferred health insurance carrier, you can apply for a plan directly with them. Most insurer websites offer an application that you can print out and send in to them. You can also contact them by phone to apply. Other companies even let you apply online for a plan.

Contact a licensed agent

There are licensed insurance agents and brokers in every part of the country. These health insurance professionals don't just offer plans from top insurance companies — they can also help you compare your options and give you expert advice.

If you want to learn about the specifics of what makes an agent qualified to sell health insurance, learn more from the [U.S. Department of Labor](#).

****Buyer Tip!** To speak with a licensed GoHealth Insurance agent, feel free to [contact us](#). And by the way, advice from our agents is provided as a free service.

Compare health insurance quotes

You also can request health insurance quotes to compare plans. Online quote services take the legwork out of finding an agent on your own. There are plenty of reputable services that can connect you with multiple local agents to help you explore your health insurance options. Some services also provide instant quotes for you to view online and let you apply online, as well.

****Buyer Tip!** With the [GoHealth Insurance Instant Quote Engine](#), you can view quotes online in seconds absolutely free.

The Advantage of an Agent

The Internet makes it easy to learn about your insurance options. But when it comes to choosing the right policy for your needs, nothing beats the expert advice of a professional insurance agent.

Insurance agents know how to help you sort through all the complicated insurance options. They'll help you understand insurance industry jargon and make sense of the fine print in any policies you look at.

When you work with an agent, they'll be able to look at your health needs and point you toward the right policy. And an increasing number of agents represent several insurance companies. That means you'll have no shortage of options to compare.

There's another important reason to talk with an agent before you apply for a policy: an agent can steer you away from plans that are likely to reject you.

When you apply for a health plan, your application goes to a medical underwriter. An underwriter's job is to determine the kind of health risks you're likely to face, based on your medical history and your lifestyle. The underwriter will decide how much your monthly premium will be. If you don't pass the "underwriting criteria," your application will be rejected.

No big deal, right? After all, there are plenty of health insurance companies. If one turns you down for coverage you just try another.

The truth is, it's a lot more complicated than that.

Though many people don't know it, health insurance companies have access to a record of your insurance activity — a lot like a credit report.

The Medical Information Bureau keeps records on medical conditions, test results, and other information that comes up during the health insurance underwriting process. If you apply for health insurance coverage and get denied, chances are it will be reported to the Medical Information Bureau. And once that rejection shows up in your record, other insurance companies are likely to reject you, too.

It's worth pointing out that the Medical Information Bureau doesn't have access to your personal medical history. They do not collect information from doctors or hospitals. The only information they get is reported to them by insurance companies. And in general, only 20% of Americans have a record with the Medical Information Bureau.

If you have a record with the Medical Information Bureau, you can request a copy of it at their website:

[Medical Information Bureau — Request Your Record](#)

If you think there is an error in your file, you can write the Medical Information Bureau at:

MIB Information Office
P.O. Box 105 Essex Station
Boston, Massachusetts 02112

A professional agent will help you avoid getting rejected. Each company uses different underwriting criteria. One company may consider your health too risky to insure, while another might cut you a good deal on premiums. An agent will know where you have the best shot at getting accepted. And many agents have professional relationships with underwriters — meaning they can get an opinion about your chances for acceptance before you officially apply.

Applying for Health Insurance

When you've weighed all your options and you've decided on a plan, it's time to apply for coverage.

Applications vary by insurance company, so not every one is the same. But here are some questions you'll run into:

- Will this new plan replace another plan? Be ready with some basic details of your old plan such as the insurance company's name.
- What is your health history? Most applications have detailed yes and no questions asking if you've ever had specific health conditions.
- Do you have any dependents that need coverage? If so, be ready with their health history and information.
- When do you want your coverage to start? This is so both you and your insurance company have an idea of when you'll be officially insured. But remember it's up to the insurer, so don't assume you have coverage until you've received an acceptance letter and your insurance card.

Also, you'll want to have any payment information ready such as your bank account number, routing number, and credit card information.

***Buyer Tip! Don't be afraid to ask for help if you need it. An agent can walk you through the application and answer all your questions. If you start an application at GoHealth Insurance, feel free to [call us](#) if you need assistance.*

Appendix A.

The Health Insurance Shopper's Checklist

When you're considering health plans, here are some questions to ask:

- Does the plan provide coverage for pre-existing conditions?
- Does the plan have waiting periods? How long are they?
- Does the plan cover maternity care?
- Does the plan cover mental health services?
- Does the plan include prescription drug coverage?
- Does the plan include coverage for dental and vision care? Can dental and vision coverage be added to the plan?
- What kind of other support and wellness services does the plan provide for its members?
- How much will the plan cost you each year?
- What is the deductible? Will you be able to afford the entire deductible if you have to meet it all at once?
- How much are the copayments and/or coinsurance?
- What is the out-of-pocket maximum?
- What is the lifetime limit on coverage?
- How large is the plan's network?
- How close are you to each plan's doctors and hospitals?
- Does the plan provide you with a wide selection of specialists?
- Does the plan have a clear arrangement for specialist referrals?
- How does the plan's appeal process for disputed claims work? Do they assist members who need to make an appeal?

Appendix B.

Health Insurance Glossary

Additional Insured: Anyone to whom your policy extends coverage to. In most cases, the additional insured must be specifically named in your policy.

Assisted Living Facility: Residential communities for senior citizens that provide nursing care.
Benefit: The dollar amount your insurance carrier will pay when you file claim a covered service.

Carrier: A company that offers insurance.

Certificate of Insurance: The printed description of your benefits and coverage limits. This certificate is a contract between you and your insurance company. It spells out precisely what will be covered, what won't, and the dollar maximums.

Claim: A request to your insurance company for benefits.

COBRA: The short name of the Consolidated Omnibus Budget Reconciliation Act, passed by Congress in 1985. This law requires group medical plans covering twenty employees or more to offer participants the option to receive continued health care benefits for up to eighteen months when they lose coverage because of job loss, a reduction in hours, or other "qualifying events." Learn more at the U.S. Department of Labor's [Frequently Asked Questions about COBRA](#).

Coinsurance: A percentage of a medical bill that you'll be responsible for paying.

Copayment: A fixed-dollar amount that you'll be required to pay when you receive medical services.

Covered Expenses: The medical services that your insurer has agreed to cover.

Deductible: The amount you'll be required to pay for health care expenses before your insurance plan will begin to reimburse you.

Exclusion: A specific circumstance or condition for which your policy will not provide a benefit.

Effective Date: This refers to the date on which your insurance plan will begin to provide coverage.

Fee-for-Service: An insurance payment model where doctors, hospitals, and clinics are paid for each service they provide. In Fee-For-Service plans, you often pay your doctor yourself, and file a claim to be reimbursed by your insurance plan.

HSA: An acronym for Health Savings Account. HSAs allow people to save tax-free income for health-related expenses. The savings in an HSA can be taken with you from job to job, and the funds accrue interest. To qualify for an HSA, you have to enroll in a high deductible health plan, or HDHP.

HDHP: An acronym for High Deductible Health Plan. Health insurance plans with a deductible of at least \$1,100 for individuals and \$2,200 for families are considered HDHPs.

HIPAA: The short name of the Health Insurance Portability and Accountability Act, passed by Congress in 1996. HIPAA has two sections. Title I makes it easier for people to remain covered for all their health needs when changing jobs. Title II sets standards for the safe-keeping of personal medical information. You can learn more at the U.S. Department of Health and Human Service's [HIPAA page](#).

HMO: An acronym for Health Maintenance Organization. HMOs are popular prepaid health benefit programs. With an HMO, you'll pay monthly premiums in return for coverage for your checkups, hospital stays, doctors' visits, surgery, emergency care, preventive care, lab tests, and X-rays. With an HMO, you'll have to receive care from the plan's network of doctors, hospitals, and other care providers.

In-network: Health care facilities or providers who are pre-approved members of your health plan.

Lifetime Maximum: The maximum level of benefits available through a policy. Many policies have lifetime limits of several millions of dollars.

LOS: An acronym for Length of Stay. It's used by insurance carriers and case managers to describe the length of time an individual spends in a hospital or an in-patient care facility.

Maximum Out-of-Pocket Expenses: The most you will have to pay during one year. Your out-of-pocket maximum is a measure of the deductible, copayments, and coinsurance you'll be responsible for.

Managed Care: A health insurance model that controls health care costs by creating pre-approved networks of care providers, negotiating discounts, and reviewing health care usage by plan members.

Medicaid: A joint program administered by the Federal government and local state governments. It provides health coverage for low-income individuals, particularly pregnant women, children, and the disabled.

Medicare: This is a Federally-sponsored health care program that offers coverage for medical and hospital care primarily to those over the age of sixty-five, and people with certain disabilities.

Network: This refers to the groups of doctors, hospitals and other medical professionals who have been contracted to provide discounted health care services to an insurance plan's members.

Out-of-Network: Any doctors, hospitals, or other health care providers that don't participate in your managed care insurance plan. Depending on your plan's guidelines, services provided by out-of-network providers may not be covered, or only covered in part.

POS: An acronym for Point-of-Service Plan. POS plans are a form of managed care that combines the features of a Health Maintenance Organization and a Preferred Provider Organization. These plans offer coverage for both in-network and out-of-network providers.

Pre-existing Conditions: Any health problems you had prior to your insurance plan's effective date. Many policies don't cover pre-existing conditions, or have a waiting period before coverage for that condition starts.

PPO: An acronym for Preferred Provider Organization. In PPO plans, networks of health care providers offer discounts on medical services. You'll receive coverage for care from out-of-network providers, but there are financial incentives for you to select providers within your PPO network.

Preventive Care: Health services that focus on preventing illness. Preventive care includes physical exams, immunizations, diagnostic tests, and mammograms.

Premium: The dollar amount you'll pay on a monthly basis to keep your insurance coverage in effect.

Primary Care Physician: A doctor who serves as your main point of contact with the health care system, providing routine care and referrals to specialists when necessary. Most HMOs and POS plans will require you to select a primary care physician. Primary care physicians are typically general practitioners, pediatricians, or OB/GYNs.

Provider: Any health care professional or institution that provides you with care.

Rider: A policy attachment that makes additions or changes to your original insurance plan.

Short-Term Health Insurance: A type of health care plan that provides you with benefits for a limited period of time. Short-term plans usually cannot be renewed.

Small Business Health Insurance: Health insurance plans that are available to businesses employing between two and fifty employees. It offers discounted premiums to employees and tax advantages to small business owners.

Waiting Period: A pre-specified time period during which you will not be covered by your insurance for a particular health care issue.

Appendix C.

State Government Resources

Alabama Department of Insurance

<http://www.aldoi.gov/>

Alaska Division of Insurance – Consumer Information

<http://www.dced.state.ak.us/insurance/consumerinfo.htm>

Arizona Department of Insurance – Consumer Resources

<http://www.id.state.az.us/consumerlifehealth.html>

Arkansas Insurance Department – Consumer Services Division

<http://www.insurance.arkansas.gov/Consumers/divpage.htm>

California Department of Insurance – Consumer Division

<http://www.insurance.ca.gov/0100-consumers/>

Colorado Division of Insurance

<http://www.dora.state.co.us/Insurance/>

Connecticut Insurance Department – Consumer Affairs Division

<http://www.ct.gov/cid/cwp/view.asp?a=1272&Q=254350&cidPNavCtr=#39394>

Delaware Department of Insurance – Consumer Services

<http://www.state.de.us/inscom/departments/consumer/consumerhp.shtml>

Florida Department of Financial Services – Division of Consumer Services

<http://www.fldfs.com/Consumers/>

Georgia Insurance and Safety Fire Commissioner

<http://www.gainsurance.org/>

Hawaii Department of Commerce and Consumer Affairs – Consumer Information

http://www.hawaii.gov/dcca/areas/ins/consumer/consumer_information/

Idaho Department of Insurance

<http://www.doi.idaho.gov/>

Illinois Division of Insurance – Consumer Information

http://www.idfpr.com/DOI/Main/consumer_info.asp

Indiana Department of Insurance

<http://www.in.gov/idoi/>

Iowa Insurance Division – Consumer Affairs Bureau

http://www.iid.state.ia.us/about_us/consumer.asp

Kansas Department of Insurance – Consumer Services

<http://www.ksinsurance.org/consumers/consumer.htm>

Kentucky Office of Insurance – Insurance Consumer Page

<http://doi.ppr.ky.gov/kentucky/quickLink.asp?DIVID=5>

Louisiana Department of Insurance – Consumer Information

<http://www.lidi.state.la.us/consumers/index.htm>

Maine Bureau of Insurance – Consumer Information

<http://www.maine.gov/pfr/insurance/consumer/index.htm>

Maryland Insurance Administration

<http://www.mdinsurance.state.md.us/sa/jsp/Mia.jsp>

Massachusetts Office of Consumer Affairs and Business Regulation – Insurance Information

<http://www.mass.gov/?pageID=ocatic&L=3&L0=Home&L1=Consumer&L2=Insurance&sid=Eoca>

Michigan Department of Labor and Economic Growth – Financial and Insurance Services

http://www.michigan.gov/cis/0,1607,7-154-10555_12902---,00.html

Minnesota Department of Commerce

<http://www.state.mn.us/portal/mn/jsp/home.do?agency=Commerce>

Mississippi Insurance Department

<http://www.mid.state.ms.us/>

Missouri Department of Insurance, Financial Institutions, and Professional Registration –
Consumer Services

<http://insurance.mo.gov/consumer/index.htm>

Montana State Auditor’s Office – Insurance Division

<http://sao.mt.gov/insurance/index.asp>

Nebraska Department of Insurance – Consumer Information

<http://www.doi.ne.gov/consumer.htm>

Nevada Division of Insurance – Consumer Services

<http://doi.state.nv.us/CS-WhatCanWeDo.htm>

New Hampshire Insurance Department – Consumer Services

<http://www.nh.gov/insurance/consumers/index.htm>

New Jersey Department of Banking and Insurance – Consumer Information

<http://www.state.nj.us/dobi/consmnu.shtml>

New Mexico Public Regulation Commission – Insurance Division

<http://www.nmprc.state.nm.us/id.htm>

New York Insurance Department – Information for Consumers

<http://www.ins.state.ny.us/consindx.htm>

North Carolina Department of Insurance – Services for Consumers

http://www.ncdoi.com/Consumer/consumer_home.asp

North Dakota Insurance Department – Consumer Information

<https://www.state.nd.us/ndins/consumer/details.asp?ID=58>

Ohio Department of Insurance – Consumer Services

<http://www.ohioinsurance.gov/ConsumServ/ConServIndex.asp>

Oklahoma Insurance Department – Consumer Assistance

http://www.ok.gov/oid/Consumers/Consumer_Assistance/Consumer_Assistance_Claims/index.html

Oregon Department of Consumer and Business Services – Insurance Division

<http://www.cbs.state.or.us/ins/consumer/consumer.html>

Pennsylvania Insurance Department – Bureau of Consumer Services

<http://www.ins.state.pa.us/ins/cwp/view.asp?a=1281&Q=544190>

Rhode Island Department of Business Regulation – Office of the Health Insurance Commissioner

<http://www.dbr.state.ri.us/divisions/healthinsurance/>

South Carolina Department of Insurance

<http://www.doi.sc.gov/>

South Dakota Division of Insurance – Consumer Information

<http://www.state.sd.us/drr2/reg/insurance/consumer/index.html>

Tennessee Department of Commerce and Insurance – Consumer Resources

<http://www.state.tn.us/commerce/insurance/consumerRes.html>

Texas Department of Insurance – Consumer Information

<http://www.tdi.state.tx.us/consumer/index.html>

Utah Department of Insurance – Consumer Services

<http://www.insurance.utah.gov/>

Vermont Department of Banking, Insurance, Securities and Health Care Administration –
Consumer Help and Services

http://www.bishca.state.vt.us/InsurDiv/Consumer/consumer_information.htm

Virginia State Corporation Commission Bureau of Insurance – Consumer Assistance

<http://www.scc.virginia.gov/division/boi/webpages/boiconsumer.htm>

Washington State Office of the Insurance Commissioner

<http://www.insurance.wa.gov/>

West Virginia Offices of the Insurance Commissioner – Consumer Services

http://www.wvinsurance.gov/consumer/consumer_services.htm

Wisconsin Office of the Commissioner of Insurance – Consumer Information

<http://oci.wi.gov/consinfo.htm>

Wyoming Insurance Department – Consumer Assistance

<http://insurance.state.wy.us/consumer.html>

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