



Types of Health Insurance

Health Maintenance Organization (HMO)

- Network of physicians and facilities that have agreed to a discounted payment rate via participation agreement.
- The HMO is based on the basic managed care foundation: lower medical costs in exchange for more limited choice.
- In-network benefits only; no out-of-network benefits.
- Patient responsible for the provider's charge.
- Preventive care services covered.
- Co-payments often associated with payment for services.

Preferred Provider Organization (PPO)

- Network of physicians and facilities that have agreed to a discounted payment rate via participation agreement.
- In-network and out-of-network benefits provided.
 - In-network benefits provided at the highest benefit level (i.e. 100% of provider's reasonable charge).
 - Out-of-network services provided at the lowest benefit level (i.e. 80% of providers reasonable charge).
 - Patient responsible for the 20% difference and the difference between the 100% provider's reasonable charge and the provider's actual charge.
- Preventive care services covered.
- Co-payments often associated with payment for services.

Point of Service Product (POS)

- Many variations, each carrier different.
- POS plans attempt to combine the freedom of a PPO with the lower cost of an HMO.
- When you enroll in a POS plan, you are required to choose a primary care physician to monitor your health care.
- Generally, allows for more freedom as far as selection of providers but that freedom has a cost in the form of a reduced benefit.
 - For example, going to a specialist out-of-network, patient must submit the paperwork and will have a lower benefit paid (70 percent of the provider's reasonable charge with the patient responsible to make up the 30 percent difference and the difference between the 100 percent of the provider's reasonable charge and the actual charge).
- Network of physicians and facilities that have agreed to a discounted payment rate via participation agreement.
- In-network and out-of-network benefits provided.

- In-network benefits provided at the highest benefit level (i.e. 100% of providers usual charge).
- Out-of-network services provided at the lowest benefit level (i.e. 80% of providers usual charge).
 - Patient responsible for the 20% difference and the difference between the 100% provider's reasonable charge and the provider's actual charge.
- Preventive care services covered.
- Co-payments often associated with payment for services.

High Deductible Health Plan (HDHP)

- Same as a PPO product benefit design (see above), but a deductible needs to be met before benefits are paid by the insurance carrier. Patient is responsible to payment of 100% of the provider's reasonable charge until the sum of those charges equals the deductible amount.
- Insurance carrier may elect to provide coverage for preventive services.
- The increased deductible results in a lower premium for these products because there is less chance that the carrier will have to make any claims payments on behalf of the patient.
- Prescription and medical costs are both applied to the deductible....no co-payments associated with prescription costs.

Health Savings Account (HSA)

- Members who have an IRS-qualified HDHP may open a HSA.
- Monies in an HSA may be used for any qualified medical expense.
- Generally, most persons use the money in an HSA to cover costs up to the level of the deductible.
- An HSA is a savings account that can be funded annually.
- Monies put into an HSA are tax-free monies and can be invested tax free.
- An HSA is portable. If an employee leaves an employer that put money in the HSA, the money goes with the employee.
- Monies in a health savings account are owned by the individual, even if the employer makes that payment to the HSA.
- The theory behind HSAs is that members will become more judicious consumers of healthcare (i.e. heart surgery in India).
- Monies in an HSA may be used for:
 - Dental and vision expense
 - Cobra continuation coverage costs
 - Medicare premiums and deductibles
 - Anything over the age of 65 but owner is required to pay marginal tax rate
 - A beneficiary upon death of the HSA account holder
 - For the medical expenses of a relative or friend provided that the expenses are qualified medical expenses
 - Long-term care insurance premiums

Please call the Pennsylvania Medical Society Insurance Agency at (866) 441-2392 with questions concerning types of insurance or any other insurance needs unique to physicians.

