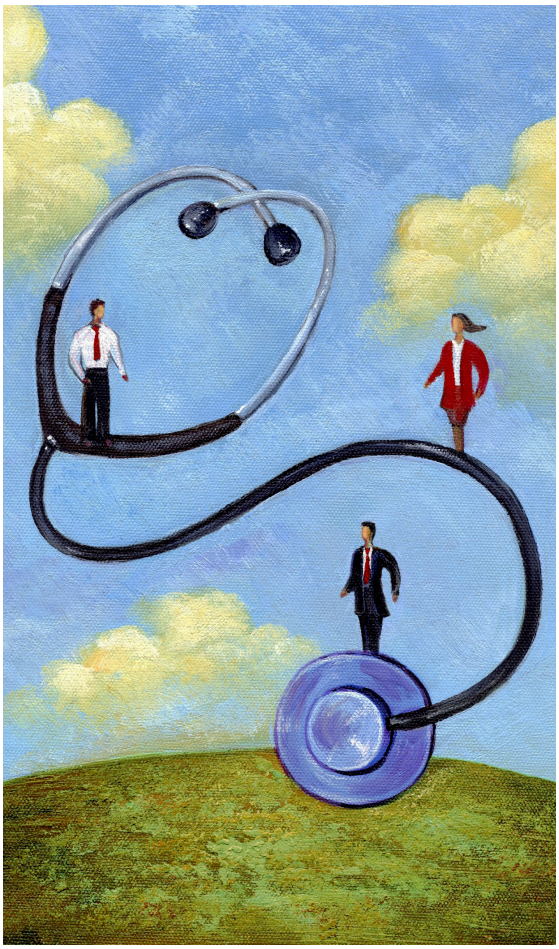
5 questions to ask

when you're shopping for an individual health plan

Making any major purchase can be difficult. But choosing individual health insurance can be particularly difficult because it touches the things that matter most: your family's health and finances. Here are five questions to ask yourself when you're shopping for a health plan.



1. Do I want short-term or long-term coverage?

Decide whether you want coverage for the long haul or for a set period – for instance, for a few months before your new employer's insurance starts. If you choose a long-term plan, your coverage is guaranteed renewable. If you choose a short-term plan, it may be easier to apply and your coverage may start faster – but you can't renew your plan when your coverage ends.

2. How much am I prepared to pay out of my own pocket?

Health insurance premiums work similar to car insurance premiums: the higher your deductible, the lower your premium. The key is to find a balance between the deductible you're prepared to pay and the premium you can afford.

If you want a higher deductible, but you're concerned about saving enough to cover it, consider a plan that's compatible with a Health Savings Account (HSA). An HSA is yours to keep from year to year and you can raise your deductible as your savings grow.

3. Are my doctors in the network?

Most individual health plans are preferred provider organization – or "PPO" – plans. When you go to a "preferred" or "in-network" provider in your plan's network:

- Your plan covers a larger share of the costs
- The provider can't "balance bill" you for amounts over what the plan allows

If you want certain doctors, make sure they're in the network for the plan you're considering. If you don't want specific doctors, but you still want to get the most value from your insurance, look for a plan with lots of network providers in your area.

4. How do I want to pay for doctor's office visits?

You're probably familiar with copayments – set amounts you pay directly to providers when you get medical care. When you shop for individual health insurance, you'll probably have a choice of plans. Some have copayments for doctor's visits, while others require you to meet a deductible first. The type of plan you choose is a matter of personal preference.

5. What optional coverage do I need?

With most employer-based health insurance, things like vision and dental coverage may be part of the plan. But this coverage is optional with many individual health plans and may cost additional monthly premium. Also, you may be able to add coverage for accidents or life insurance for also an additional charge.

Continued on back ›

Whatever plan you choose, it's important to understand what you've bought. Here's a simple guide to how health insurance works.

Understanding how health insurance works can help you choose the right plan for your family – and help you use your plan with confidence. Here's an overview of how a standard PPO plan works.

When you go to a doctor, hospital, or other healthcare provider, the office staff asks for your health insurance ID card. The card gives providers the information they need to submit a bill to the insurance company. The provider's bill includes itemized codes for each service you received. Codes are standard across the United States for every provider service.

After providers submit charges, the bill becomes a claim – a request for payment from your insurance company. Claim processing is basically a series of questions:

- **Is the provider in the network?**

  If you went to a doctor in your plan's network, your share of the costs is based on the amount the provider has agreed to with the insurance company. If the provider isn't in your network, the claim is calculated according to what a provider would charge. An out-of-network provider can bill you for the amount over what your insurer pays to network providers.

- **Is the service covered?**

  The insurance company looks at the services you received – based on the codes the provider submitted – and determines whether your plan provides benefits for the services. For a covered service, your plan specifies a certain payment level. If it isn't covered, you're responsible for the charges.

- **Have you met your deductible?**

  Generally, you have to pay for a set amount of healthcare on your own before your plan pays for most services. If you haven't reached that amount, called a deductible, the insurance company asks the provider to bill you for the charges – minus the copayment if you paid one. If you've met your deductible, your plan pays coinsurance – a percentage of the remaining charges – and you pay the rest.

- **Have you met your coinsurance out-of-pocket maximum?**

  Once you've paid a certain amount out of your own pocket, your insurance pays 100% of covered services from providers in the plan's network for the rest of the year. It's important to note that copayments for things like office visits and prescription drugs usually don't apply to the out-of-pocket maximum. And sometimes the deductible doesn't either.

After your claim is processed, your insurer provides an Explanation of Benefits (EOB). The EOB summarizes what your plan paid and what part of the charges, if any, you'll need to pay.

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