

How does health insurance work?

By Sylvia Bittner

Health insurance is a contract between you and the insurance company that says the insurance company will pay a portion of your medical expenses if you're sick or injured and need medical care, and in exchange, you will pay the insurance company a premium each month. Some contracts also specify that the insurance company will pay a portion of your medical expenses to make sure you don't get sick, such as paying for annual physical exams, wellness visits and immunizations. The amount your insurance company will pay, and under what circumstances they'll pay is known as coverage and can differ significantly from policy to policy.

What you'll pay out-of-pocket

The contract spells out what portion of your medical expenses the insurance company will pay and how much you'll be required to pay out of your pocket. For example, a policy may cover office visits, but you may be required to pay a \$20 copayment per visit. Or the policy may not pay anything until you've paid a specified amount out of your pocket, which is known as a deductible. Deductibles can range from \$100 to \$10,000 annually. Be sure and ask how many deductibles are required per family if you're planning to cover your spouse and children on your policy. Generally, the higher the deductible, the lower your insurance premium will be.

Your policy may also require you to pay a percentage of the bill, known as a coinsurance, in addition to your deductible and copayment. Usually the coinsurance is capped at an annual maximum amount, at which point the insurance company would pay 100% of your covered benefits for the remainder of that calendar year.

Benefits may be limited

The contract will also state the total amount the insurance company will pay out in benefits for you over the life of the policy, or your lifetime benefit maximum. Usually this amount is \$1 million or more, but some plans limit you to as little as \$25,000 per year. To protect your assets in the event of a serious injury or illness, purchase a health care plan with a minimum of \$5 million lifetime benefit maximum.

The contract will include some other limitations too, so be sure and look for those. These may include a preexisting condition waiting period of up to a year for health conditions you already have, or a dollar limit on certain medical services like human organ transplants or mental health care.

Use participating providers

Your policy should also tell you if you're restricted to certain doctors, hospitals and other health care providers you can use for services. If it does, make sure your doctors participate with the plan you choose. Some plans require you to choose a primary care physician from their list of doctors and get advance approval (or a referral) to see a specialist. If you don't use providers who participate with the health insurance plan, you may have to pay a higher portion of the costs – or all costs – billed by those providers. And if your doctor charges more than the "usual and customary" fee for a particular service, you'll generally have to pay the difference between the amount the insurance company will pay and the amount the doctor charges, in addition to your deductible, coinsurance or copayments.

The bottom line is, don't purchase a health insurance plan without reading the fine print or it could be the most costly decision you ever make.

Sylvia Bittner is the Health Services Coordinator for Michigan Farm Bureau. Michigan Farm Bureau is a membership based association and the largest general farming organization in Michigan. For over 65 years, Michigan Farm Bureau has partnered with Blue Cross® Blue Shield® of Michigan to offer unique health insurance plans specifically for our members. For more information about Farm Bureau's health insurance plans and other member benefits, contact your local Farm Bureau Insurance agent or call 1-888-294-4335.