

Health Insurance Basics

Course 2

Topic: 01 | Page: 01

Health Insurance Basics

Exit

Course Introduction

1 of 3

Course Introduction



[Text Description of Image or Animation](#)

Menu

Help

Glossary

Resources

NEXT >

Long Description:

Animation. Welcome to the Health Insurance Basics Course. The Department of Health & Human Services logo. Health Insurance Marketplace logo.

Health Insurance Basics

[Exit](#)

Course Introduction

2 of 3

Overview

Welcome to Health Insurance Basics! In this course you will learn about basic health insurance concepts. These concepts are important to equip you with knowledge to help consumers.

This course:

- Explains the purpose and types of health insurance available to consumers
- Defines managed care
- Identifies the different ways a consumer can purchase health insurance
- Covers common health insurance terms
- Defines health insurance provider networks
- Lists general types of costs associated with health coverage
- Defines prescription drug formularies and types of health insurance plans

The course concludes with an exam on topics covered throughout the course.

Click **NEXT** to begin.

[Menu](#)[Help](#)[Glossary](#)[Resources](#)[◀ BACK](#)[NEXT ▶](#)

Health Insurance Basics

[Exit](#)

Course Introduction

3 of 3

How to Navigate this Training

Navigation

- Use the **BACK** and **NEXT** buttons at the bottom of the page to move forward and backward in a module.
- Use the **Menu** button at the bottom of the page to go to any module in the course.
- Use the **Resources** and **Glossary** buttons for additional information.
- Use the **Help** button for a more detailed explanation of the navigation features in this course.
- Use the **Exit** button at the top right corner to close this course. This course contains a bookmarking feature, which lets you to exit the training at any point and return to the place you left off at a later time.

Note: If you exit during an exam, any previous answers will be lost and you'll be required to restart the exam from the beginning during your next session. Once you have started an exam, you must complete it. If you need to stop and return to it later, your progress will not be saved. You will need to start the exam over from the beginning.

About this Course

This course doesn't contain audio. You don't need speakers or a headset unless you are working with assistive technology. For assistance with accessibility options, please select the **Help** button located at the bottom of the page.

This course contains knowledge checks or practice exercises to help prepare you for the exam you're required to take at the end of each course.

[Menu](#)[Help](#)[Glossary](#)[Resources](#)[◀ BACK](#)[NEXT ▶](#)

Health Insurance Basics

[Exit](#)

Overview of Health Insurance

1 of 11

Overview of Health Insurance

This is the first in a series of training courses that will prepare you to assist consumers with general questions about health coverage.

This training will provide you with the skills to:

- Identify the purpose of health insurance
- Define the concept of managed care
- Identify different ways a consumer can get health insurance

Click **NEXT** to continue.

[Menu](#)[Help](#)[Glossary](#)[Resources](#)[NEXT >](#)

Health Insurance Basics

[Exit](#)

Overview of Health Insurance

2 of 11

Potential Questions from Consumers

To effectively assist consumers, it's important that you're able to answer as many questions as possible or are able to quickly access the answers through available resources.

The questions asked will likely be as diverse as the consumers you help. Questions may include:

- What is health insurance?
- Why is health insurance important?
- How does health insurance work?
- How can I get health insurance?

Your job is to help consumers understand their options and find the health coverage that fits their budget and specific needs.

[Menu](#)[Help](#)[Glossary](#)[Resources](#)[◀ BACK](#)[NEXT ▶](#)

Health Insurance Basics

[Exit](#)

Overview of Health Insurance

3 of 11

Definition of Health Insurance

Health insurance is a contract between a consumer and a health insurance company* that requires the insurance company to pay or reimburse some or all of a consumer's health care costs when he or she gets sick or needs medical care. A consumer is required to pay a fixed monthly amount as part of the contract.

When consumers have insurance, they pay some costs and, the insurance company pays some costs. The different costs associated with health insurance, and the way the costs are split between the consumer and the health insurance company, will be explained in detail later in this course.

*Note: Health insurance companies may also be called health insurance issuers, insurers or payers.

[Menu](#)[Help](#)[Glossary](#)[Resources](#)[◀ BACK](#)[NEXT ▶](#)

Health Insurance Basics

[Exit](#)

Overview of Health Insurance

4 of 11

Importance of Health Insurance



Consumers may ask you why they need health insurance and how they can purchase coverage.

You can tell consumers:

- Health insurance allows consumers to get preventive health care services to help them stay healthy.
- Health insurance helps pay for health care services if a consumer becomes sick or injured.
- Without health insurance, costs for health services can be extremely high and may result in serious financial hardship.
- The Affordable Care Act requires consumers to have health insurance or pay a fee.

[Menu](#)[Help](#)[Glossary](#)[Resources](#)[◀ BACK](#)[NEXT ▶](#)

Health Insurance Basics

Exit

Overview of Health Insurance

5 of 11

How Health Insurance Works



Health insurance companies contract with certain hospitals, doctors, pharmacies, and other health care providers to deliver medical services for an agreed upon rate. These groups are known as a health insurance company's provider network.

Health insurance companies use various provider networks to develop different health plan options to deliver care to plan members. It's important for consumers to carefully review provider networks before selecting a health plan to make sure the doctors they want to see participate in their selected health plan.

Consumers are required to renew their participation in health plans every year. Consumers can change their health plans when they renew coverage.

Menu

Help

Glossary

Resources

< BACK

NEXT >

Health Insurance Basics

[Exit](#)

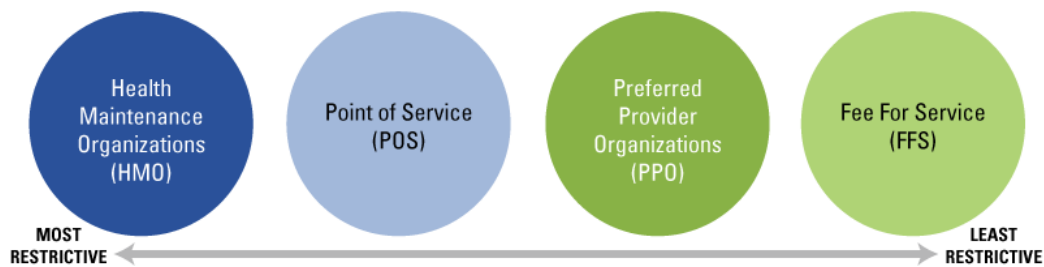
Overview of Health Insurance

6 of 11

Concept of Managed Care

Nearly all health insurance companies use managed care to deliver health care services. Managed care is a way for health insurance companies to manage the quality, cost, and access to services. In managed care, health insurance companies develop contracts with providers to create provider networks that will deliver care to consumers. There may be limits on benefits or additional costs to consumers if they use non-contracted providers (also called out-of-network providers).

Examples of types of managed care plans include Health Maintenance Organizations (HMO), Point of Service (POS) plans, and Preferred Provider Organizations (PPO). These plans vary by consumers' access to providers. As an alternative to managed care, health coverage may also be delivered through a Fee-for-Service (FFS) plan. This is also called an indemnity plan. An FFS plan allows consumers to choose their own providers, and the health insurance company reimburses providers a portion of the total cost for each service consumers use.

[Menu](#)[Help](#)[Glossary](#)[Resources](#)[◀ BACK](#)[NEXT ▶](#)

Health Insurance Basics

Exit

Overview of Health Insurance

7 of 11

Knowledge Check

Which of the following programs is NOT a type of managed care plan? Choose the best answer.

Select the correct answer and then click **Check Your Answer**.

- A. Fee-for-Service plan
- B. Point of Service plan
- C. Health Maintenance Organization
- D. Preferred Provider Organization

[Menu](#)[Help](#)[Glossary](#)[Resources](#)[◀ BACK](#)[NEXT ▶](#)

Correct Answer:

A

Feedback for Correct Answer:

Correct! FFS is NOT a managed care plan, but a way of delivering services where consumers can freely choose their own providers.

Feedback for Incorrect Answer:

Incorrect. The correct answer is A. FFS is NOT a managed care plan, but a way of delivering services where consumers can freely choose their own providers.

Health Insurance Basics

Exit

Overview of Health Insurance

8 of 11

How to Get Health Insurance in the Private Market

You may need to explain the different ways a consumer can get health insurance. Health insurance programs can be run by a private organization (including non-profits) or by a government agency.

Select each program title below to learn more about different ways to get privately run health insurance. Click on each item before advancing to the next page.



[Text Description of Image or Animation](#)

Menu

Help

Glossary

Resources

< BACK

NEXT >

Long Description:

Circles defining different ways a consumer can get privately run health insurance.

Health Insurance Inside the Marketplace

Consumers can enroll in health coverage through the Marketplace beginning on October 1, 2013. For consumers who enroll before December 15, 2013, coverage will begin on January 1, 2014. Depending on a consumer's income, health coverage may be available at a reduced cost.

Health Insurance Outside the Marketplace

Consumers can obtain health coverage through a health insurance company that sells insurance outside of the Marketplace.

Job-based Insurance

Consumers who are currently employed may be able to purchase health coverage through their employer, called employer-sponsored or job-based. If consumers lose or quit their job, they may extend the job-based health insurance through a program called Consolidated Omnibus Budget Reconciliation Act (COBRA).

COBRA

Allows consumers to continue their existing health coverage for a limited period of time, typically at a higher rate than when they were employed. Instead of choosing COBRA, consumers may also enroll in coverage through the Marketplace.

Insurance Under a Parent's Policy

Young adults (up to 26-years-old) are eligible to enroll in health coverage under their parent's health insurance plans if those plans cover dependents.

health coverage under their parent's health insurance plans if those plans cover dependents.

Health Insurance Basics

Exit

Overview of Health Insurance

9 of 11

Additional Health Coverage Options

In addition to privately run plans, the government also operates public coverage programs. To be able to help consumers find the right health coverage, you'll need to understand these programs.

Select each program title below to learn more about different public coverage programs. Click on each item before advancing to the next screen.



[Text Description of Image or Animation](#)

Menu

Help

Glossary

Resources

< BACK

NEXT >

Audio -- Transcript:

Long Description:

Circles defining additional health coverage options.

Medicare

Medicare is the federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).

Medicaid

A joint federal and state-administered health insurance program for low-income families and children, pregnant women, the elderly, people with disabilities, and in some states, other adults. The Federal government provides a portion of the funding for Medicaid and sets guidelines for the program. States also have choices in how they design their program, so Medicaid varies state by state and may have a different name in your state.

Children's Health Insurance Program (CHIP)

Chip is a program jointly funded by state and federal government that provides health coverage to low-income children and, in some states, pregnant women, in families who earn too much income to qualify for Medicaid, but cannot afford private health insurance.

TRICARE

TRICARE is the Department of Defense (DoD) health care program available to eligible members and their families of the seven uniformed services: the U.S. Army, U.S. Navy, U.S. Air Force, U.S. Marine Corps, U.S. Coast Guard, Commissioned Corps of the U.S. Public Health Service, and the National Oceanic and Atmospheric Administration.

Veteran's Affairs (VA) Health Benefits

The VA provides health coverage for eligible veterans who served in the U.S. military. U.S. Department of Veterans Affairs administers a variety of benefits and services that provide financial and other forms of assistance to servicemembers, veterans, their dependents and survivors.

Health Insurance Basics

[Exit](#)

Overview of Health Insurance

10 of 11

Knowledge Check

Which of the following programs allows consumers to keep their existing coverage if they lose or quit their jobs?

Select the correct answer and then click **Check Your Answer**.

- A. TRICARE
- B. Medicare
- C. COBRA
- D. CHIP

[Check Your Answer](#) [Reset](#)

[Menu](#)[Help](#)[Glossary](#)[Resources](#)[← BACK](#)[NEXT →](#)

Correct Answer:

C

Feedback for Correct Answer:

Correct! COBRA allows consumers to purchase their same job-based health insurance if they lose or quit their jobs.

Feedback for Incorrect Answer:

Incorrect. The correct answer is C. COBRA allows consumers to purchase their same job-based health insurance if they lose or quit their jobs.

Health Insurance Basics

[Exit](#)

Overview of Health Insurance

11 of 11

Key Points

You're responsible for explaining the different types of health insurance available to consumers.

Consumers purchase health insurance to help pay for medical care and avoid serious financial hardship.

Health insurance companies contract with groups of hospitals, doctors, pharmacies, and other health care providers – known as provider networks – to provide health care services for an agreed upon rate.

Managed care is a way for insurance companies to manage the cost, quality, and access to health care services.

You have successfully completed this module.

Click **NEXT** to return to the main menu.

[Menu](#)[Help](#)[Glossary](#)[Resources](#)[◀ BACK](#)[NEXT ▶](#)

Health Insurance Basics

[Exit](#)

Common Health Insurance Terminology

1 of 11

Introduction to Common Health Insurance Terminology

Consumers you serve may be new to the insurance market and some may be getting insurance for the first time. These consumers will have different levels of understanding and comfort with health insurance terminology.

Examples of health insurance terms include:

- Provider network
- Premiums, copays, and deductibles
- Formulary
- Health Maintenance Organization (HMO) and Preferred Provider Organization (PPO)

To effectively help consumers, you need to be familiar with and be able to describe these terms.

This training will provide you with the skills to:

- Describe health insurance provider networks
- List the general types of costs associated with health coverage
- Define prescription drug formularies
- Define the different types of health insurance plans

Click **NEXT** to continue.

[Menu](#)[Help](#)[Glossary](#)[Resources](#)[NEXT >](#)

Health Insurance Basics

[Exit](#)

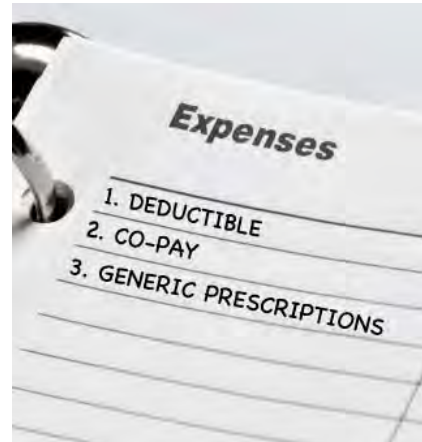
Common Health Insurance Terminology

2 of 11

Provider Networks

Remember that nearly all health insurance companies use managed care with provider networks to manage the costs of providing care to consumers. Some health plans, such as health maintenance organizations (HMOs), will only pay for services that are performed by a provider within their network, also known as in-network providers. Other plans, such as preferred provider organizations (PPOs), may pay for services by any provider, even if they're not in-network. Going to a doctor that isn't in a consumer's network, or is out-of-network, is often more expensive for consumers.

Some plans require consumers to choose an in-network primary care doctor. Costs charged, including copays, for services provided by a primary care doctor are typically lower than those for specialists who are either in-network or out-of-network. A primary care doctor is a physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient. They may be responsible for coordinating care and making referrals to specialists.

[Menu](#)[Help](#)[Glossary](#)[Resources](#)[◀ BACK](#)[NEXT ▶](#)

Health Insurance Basics

Exit

Common Health Insurance Terminology

3 of 11

Costs Associated with Health Insurance

To assist consumers with choosing the right health coverage, you need to make sure they understand the terms related to health insurance costs.

Select each term below to learn more about costs associated with health insurance. Click on each item before advancing to the next screen.

[Text Description of Image or Animation](#)

Menu

Help

Glossary

Resources

< BACK

NEXT >

Long Description:

Premium

Premium is the amount that must be paid to a health insurance company for a health insurance plan. Consumers and/or their employers usually pay it monthly, quarterly, or yearly.

Copayment (or copay)

Copayment is a fixed amount (e.g., \$15) consumers pay for a covered health care service, usually at the time of service. The amount can vary by the type of covered service, such as seeing a doctor, filling a prescription, or going to the emergency room. Copays are generally lower for services delivered by primary care doctors than by specialists. Remember that copays for in-network providers are typically lower than for out-of-network providers.

Deductible

Deductible is the amount a consumer owes for health care services before his or her health insurance plan begins to pay. For example, if a consumer's deductible is \$1,000, the plan won't pay anything until the consumer has met his or her \$1,000 deductible for covered health care services. Some health care services may be covered by the health plan even if the consumer hasn't met the deductible. Premiums and copays don't count toward the deductible.

Coinsurance

Coinsurance is a consumer's share of the cost of a covered health care service, calculated as a percent of the amount allowed by the health plan for that service. A consumer pays coinsurance plus any deductibles that are owed. For example, if the health insurance plan's allowed amount for an office visit is \$100 and a consumer has met his or her deductible, the coinsurance payment of 20% would be \$20. The health insurance plan pays the rest of the amount owed.

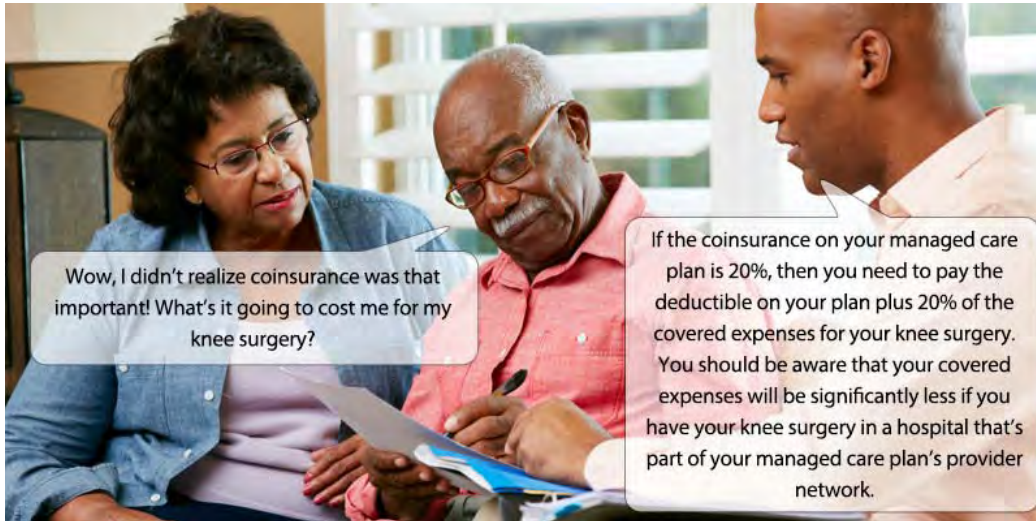
Health Insurance Basics

Exit

Common Health Insurance Terminology

4 of 11

Costs Associated with Health Insurance



[Text Description of Image or Animation](#)

Menu

Help

Glossary

Resources

< BACK

NEXT >

Long Description:

The man says, "Wow. I didn't realize coinsurance was that important. What's it going to cost me for my knee surgery?" The consumer assister says, "If the coinsurance on your managed care plan is 20%, then you'll pay for the deductible on your plan plus 20% of the covered expenses for your knee surgery. You should be aware that your covered expenses will be significantly less if you have your knee surgery in a hospital that's part of your managed care plan's provider network."

Health Insurance Basics

[Exit](#)

Common Health Insurance Terminology

5 of 11

Additional Costs Associated with Health Insurance

Claim: A request for payment that a consumer or health care provider submits to the health insurance company for items or services they think are covered.

Allowed Amount: Maximum amount allowed to be paid for a covered health service by a health insurance company. This may also be called "eligible expense," "payment allowance," or "negotiated rate." If a provider charges more than the allowed amount, the consumer may have to pay the difference.

Balance Billing: When a provider bills a consumer for the difference between the provider's charge and the amount allowed by the health plan. For example, if the provider's charge is \$100 and the allowed amount is \$70, the provider may bill the consumer for the remaining \$30. Some providers may not balance bill consumers for covered services. This typically happens if the provider has a contract with the consumer's health insurance company to provide services at a discount. You should remind consumers of the importance of understanding their plan's provider network and whether they may have to pay more to see certain providers.

[Menu](#)[Help](#)[Glossary](#)[Resources](#)[◀ BACK](#)[NEXT ▶](#)

Health Insurance Basics

Exit

Common Health Insurance Terminology

6 of 11

Knowledge Check

Helen is a 46-year-old mother of three children. Her husband's health plan has a \$1,000 deductible for the family each calendar year. Helen's 8-year-old son requires a medical procedure that will cost \$1,500. Helen has already paid \$750 toward her deductible this year. Assuming that the service is covered by her health plan, that there are no copayments or coinsurance, and balance billing doesn't apply, what will Helen pay for her son's medical procedure?

Select the correct answer and then click **Check Your Answer**.

- A. \$250
- B. \$500
- C. \$1000
- D. \$1500

Check Your Answer Reset

Menu

Help

Glossary

Resources

< BACK

NEXT >

Correct Answer:

A

Feedback for Correct Answer:

Correct! Helen's cost for her son's medical procedure will be \$250 since this is the remaining balance on the \$1,000 annual deductible before the health plan will pay any expenses for covered health care services.

Feedback for Incorrect Answer:

Incorrect. The correct answer is A. Helen's cost for her son's medical procedure will be \$250 since this is the remaining balance on the \$1,000 annual deductible before the health plan will pay any expenses for covered health care services.

Health Insurance Basics

[Exit](#)

Common Health Insurance Terminology

7 of 11

Formularies



Health plans use the term "formulary" to describe the list of prescription drugs that they cover.

A formulary typically includes details about the copayment the consumer pays for each type of covered drug. If the plan uses "tiers," the formulary will list which drugs are included in each tier. Tiers are groups of drugs that have a different cost for each group. A drug in a lower tier will cost less than a drug in a higher tier. In general, a tiered formulary encourages consumers to select lower-cost drugs, such as non-brand name, or generic drugs.

For example, under a three-tiered formulary approach:

- The first tier typically includes generic drugs with the lowest cost to the consumer (e.g., \$10 copay).
- The second tier includes preferred brand name drugs with a higher cost to the consumer (e.g., \$25 copay).
- The third tier includes non-preferred brand name drugs with the highest cost to the consumer (e.g., \$40 copay).

[Menu](#)[Help](#)[Glossary](#)[Resources](#)[◀ BACK](#)[NEXT ▶](#)

Health Insurance Basics

Exit

Common Health Insurance Terminology

8 of 11

Different Types of Health Insurance Plans

Now that you understand basic health insurance terms, let's see how they apply to the different types of health plans. Health plans differ based on their provider networks, how much consumers are responsible for paying, and the benefits offered.

Select each term below to learn more about different health plan types. Click on each item before advancing to the next screen.



[Text Description of Image or Animation](#)

Menu

Help

Glossary

Resources

< BACK

NEXT >

Long Description:

Preferred Provider Organization (PPO) A type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. Consumers pay less if they use providers that belong to the plan's network. Consumers can visit doctors, hospitals, and providers outside of the network at an additional cost. Referrals are often not needed to see specialists. In exchange for greater access to providers, premiums are generally higher in a PPO than in an HMO.

Point of Service (POS) Plan A type of plan in which consumers pay less if they use doctors, hospitals, and other health care providers that belong to the plan's network. With this type of plan, a consumer may go to out-of-network providers at a higher cost. POS plans may also require consumers to get a referral from their primary care doctor in order to see a specialist.

Health Maintenance Organization (HMO) A type of health insurance plan that usually limits coverage to care from in-network doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency. An HMO may require consumers to live or work in its service area to be eligible for coverage. In exchange for the limited access to providers, premiums are typically lower in an HMO than in other types of plans.

High Deductible Health Plan (HDHPs) A plan that features higher deductibles than traditional insurance plans in exchange for lower monthly premiums. HDHPs can be combined with a health savings account (HSA) or a flexible spending account (FSA). These health reimbursement arrangements allow a consumer to pay for qualified out-of-pocket medical expenses on a pre-tax basis. The money that's contributed to an HSA or an FSA is not subject to federal income tax at the time of deposit but must be used to pay for qualified medical expenses. A consumer uses the money in the HSA to help meet their deductible before their high deductible insurance plan kicks in. The funds that are contributed to an HSA roll over year to year if a consumer doesn't spend them. FSA funds can't carry over from year to year. Any funds that consumers don't spend by the end of the plan year can't be used for expenses in the next year.

Catastrophic Health Plan A type of plan that's designed to provide emergency services and to protect consumers from unexpected medical costs, but has limits on regular doctor visits. The premium amount that a consumer pays each month for health care is generally lower than other types of plans, but the out-of-pocket costs for deductibles, copayment, and coinsurance are generally higher.

Health Insurance Basics

[Exit](#)

Common Health Insurance Terminology

9 of 11

Summary of Benefits and Coverage

Health insurance companies and group health plans (e.g., health plans provided by employers, also known as job-based coverage) are required to provide consumers with an easy-to-understand summary of the health plan's benefits and coverage.

This summary is referred to as the Summary of Benefits and Coverage (SBC), or Explanation of Benefits (EOB), and is accompanied by a glossary of terms like the ones found in this course. It allows consumers to easily compare plans and understand what each health plan offers.

The SBC also includes details, called coverage examples, which are comparison tools that allow consumers to see what the plan would generally cover in two common medical situations. Consumers have the right to get the SBC when shopping for or enrolling in coverage or if they request a copy from their health insurance company or group health plan.

[Menu](#)[Help](#)[Glossary](#)[Resources](#)[← BACK](#)[NEXT →](#)

Health Insurance Basics

[Exit](#)

Common Health Insurance Terminology

10 of 11

Knowledge Check

Juan, a 50-year-old construction supervisor, is very particular about the doctors that he sees for his back problem. He asks you which plans give him the option to see out-of-network providers and which plans will pay for at least a portion of the health care costs. Which of the following do you tell him?

Select **all that apply** and then click **Check Your Answer**.

- A. Preferred Provider Organization (PPO)
- B. Point of Service (POS)
- C. Health Maintenance Organization (HMO)
- D. Health Savings Account (HSA)

[Check Your Answer](#) [Reset](#)

[Menu](#)[Help](#)[Glossary](#)[Resources](#)[◀ BACK](#)[NEXT ▶](#)

Correct Answers:

A ,B

Feedback for Correct Answer:

Correct! PPOs and POS' allow consumers to see out-of-network providers and will pay for a portion of those health care costs.

Feedback for Incorrect Answer:

Incorrect. The correct answer is A and B. PPOs and POS' allow consumers to see out-of-network providers and will pay for a portion of those health care costs

Health Insurance Basics

[Exit](#)

Common Health Insurance Terminology

11 of 11

Key Points

Health plans often contract with a network of health care providers to provide care to consumers. The plans differ based on their provider networks, how much consumers are responsible for paying, and the benefits offered.

Insurance companies use deductibles, copayments, and coinsurance to share health care costs with consumers.

The most common types of health insurance plans that consumers should know about include Preferred Provider Organization (PPO), Point of Service (POS) Plan, Health Maintenance Organization (HMO), High Deductible Health Plan (HDHP), and Catastrophic Health Plan.

You're responsible for describing the different types of health plans that are available to consumers and the common terms that consumers may hear while enrolled in a plan.

You have successfully completed this course.

Click **EXIT** to leave the course and take the *Health Insurance Basics* exam. Once you have started an exam, you must complete it. If you need to stop and return to it later, your progress will not be saved. You will need to start the exam over from the beginning.

[Menu](#)[Help](#)[Glossary](#)[Resources](#)[◀ BACK](#)[NEXT ▶](#)

