Connecticut Institute of Finance
Bob Walsh
4749 Main St.
Bridgeport, CT 06606
203-371-4242
203-371-2232 (Fax)
rwalsh@americanportfolios.com

centaurus financial inc.

Health Insurance Made Simple

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Let's face it--in today's world, health insurance is a necessity. In fact, most U.S. citizens and legal residents must have qualifying health insurance or face a penalty tax. Yet the cost of medical care is soaring higher every year, and it's becoming increasingly difficult (and in some cases, impossible) to pay medical costs out of pocket. Whether you already have health insurance or want to get it, here's some basic information to help you understand it.

Not part of a group? You may have to go it alone

You may have group health insurance or be able to buy it through your employer. Group insurance is most commonly offered through employers. It is also offered through some civic groups and other organizations (e.g., auto clubs, chambers of commerce). A single policy covers the medical expenses of a group of people. All eligible members of the group can be covered by a group policy regardless of age or physical condition. The premium for group insurance is calculated based on characteristics of the group as a whole, such as average age and degree of occupational hazard. It's generally less expensive than individual insurance.

If you can't join a group, consider buying individual insurance. Unlike group insurance, individual insurance is purchased directly from an insurance company or agent. When you apply, you are evaluated in terms of how much risk you present to the insurance company. Your risk potential will determine whether you qualify for insurance and how much it will cost, depending on state laws. You must pay the full premiums yourself.

If you have to go it alone, you can shop for health insurance coverage through state-based Affordable Insurance Marketplaces. You can compare health plans according to price and quality, and ultimately purchase an affordable plan that best meets your health insurance needs.

Know what's out there

The cost and range of protection that your health insurance provides will depend on your insurance provider and the particular policy you purchase. You may have comprehensive health insurance that involves several types of coverage, or basic coverage that includes hospital, surgical, and physicians' expenses. In addition, major medical coverage is necessary in the event of a catastrophic accident or illness. Many plans also cover prescriptions, mental health services, and other health-related activities (e.g., health-club memberships).

When it comes to health insurance, HMO, PPO, and POS are more than just letters. You need to know the types of health plans available so that you can make an informed decision. You can obtain health insurance through traditional insurers like Blue Cross/Blue Shield, health maintenance organizations (HMOs), preferred provider organizations (PPOs), point of service (POS) plans, and exclusive provider organizations (EPOs).

- Traditional insurers: These plans usually allow you flexibility regarding choice of doctors and other health-care providers. Some policies reimburse you for covered expenses, while others make payments directly to medical providers. You will pay a deductible and a percentage of each bill, known as coinsurance.

- HMOs: Health maintenance organizations cover only medical treatment provided by physicians and facilities within their networks. You must choose a primary care physician, who will either approve or deny any requests to see a specialist. You usually pay a fixed monthly fee for health-care coverage, as well as small co-payments (e.g., $10 for each office visit and prescription).

- PPOs: Preferred provider organizations do not require members to seek care from PPO physicians and hospitals, but there is usually strong financial incentive to do so (in terms of percentage of reimbursement). You usually pay a fixed monthly fee for health-care coverage, as well as small co-payments (e.g., $10 for each office visit and prescription).

- POSs: Point of service plans combine characteristics of the HMO and PPO. You must choose a primary care physician to be responsible for all of your referrals within the POS network. Although you can choose to go outside the network with this type of plan, your health care will be covered at a lower level.

- EPOs: Exclusive provider organizations are basically PPOs with one important difference: EPOs provide

no coverage for non-network care.

• Read your contract

- You should have a basic understanding of what your policy does and does not cover. This may help you prevent an unexpected medical bill from arriving in your mailbox, because you'll know ahead of time, for instance, whether or not liposuction is covered. You must read your policy carefully, particularly the section on limitations and exclusions. The specifics will vary from policy to policy. In general, though, most policies will at least mention the following:

- Pre-existing conditions: An illness or injury that began or occurred before you obtained coverage under the policy. The Affordable Care Act eliminated the ability of a health insurance policy or plan covering essential health conditions to deny coverage for pre-existing conditions. However, pre-existing conditions may be imposed for other than essential health benefits.

- Nonduplication of benefits: Benefits will not be paid for amounts reimbursed by other insurance companies.

- Your health insurance policy should also address the following issues:

- Deductible: The amount that you must pay before insurance coverage begins (usually an annual figure

- Coinsurance: The portion of each medical bill for which you are responsible

- Co-payment: The fixed fee that you pay for each doctor visit or prescription

- Family coverage: Many group plans allow you to cover your spouse and dependents for an increased premium

- Out-of-pocket maximum: This provision is designed to limit your liability for medical expenses in the calendar year; you won't have to make coinsurance payments in excess of this figure

- Benefit ceiling: The maximum lifetime payout under the insurance policy, usually at least $1 million

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