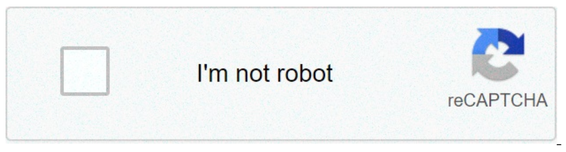

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The health of Americans has continued to decline for decades causing a rise in insurance premiums. To combat this problem, businesses and insurance companies are implementing wellness programs offering incentives for employees to get healthy.By Melissa JeffriesMost people with pre-existing conditions have a hard time finding health insurance. That's where high-risk health insurance pools come in. After all, if you're sick, you still need your medication.By Melissa JeffriesIn the olden days, if you had surgery or had an accident, you could have spend several days -- or even weeks -- in the hospital. Today, you could be out in a matter of hours.By Melissa JeffriesHow does a pre-existing condition affect your health coverage? There is no easy answer to this question -- it all depends on the specific condition, the health plan and your health insurance history.A health insurance exclusion refers to anything an insurance plan doesn't cover, from drugs to surgeries. Exclusions can vary, so it's essential that you get to know the details of your plan.Utilization review is a health insurance company's opportunity to review a request for medical treatment. The purpose of the review is to confirm that the plan provides coverage for your medical services.By Melissa JeffriesPreferred provider organizations (PPOs) are the fastest-growing kind of health care plan. With more than 158 million Americans enrolled in a PPO this year, this plan has become the choice of more than half of all Americans with health insurance coverage.By Melissa JeffriesChoosing the proper insurance plan is a huge decision. To find out what kind of coverage you need, and to avoid paying for what you don't, there are several questions you should carefully consider before you sign on the dotted line.By Melissa JeffriesThanks to advances in technology, more and more medical treatments are being made on an outpatient basis. But what qualifies as an outpatient service? How do they differ from inpatient benefits, and what does that mean for your insurance coverage?By Melissa JeffriesCoinsurance is used in several different types of insurance, from property to health. The basic concept is that you and your insurance company share the risks.By Melissa JeffriesA provider network is a list of physicians, hospitals and other providers that offer health care services to patients in a managed-care insurance plan. Managed-care plans are usually more affordable than other kinds of plans -- but they limit your freedom to choose your own doctors.By Melissa JeffriesYou've probably wondered what happens to all those forms you fill out at the doctor's office. Where do they go next -- and what happens if your insurance claim is denied?By Melissa Jeffries Health insurance is a type of insurance coverage that pays for health and medical expenses. Health insurance covers some or all of the costs of routine care, emergency care, and treatment for chronic illnesses. In the United States, health insurance is often provided by employers as part of a benefits package, while Medicare and Medicaid provide retired and low-income citizens with health insurance coverage.Deeper definitionHealth insurance companies charge their customers a monthly premium for coverage, and in exchange the company agrees to pay all or most of the person’s medical costs. Even under the most generous plans, insured people must pay various out-of-pocket expenses for medical care. Primarily these expenses include copays and deductibles, which are up-front costs paid by the insured to medical professionals before they receive services.Health insurance plans fall into two broad categories: private insurance and public insurance. Private plans are available from health insurance companies and are most commonly obtained through employers. Some of the top private insurance companies in the U.S. include: UnitedHealth Group Humana Anthem Cigna Blue Cross/Blue Shield Wellpoint In contrast, public insurance is provided by the government to eligible individuals and families. Medicaid is a state-run government insurance plan offered at little to no cost to low-income people. Who qualifies and the coverage available varies from state to state. Medicare is available to all Americans over the age of 65 and people with certain disabilities. Medicare only covers a portion of medical expenses, and individuals often need supplemental coverage to go along with it.The Affordable Care Act (ACA), passed by Congress and signed into law by President Barack Obama in 2010, has materially altered the provision of health insurance in the U.S. over the last decade. The ACA sought to reform the medical care system, to extend health insurance to all uninsured Americans, and to lower health care costs.The following terms are commonly used to describe different parts of health insurance policies: Co-insurance: The percentage of health care costs that the insured must pay, even after they meet the deductible. For example, after meeting the deductible, the insured may be responsible for 20 percent of costs and the insurance company covers the other 80 percent. Provider: The physician, health care professional or facility that provides medical services to the insured. A primary care physician is the doctor that oversees the patient’s overall care and manages a wide range of services. Network: The providers and facilities contracted to provide health care services for patients who have coverage with certain insurance plans. Preauthorization: Prior approval from a health insurance company required before a patient can access certain health care services, medications or equipment. Do you have more questions about health insurance? Check out Bankrate’s comprehensive health insurance FAQ. Health insurance exampleThe five main types of private health insurance plans available in the U.S. are: Health maintenance organization (HMO) Preferred provider organization (PPO) High-deductible health plan (HDHP) Point-of-service plans (POS) Exclusive provider organization plans (EPO) These plans offer varying amounts of flexibility to consumers. Some allow patients to visit any doctor they choose, while others only allow patients to visit doctors within a small network. The amount that the insured has to pay for premiums also varies. Home > Navigating Cancer Care > Financial Considerations > Health Insurance In the United States, insurance provides access to health care. Health insurance can help reduce the amount you need to pay for cancer care. Most people get health insurance in 1 of 2 ways: Through an employer Through a government program. Government health insurance options include Medicare and Medicaid. But some people do not receive health insurance at work. Others do not qualify for Medicare or Medicaid. If this is your situation, visit www.HealthCare.gov. The website will outline options for purchasing health insurance. Or call 800-318-2596 (TTY: 855-889-4325). These options are available because of the 2010 Patient Protection and Affordable Care Act (ACA). This law also changed U.S. health care insurance coverage rules. Types of private health insurance Medical costs that you have to pay for out of pocket will depend on the type of insurance that you have. This glossary may help you explore the following insurance types and commonly used health insurance words. Private health insurance Private health insurers use different care models. Two common types are: Health maintenance organizations (HMOs) Preferred provider organizations (PPOs) HMO. This type of model covers costs within a network of contracted health care providers. People choose a primary care doctor within the network. That doctor oversees a person's health. And he or she refers the person to specialists when needed. HMOs often have the lowest patient costs for private health insurance. But HMOs generally limit coverage in these ways: You have fewer choices of doctors and hospitals. Only doctors and hospitals contracted with the HMO are covered under the plan. But insurance companies may make exceptions for emergencies and medical necessity. Access to a specialist requires a referral from your primary care doctor. You may need precertification for some services, such as non-emergency hospital visits and some specialist care. Precertification means getting the HMO’s approval before receiving care. HMOs also may require notification within 24 hours of emergency care. Some types of services may not be covered. PPO. This model contracts health care providers to offer services at a lower cost. Providers include doctors, hospitals, and other health care professionals. PPOs typically have a larger pool of in-network doctors than HMOs. Most medical costs are covered when visiting in-network doctors. You only pay a small set fee. This is called a co-payment or co-pay. Also, PPOs allow visits to any doctor without a referral. PPOs may provide freedom to visit out-of-network doctors. But you may pay a larger portion of the bill. PPOs may limit coverage in these ways: You may need precertification for some types of care. That is more likely with out-of-network care. Some types of service may not be covered. Savings accounts Flexible Savings Accounts (FSAs) and Health Savings Accounts (HSAs) are 2 types of special bank accounts. They help you plan for medical expenses and receive tax benefits. Many employers offer these through private health insurance plans. FSAs. You reserve a portion of your paycheck throughout the year. It is pre-tax money to use for out-of-pocket medical expenses. You decide the amount based on your estimated annual expenses. Some plans provide an FSA debit card. For others, you pay first and submit your receipts for reimbursement. At the year end, any unused funds will be lost. HSAs. The funds you put in an HSA do not expire. Unused funds remain in your account for the next year. You may keep the account after leaving a job. You also have the option to invest the money. But only high-deductible health insurance plans offer HSAs. With a high-deductible health plan, you are responsible for 100% of costs until meeting a deductible. Usually, this deductible is several thousand dollars. After you reach this amount, your insurance will pay 100% of covered medical services. You start with a new deductible each year. Government-sponsored insurance programs Medicare. Medicare is the federal health insurance program. It covers people 65 and older and some disabled Americans. It has different parts. Medicare Part A covers these costs: Inpatient care Skilled nursing care Hospice care Some home care services Medicare Part B covers these costs: Physician services Outpatient care Physical and occupational therapy Many cancer drugs given in outpatient medical offices and clinics Selected supplies that are deemed “medically necessary” You are not required to enroll in Part B. But if you enroll later, you may face a late-enrollment fee. Medicare Part C is also called Medicare Advantage. It allows Medicare-approved companies to provide Part A and B benefits. Sometimes, Medicare Advantage plans include Part D benefits. Medicare Part D is a voluntary prescription drug benefit. It covers prescription drugs not otherwise covered under Medicare Parts A or B. Medicare does not cover all health care expenses. As a result, some people purchase supplemental insurance policies. These may be private insurance products called “Medigap” policies. Medicaid. The federal and state governments both fund Medicaid. Each state has its own program. This means eligibility and services are different for each state. Traditionally, Medicaid has covered low-income people who are older or have a disability. It may also cover certain people with dependent children. Some states elected to expand Medicaid under the ACA. These states may provide coverage for other low-income adults. Find more information about Medicare and Medicaid at www.cms.gov and www.medicare.gov. Visit www.HealthCare.gov for information about Medicare and Medicaid under the ACA. Other types of insurance Health insurance covers some costs of cancer care. But typically, one plan does not cover all the costs. Other types of insurance are available to cover additional expenses. Supplemental insurance. This helps cover expenses not covered by your primary insurance. Or it may cover costs you pay within your existing plan, including: Deductibles Co-insurance Co-payments Other out-of-pocket expenses Supplemental insurance may also offer other benefits. For example, some plans cover for income lost from missed work. Disability insurance. This replaces income lost if health issues keep you from working. Qualifying health issues include long-term illnesses and injuries. Typically, employers and government-sponsored programs provide disability insurance. But individual policies are also available. Hospital indemnity insurance. This provides limited coverage for hospital stays. It is usually a fixed amount for each day. And it is usually capped at a maximum length of stay. This particularly benefits people with a basic insurance plan that limits coverage of hospital care. Long-term care insurance. This provides coverage to offset costs of long-term care, such as nursing home care. Most private insurance plans and Medicare provide limited long-term care coverage. How insurance works It is important to understand an insurance plan’s benefits and limitations. The following examples show how co-pays, co-insurance, and deductibles work. You should also talk with a representative of your insurance provider. He or she can explain the details of your specific plan. Example #1: Co-pays Anna needs to see 2 specialists this week. Dr. Martinez charges $100 per visit. Meanwhile, Dr. Jones charges $500 per visit. Anna’s insurance requires her to pay a $20 co-pay to visit a specialist. How much will the doctors charge her for the appointments? Answer: Anna's out-of-pocket costs will be $20 for each appointment. That is a total of $40. Co-payments are a set amount. This means Anna’s payment does not depend on the bill amount. Example #2: Co-insurance Martin needs to see 2 specialists this week. Dr. Andrews charges $100 per visit. Meanwhile, Dr. Lee charges $500 per visit. Martin’s insurance requires a 20% co-insurance for specialist visits. How much will the doctors charge him for the appointments? Answer: Martin will pay Dr. Andrews $20. He will pay Dr. Lee $100. A co-insurance payment is calculated by multiplying each bill by the co-insurance percentage. It is not a set amount like a co-pay. Dr. Andrews will charge Martin $20 because $100 x 20% = $20. Dr. Adams will charge Martin $100 because $500 x 20% = $100. Example #3: Co-insurance and deductibles Jasmine has a deductible of $2,000 a year. And she has not had any medical expenses yet this year. Her co-insurance for a hospital visit is 20%. She recently had a surgery that cost $10,000. How much will she need to pay? Answer: Jasmine will pay $3,600 out of pocket for her procedure. The steps below explain how: STEP ONE. Subtract the deductible from the total bill: $10,000 – $2,000 = $8,000. STEP TWO. Multiply the difference by the co-insurance percentage: $8,000 x 20% = $1,600. This gives Jasmine’s co-insurance amount. STEP THREE. Add the deductible and the co-insurance amounts. $2,000 + $1,600 = $3,600. What happens if Jasmine has another identical surgery within the same year? She already paid her deductible. Thus, she would have only the co-insurance payment. That would be $2,000 because $10,000 x 20% = $2,000. Taxes Some medical expenses not covered by insurance can be deducted from federal income taxes. Examples of expenses that may be tax-deductible are: Mileage for trips to and from appointments Prescription drugs Meals during lengthy medical visits A tax advisor can explain rules about medical expense deductions. 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