Health Insurance FAQ

What are the principal types of medical expense insurance coverage?

Major medical plans are available in 3 basic forms: HMO, Point of Service (POS) and Preferred Provider Organization (PPO).

POS and PPO offer generous in-network coverage with low coinsurance costs. They also offer out-of-network coverage which applies a deductible to initial expenses, generally ranging from $250 to $1000 per calendar year. After the deductible is satisfied, major medical plans typically reimburse 70% or 80% of eligible expenses up to a relatively high maximum, e.g. unlimited in-network or $5,000,000 out-of-network. Major medical plans typically cover a broad list of medical expenditures, including hospital expense, surgical expense, physician (non-surgical) expense, private duty nursing, diagnostic x-ray and laboratory services, prescription drug expenses, artificial limbs and organs, ambulance services, and many other types of medical expenses when prescribed by a duly licensed physician.

HMO plans offer the same generous in-network benefits, but do not include payments to providers outside of their netowrk.

We can quote all types so that you can choose the right plan for your company.

Is medical expense coverage available for substance abuse and mental illness?

Major medical expense plans also generally provide coverage for treatment of substance abuse (e.g., alcoholism and drug usage) and mental illness. A higher coinsurance percentage (e.g., 50 percent) and a lower lifetime benefit limit (e.g., $25,000 or $50,000) generally applies, however. In addition, the extent of coverage may depend on whether treatment is provided on an inpatient or outpatient basis.

What types of expenditures are commonly excluded under major medical expense plans?

Although providing very broad coverage, major medical plans typically contain a number of exclusions. Common exclusions include medical expenditures arising from:

(1) convalescent or custodial care;
(2) physical examinations, unless required for the treatment of an injury or illness (it should be noted that some plans now cover this expenditure);
(3) cosmetic surgery unless required to correct a condition resulting from an injury or a birth defect; (4) occupational injuries and illnesses that are otherwise covered under a Workers' Compensation law; and
(5) routine dental and vision care (care required for treatment of an injury and dental and eye surgery are frequently covered, however).

Other common exclusions relate to benefits provided by government agencies (e.g., VA hospitals) and expenses paid under other insurance programs, including Medicare and Personal Injury Protection Coverage under your Personal Automobile Policy.

Even though major medical plans provide broad coverage, insureds still incur certain "out-of-pocket" costs. What are these costs?

An insured's "out-of-pocket" costs under major medical expense plans include the deductible, cost-sharing amounts arising from the operation of the coinsurance clause, and medical expenditures that are deemed by the plan to be in excess of "reasonable and customary" charges.

Only charges that are "reasonable and customary" for a specific type of service, in a particular location or geographic area, are eligible for reimbursement under medical expense plans. The definition of "reasonable and customary" may vary somewhat from one medical expense plan to another.

What is the coinsurance clause in medical expense plans and how does it work?

Coinsurance, sometimes called "percentage participation," requires the insured to share in the cost of medical care. Under an 80/20 coinsurance provision, the medical expense plan pays 80 percent of eligible medical charges above any deductible. The insured is required to pay the remaining 20 percent. Other coinsurance arrangements, e.g. 70/30, are sometimes used.

In the event of large or catastrophic medical expenses, an insured might suffer severe financial hardship due to the operation of the coinsurance clause. To compensate for this possibility, many major medical expense plans contain a coinsurance cap, or stop-loss limit. This provision places a limit on the insured's out-of-pocket costs in a given year arising from the operation of the coinsurance clause. The size of the coinsurance cap generally ranges from $2,000 to $3,000, depending on the plan. Once the coinsurance cap has been reached, all eligible expenses above this amount are paid in full, up to the plan's overall limit of coverage.

What is the difference between coinsurance and co-payment?

On occasion, these terms have been used interchangeably. However, it is preferable to define the two terms differently, despite their similarity of purpose. Under a CO-payment or co-pay provision, the insured usually is required to pay a set or fixed dollar amount (e.g., $10, $15, or $20) each time a particular medical service is used. Co-pay provisions are frequently found in medical plans offered by health maintenance organizations (HMOs) where a nominal CO-payment is applied to each office visit and to each prescription that is filled.

What is a preexisting conditions clause and what is the effect of its inclusion in major medical expense plans?

A preexisting condition is often defined as a medical condition (i.e., an injury or illness) that required treatment during a prescribed period of time, e.g., 3 or 6 months, prior to the insured's effective date of coverage under the major medical expense plan.

Sometimes, a preexisting condition is defined to include medical conditions that were known to the insured, even though no treatment was provided during the prescribed period. A preexisting conditions clause excludes coverage for preexisting conditions for possibly as long as 12 months after the effective date of coverage.

Because the definition of a preexisting condition, and the provisions of the clause itself, may differ considerably from one plan to another, it is recommended that newly insured individuals (and prospective insureds) completely familiarize themselves with this policy provision.

How does the medical expense coverage offered by Health Maintenance Organizations (HMOs) differ from the coverage provided under basic and major medical expense plans?

Major medical expense plans are generally classified as indemnity contracts. These plans indemnify, or reimburse, the insured for medical expenses incurred and typically require the completion and filing of claim forms. In addition, these plans usually contain deductible and coinsurance cost sharing provisions and may restrict coverage for certain types of medical care expenditures. Indemnity plans, however, provide the insured

with substantial freedom relative to the choice of physician, including whether a primary care physician or a specialist will be seen.

In contrast, HMO coverage emphasizes comprehensive (including preventive) care and typically contains very few exclusions, no deductibles, and nominal co-payments. However, there is much less freedom of choice of physician under traditional HMO coverage since the patient is typically required to be under the care of a primary care physician who serves as a "gatekeeper." In this role the primary care physician determines whether the services of a specialist are needed, in addition to determining what other medical services are required for treatment. Some HMOs today offer a point-of-service option, whereby patients may opt for indemnity type coverage (with a deductible and coinsurance) when they desire medical treatment outside the HMO network.