ABA INSURANCE™ Administered by USI Affinity | eHealth®

Individual and Family Medical Insurance

FAQs Frequently Asked Questions

ABA Insurance and eHealth are here to help be a resource, a guide, and to answer any questions you have. Here are some frequently asked questions we compiled for you.

Q. What is individual and Family health insurance?

A. Individual and family health insurance is a type of health insurance coverage that is made available to individuals and families, rather than to employer groups or organizations.

When possible, most people would prefer to have their employer provide group health insurance coverage. But, if this is not an option for you, it is still important for you to seek coverage. You may be pleasantly surprised with the variety and affordability of the individual and family health insurance options available.

Q. What kinds of individual and family insurance plans are available?

A. Individual and family health insurance plans are usually described as either "indemnity" or "managed-care" plans. Put broadly, the major differences concern choice of health care providers, out-of-pocket costs, and how bills are paid.

Typically, indemnity plans offer a broader selection of health care providers than managed-care plans. Indemnity plans pay their share of the costs for covered services only after they receive a bill (which means that you may have to pay up front and then obtain reimbursement from your health insurance company).

There are several different types of managed-care health insurance plans. These include HMO, PPO, and POS plans. Managed-care plans typically use health care provider networks. Health care providers within a network agree to perform services for managed-care plan patients at pre-negotiated rates and will usually submit the claim to the insurance company for you.

In general, you'll have less paperwork and lower out-of-pocket costs with a managed-care health insurance plan, and you'll have a broader choice of health care providers with an indemnity plan.

Q. How does a PPO plan work?

A. As a member of a PPO (Preferred Provider Organization) plan, you'll be encouraged to use the insurance company's network of preferred doctors and hospitals. These health care providers have been contracted to provide services to the plan's members at a discounted rate. You typically won't be required to pick a primary care physician but will be able to see doctors and specialists within the network at your own discretion.

You will probably have an annual deductible to pay before the insurance company starts covering your medical bills. You may also have a copayment for certain services or be required to cover a certain percentage of the total charges for your medical bills.

With a PPO plan, services rendered by an out-of-network physician are typically covered at a lower percentage than services rendered by a network physician.

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Q. How does an HMO plan work?

A. Though there are many variations, HMO (Health Maintenance Organization) plans typically give members lower out-of-pocket health care expenses but also offer less flexibility in the choice of physicians or hospital than other health insurance plans. As a member of an HMO, you'll be required to choose a primary care physician (PCP). Your PCP will take care of most of your health care needs. Before you can see a specialist, you'll need to obtain a referral from your PCP.

With an HMO, you'll likely have coverage for a broader range of preventive health care services than you would through another type of plan. You may not be required to pay a deductible before coverage starts and your copayments could be minimal. With an HMO plan, you typically won't have to submit any of your own claims to the insurance company. However, keep in mind that you'll likely have no coverage at all for services rendered by non-network providers or for services rendered without a proper referral from your PCP.

Q. How does a POS plan work?

A. A POS (Point of Service) plan combines some of the features offered by HMO and PPO plans. As with an HMO, members of a POS plan may be required to choose a primary care physician (PCP) from the plan's network of providers. Services rendered by your PCP may or may not be subject to a deductible. Also, like HMOs, POS plans typically offer coverage for preventive care visits.

Typically, however, you will receive a higher level of coverage for services rendered or referred by your PCP. Services rendered by a non-network provider may be subject to a deductible and will likely be covered at a lower level. If services are rendered outside of the network, you'll likely have to pay up-front and submit a claim to the insurance company yourself. Please note this information may vary by insurance company.

Q. How does an HSA work?

A. Legislation establishing Health Savings Accounts (or "HSAs") took effect on January 1, 2004. HSAs and HSA-compatible health insurance plans are becoming more and more popular. Here are the basics:

- An HSA is a tax-favored savings account that may be used in conjunction with an HSA-compatible high deductible health insurance plan to pay for qualifying medical expenses.
- Choosing an HSA-compatible health insurance plan may help you save money. Typically, the monthly premium on an HSA-compatible high deductible plan is less expensive than the monthly premium for a lower-deductible health insurance plan.
- Contributions to an HSA may be made pre-tax, up to certain annual limits.
- Funds in the HSA may be invested at your discretion. Unused funds remain in the account and accrue interest year-to-year, tax-free.

Not all high-deductible plans are eligible for use in conjunction with an HSA.

Q. What is a copayment?

A. A copayment or "copay" is a specific charge that your health insurance plan may require that you pay for a specific medical service or supply. For example, your health insurance plan may require a $15 copayment for an office visit or brand-name prescription drug, after which the insurance company often pays the remainder of the charges.

Q. What is a deductible?

A. A deductible is a specific dollar amount that your health insurance company may require that you pay out-of-pocket each year before your health insurance plan begins to make payments for claims for certain services. Not all health insurance plans require a deductible. As a general rule (though there are many exceptions), HMO plans typically do not require a deductible, while most indemnity and PPO plans do.

Q. What is coinsurance?

A. Coinsurance is the term used by health insurance companies to refer to the amount that you are required to pay for a medical claim, apart from any copayments or deductible. For example, if your health insurance plan has a 20% coinsurance requirement (and does not have any additional copayment or deductible requirements), then a $100 medical bill would cost you $20, and the insurance company would pay the remaining $80.

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Q. What is the difference between in-network and out-of-network?

A. An in-network provider is one contracted with the health insurance company to provide services to plan members for specific pre-negotiated rates. An out-of-network provider is one not contracted with the health insurance plan.

Typically, if you visit a physician or other provider within the network, the amount you will be responsible for paying will be less than if you go to an out-of-network provider. Though there are some exceptions, in many cases, the insurance company will either pay less or not pay anything for services you receive from out-of-network providers. As a general rule, PPO, POS, and HMO plans make use of provider networks. Indemnity plans typically do not.

Q. How does eHealth protect my private information?

A. Shopping with eHealthInsurance is safe. As your health insurance agent, we're committed to protecting your privacy and the information you provide to us. eHealthInsurance will not sell, trade, or give away your personal information to anyone, except those specifically involved in the referral or processing of your health insurance quote or application. We use industry-leading technologies to ensure the security of all the information under our control.

We're proud to have received the privacy seal of approval from TRUSTe, the largest privacy advocacy organization on the Internet, and we encourage you to read through our Privacy Policy online. If you have any questions about our privacy policy or how your personal information is protected at eHealthInsurance, contact us by email at privacy@ehealthinsurance.com.

Q. When I buy an insurance plan, how do I make payments?

A. In most cases, when you complete your application, you'll provide a credit card number or a check written to the health insurance company for the first premium payment. Typically, your credit card will not be charged nor will your check be cashed until you are approved for coverage. If you are not approved for coverage or if you cancel your application, your card will not be charged and any check payment you made will be returned or refunded.

Once you've been approved for coverage, your ongoing premium payments are paid to your health insurance company typically on a monthly or quarterly basis. Insurance companies typically offer several payment options including monthly billings to be paid by check, credit card, automatic bank drafts, or automated credit card charges. Please note that credit card billing of premiums is optional, and you can obtain coverage without using that method of payment.

Q. Do you offer the best prices?

A. Health insurance premiums are filed with and regulated by your state's Department of Insurance.

Whether you buy from eHealthInsurance, your local agent, or directly from the health insurance company, you'll pay the same monthly premium for the same plan. This means that you can enjoy the advantages and convenience of shopping and purchasing your health insurance plan through eHealthInsurance and rest assured that you're getting the best available price.

Q. Can I contact someone if i need help?

A. Yes. ABA Insurance and eHealth believe in providing you with top-quality customer service. Our customer care center is staffed with licensed health insurance agents and knowledgeable representatives, ready to assist you.

Call us for more information at 1.855.967.0415

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