

Health Insurance Choices

With the ever-increasing cost of health care, health insurance is a necessity to protecting one's financial stability. But having good health insurance often means making choices.

If you're not covered by group insurance on the job, your first choice is the kind of individual health policy to buy. If your budget for premium dollars is limited, concentrate them for maximum protection by buying a major medical policy with the highest possible lifetime coverage and the lowest deductible you can afford. It's the extraordinary cost of major illness that can wipe out a family budget after all, not the ordinary costs of checkups and the flu.

If you are covered by group insurance on the job, as most people are, you may still be presented with a choice. More and more employers today are offering choices among health care plans, both when you first start work and then in an annual open enrollment period.

The basic choices are usually between a fee for service (FFS), a traditional health insurance package, and some form of managed care program. The managed care plan could be in the form of a health maintenance organization (HMO), preferred provider organization (PPO), and point of service plans (POS)

If you have the opportunity to make this choice, here's what you should know:

- Traditional or FFS health insurance reimburses you for designated out-of-pocket expenses, subject to deductibles (the dollar amount you must pay before any insurance is payable) and co-insurance (the proportion you must pay of each subsequent bill, typically 20 percent, up to a specified ceiling). You can go to doctors and hospitals of your choice, but you frequently must spend the money and then file a claim for reimbursement. And preventive care, such as annual checkups, is often not covered at all.
- HMOs provide care as well as pay for it. This means that you must go to doctors and hospitals designated by the HMO, either in the HMO's own building or in the private offices of physicians affiliated with an HMO network. You receive total care, for checkups and preventive care as well as treatment, for a fee that is

typically \$5 to \$10 per visit. But you should inquire about care when you are away from home.

- POS and PPOs, offer what may be the best of both worlds. You can go to a participating physician in the PPO or POS network and receive HMO-type care at little or no cost. To receive the plan's highest level of benefits, however, you must choose a doctor or hospital within the "network." If you choose a provider *outside* the network, you will have to pay the difference in costs. A POS plan usually requires you to select a primary care physician, who acts as a "gatekeeper" to control and direct all of your care. This doctor will refer you to specialists, if needed.

When comparing different plans, get the "summary plan descriptions" from your employer or health insurance agent. These will allow you to compare the various types of medical coverage and costs. While these descriptions can be tedious reading, they'll answer most of your questions. You can also get a lot of information from your health insurance agent, or the main office of the plans you are considering. Also talk to co-workers and see what's worked best for them.

SOME THINGS TO CHECK OUT

Is your current doctor a member of the plan? If not, are you willing to choose a new doctor? Will your relationship with your doctor change depending on your plan choice?

Does the plan require that you choose and use a primary care physician? How easy is it to change primary care physicians, if you ever feel the need to?

Do you have to pay if you go *outside* the network for care? If so, how much, and can you afford it?

Is the plan's care readily accessible? That is, are the doctors and hospitals conveniently located for you? Are there long waits for appointments? How do you get emergency care? Are specialists available for medical problems that concern you?