

## What is Health Insurance by Selected Benefits of Houston Texas

Health insurance is insurance that pays for medical expenses. It can encompass also to include insurance covering disability or long-term nursing or custodial care needs. Government-sponsored social insurance program, or from private insurance companies are the two ways it is administered. Group basis (e.g., by a firm to cover its employees) or purchased by individual consumers are the two ways it is disseminated to the consumer. Regardless of the classification groups or individuals pay premiums or taxes to help protect themselves from high or unexpected healthcare expenses. Similar benefits paying for medical expenses may also be provided through social welfare programs funded by the government.

### History and evolution

Health insurance was first proposed in 1694 by Hugh the Elder Chamberlen from the Peter Chamberlen family. Then late in the 19th century, "accident insurance" began to be available; also is described as disability insurance. This payment model continued until the start of the 20th century in some jurisdictions, where all laws regulating health insurance actually referred to disability insurance.

Franklin Health Assurance Company of Massachusetts was the first to introduce Accident Insurance. Founded in 1850 they offered insurance against injuries arising from railroad and steamboat accidents. As a result 60 organizations were offering accident insurance by 1866, however the industry contracted in the number of providers soon thereafter as a result of market forces.

Patients were expected to pay all other health care costs out of their own pockets before the inception of health insurance, under what is known as the fee-for-service business model. Traditional disability insurance evolved into modern health insurance programs during the middle of the twentieth century. Today, most comprehensive private health insurance programs cover the cost of routine, preventive, and emergency health care procedures, and most prescription drugs, but this was not always the case.

### How it works

A health insurance policy is a contract between an insurance company and an individual or his sponsor (e.g. an employer). The contract can be renewable annually or monthly. The type and amount of health care costs that will be covered by the health insurance company are specified in advance, in the member contract or "Evidence of Coverage" booklet. The individual insured person's obligations may take several forms.

**Premium:** The amount the policy-holder or his sponsor (e.g. an employer) pays to the health plan each month to purchase health coverage.

**Deductible:** The amount that the insured must pay out-of-pocket before the health insurer pays its share. For example, a policy-holder might have to pay a \$500 deductible per year, before any of their health care is covered by the health insurer. It may take several doctor's visits or

prescription refills before the insured person reaches the deductible and the insurance company starts to pay for care.

**Co-payment:** The amount that the insured person must pay out of pocket before the health insurer pays for a particular visit or service. For example, an insured person might pay a \$45 co-payment for a doctor's visit, or to obtain a prescription. A co-payment must be paid each time a particular service is obtained.

**Coinsurance:** Instead of, or in addition to, paying a fixed amount up front (a co-payment), the co-insurance is a percentage of the total cost that insured person may also pay. For example, the member might have to pay 20% of the cost of a surgery over and above a co-payment, while the insurance company pays the other 80%. If there is an upper limit on coinsurance, the policy-holder could end up owing very little, or a great deal, depending on the actual costs of the services they obtain.

**Exclusions:** Not all services are covered. The insured person is generally expected to pay the full cost of non-covered services out of their own pocket.

**Coverage limits:** Some health insurance policies only pay for health care up to a certain dollar amount. The insured person may be expected to pay any charges in excess of the health plan's maximum payment for a specific service. In addition, some insurance company schemes have annual or lifetime coverage maximums. In these cases, the health plan will stop payment when they reach the benefit maximum and the policy-holder must pay all remaining costs.

**Out-of-pocket maximums:** Similar to coverage limits, except that in this case, the insured person's payment obligation ends when they reach the out-of-pocket maximum, and the health company pays all further covered costs. Out-of-pocket maximums can be limited to a specific benefit category (such as prescription drugs) or can apply to all coverage provided during a specific benefit year.

**Capitation:** An amount paid by an insurer to a health care provider, for which the provider agrees to treat all members of the insurer.

**In-Network Provider:** (U.S. term) A health care provider on a list of providers preselected by the insurer. The insurer will offer discounted coinsurance or co-payments, or additional benefits, to a plan member to see an in-network provider. Generally, providers in network are providers who have a contract with the insurer to accept rates further discounted from the "usual and customary" charges the insurer pays to out-of-network providers.

**Prior Authorization:** A certification or authorization that an insurer provides prior to medical service occurring. Obtaining an authorization means that the insurer is obligated to pay for the service, assuming it matches what was authorized. Many smaller, routine services do not require authorization.

**Explanation of Benefits:** A document sent by an insurer to a patient explaining what was covered for a medical service, and how they arrived at the payment amount and patient responsibility amount.

Prescription drug plans are a form of insurance offered through some employer benefit plans in the U.S., where the patient pays a copayment and the prescription drug insurance part or all of the balance for drugs covered in the formulary of the plan.

Some, if not most, health care providers in the United States will agree to bill the insurance company if patients are willing to sign an agreement that they will be responsible for the amount that the insurance company doesn't pay. The insurance company pays out of network providers according to "reasonable and customary" charges, which may be less than the provider's usual fee. The provider may also have a separate contract with the insurer to accept what amounts to a discounted rate or capitation to the provider's standard charges. It generally costs the patient less to use an in-network provider.

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