



*Fundamentals  
of  
Employee Benefit Programs*

**PART THREE  
HEALTH BENEFITS**

---

# Table of Contents

chapter		page
20	Health Benefits: Overview .....	3
21	Prescription Drug Plans .....	25
22	Dental Care Plans .....	35
23	Vision Care Plans .....	41
24	Health Promotion and Disease Management Programs .....	47
25	Mental Health and Substance Abuse Benefits .....	57
26	Retiree Health Benefits .....	69
27	COBRA Continuation of Coverage .....	85
28	Nondiscrimination and Health Benefits .....	95
29	Managing Health Care Costs .....	101

---

# Chapter 20

## Health Benefits: Overview

### Introduction

Employers offer health benefits in order to provide workers and their families with protection from financial losses that can accompany unexpected serious illness or injury. They also offer the benefits to promote health, to increase worker productivity, and as a form of compensation to recruit and retain qualified workers.

Employment-based health benefit programs have existed in the United States for more than 130 years. In the 1870s, for example, railroad, mining, and other industries began to provide the services of company doctors to workers. In 1910, Montgomery Ward entered into one of the earliest group insurance contracts for its employees.

Prior to World War II, few Americans had health insurance, and most policies covered only hospital room, board, and ancillary services. During World War II, the number of persons with employment-based health insurance coverage started to increase. When the National War Labor Board froze wages and a shortage of workers occurred, employers sought ways to get around the wage controls in order to attract scarce workers, and health insurance was often used in this way. Health insurance was an attractive means to recruit and retain workers during a labor shortage for two reasons: unions supported employment-based health insurance and workers' health benefits were not subject to income tax or Social Security payroll taxes as cash wages were.

Today, as the cost of health care climbs, health insurance remains a valuable employee benefit. Employers view it as an integral component of the overall compensation packages that allow them to attract and retain workers. In addition to health protection for themselves and their family members, many employees view health insurance as a significant source of income protection. Depending on the nature of an illness and the benefits provided, an employee's financial well-being could be jeopardized by unanticipated medical expenses, if he or she lacks health insurance.

Currently, employment-based health insurance is the most common form of health insurance coverage in the United States. In 2003, 101.5 million workers ages 18–64 were covered by employment-based health benefits (Fronstin, 2004). Seventy-six percent of these workers had coverage

through their own employer, while a family member's employer covered the remainder. The employment-based health benefits system also covers 14.9 million nonworking adults, ages 18–64, and 42.9 million children under age 18. In 2003, virtually all employers with 200 or more employees offered health benefits to their workers, while 61 percent of employers with 3–199 employees made the same offering (Gabel et al., 2004).

This chapter first explains the taxation of employment-based health benefits. The chapter continues with sections on employee participation, insurance program administrators, managed care, health providers reimbursement, beneficiary out-of-pocket responsibilities, preexisting condition limitation provisions, health insurance program comparison, other health care plans, the Employee Benefits Security Administration (EBSA),<sup>1</sup> and federal laws.

## **Taxation of Health Benefits**

Under the current tax code, health insurance premiums paid by employers are deductible as a business expense (see Internal Revenue Code (IRC) Sec. 162(a)), and are excluded, without limit, from most workers' taxable income. The exceptions are some cases of highly compensated employees (HCE), when the benefits discriminate in favor of HCEs in non-fully insured plans, and, starting in 2003, in the case of self-employed individuals, partners, and Subchapter S owners who participate in health insurance programs that are not medical savings accounts (see IRC Sec. 162(l)). In addition, workers whose employers sponsor flexible spending accounts (FSAs) are able to pay for health care expenses with pretax dollars through the FSA, meaning they are not taxed on the amount of money that is put into the FSA (see IRC Secs. 105(h)(6) and 125(a)), and workers with certain high-deductible health plans are able to make contributions to a health savings account on a tax-preferred basis. Furthermore, for individuals who do not receive employment-based health benefits, total health care expenses (including premiums) are deductible only if they exceed 7.5 percent of adjusted gross income (AGI), and only the amount that exceeds 7.5 percent of AGI is deductible, though individuals are also allowed to deduct the entire contribution to an HSA even if the amount does not exceed 7.5 percent of AGI. Figure 20-1 contains a summary of the sections in the IRC that affect the provision of employment-based health benefits. The Internal Revenue Service (IRS) Web site ([www.irs.gov](http://www.irs.gov)) provides extensive information on all these matters.

The tax preference for health insurance is generally viewed as being regressive. In dollar amounts, the tax exclusion can be viewed as regressive

---

<sup>1</sup> Formerly the Pension and Welfare Benefits Administration.

Figure 20-1

**PROVISIONS IN THE INTERNAL REVENUE CODE (IRC) AFFECTING  
EMPLOYMENT-BASED HEALTH BENEFITS**

IRC SECTION	DESCRIPTION
104(a)(3)	Exclusion from gross income of employee for benefits attributable to employee contributions. Available to partners, Subchapter S owners, and self-employed individuals as if they were employees.
105(b)	Exclusion from gross income of employee for benefits attributable to employer contributions (including benefits received from such plans by partners, Subchapter S Owners and self-employed individuals).
105(h)	Any non-fully insured medical reimbursement plan that fails to meet nondiscrimination requirements will result in Highly Compensated Employees (HCEs) being taxed on the "excess reimbursement."
106(a)	Value of employment-based health accident or health plan provided by the employer is excluded from employee's gross income. Not available to partners, Subchapter S Owners and self-employed individuals (see Sec. 162(1) below).
106(b)	Exclusion for contributions to a medical savings account (MSA), but only to the extent allowed under Sec. 220. Also see Sec. 162(1) below(b)(1).
125(a)	Cafeteria plans provide participants with choices between cash (which may include certain taxable benefits) and qualified nontaxable benefits. Participant who chooses nontaxable benefit not taxed on the cash that could have been chosen. If cash is chosen, taxed on cash. HCEs receive this advantage only if the plan does not discriminate in favor of HCEs.
162(1)	Insurance paid for medical care to partners, Subchapter S Owners, and self-employed individuals is deductible from such individuals' gross income (and includable in the income of partners, Subchapter S Owners, and self-employed individuals). For taxable year 2002, 70 percent is deductible; and taxable years 2003 and after 100 percent is deductible from gross income. The remaining premiums that are not deductible, may, with all other IRC Sec. 213(d) allowed medical expenses, be itemized on Form 1040 Schedule A, subject to the 7.5 percent limit and overall limits for itemized deductions allowed under IRC Sec. 68.
213(d)	Determines whether the benefit is a medical benefit that can be excluded from gross income.
220	Tax-favored individual accounts that eligible individuals may establish pursuant to IRC Sec. 220. The Job Creation and Worker Assistance Act of 2002 extends the demonstration period through Dec. 21, 2003. MSAs were originally enacted as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

(continued on following page)

(continued from previous page)

7702B Long-term care benefits are defined as accident and health insurance and the amounts received under such long-term care benefits are considered as reimbursement under Sec. 213. Favorable tax treatment is not permitted for long-term insurance under IRC Sec. 125.

because it benefits higher-income individuals more than lower-income individuals. The regressive tax structure enables workers in higher tax brackets to receive greater tax advantages in dollar amounts than those received by lower-paid workers. This occurs because, although the amount of the benefits is generally the same for all workers with the same employer regardless of income, high-income workers face a higher marginal tax rate.

Figure 20-2 illustrates the value of the health insurance tax exclusion to families with different income levels who work for the same firm. Under the 2003 tax rate structure, the first family in Figure 20-2 faces a 10 percent marginal tax rate. If a \$5,000 health plan were excluded from income, the value of the exclusion in terms of taxes not paid that would be attributable to health insurance would be worth \$500. For the second family, with \$45,000 of taxable income and a 15 percent marginal tax rate, the absolute value of the exclusion is \$750, and the absolute value increases to \$1,750 for the family with \$350,000 of taxable income. The tax exclusion is worth nearly twice as much or more to families in the 28 percent tax rate bracket

Figure 20-2

**VALUE OF \$5,000 EXCLUSION TO SIX FAMILIES OF DIFFERENT TAXABLE INCOME LEVELS, A SIMPLE ILLUSTRATION**

	Taxable Family Income	Exclusion as a Percentage of Taxable Income	Marginal Tax Rate	Amount of Exclusion	Exclusion as a Percentage of Taxable Income
Family 1	\$10,000	50%	10%	\$500	5.0%
Family 2	45,000	11	15	750	1.7
Family 3	100,000	5	25	1,250	1.3
Family 4	150,000	3	28	1,400	0.9
Family 5	250,000	2	33	1,650	0.7
Family 6	350,000	1	35	1,750	0.5

Source: Employee Benefit Research Institute calculations based on 2003 U.S. tax tables for married persons filing jointly.

as it is to families in the 15 percent bracket. For families with no taxable income, the value of the exclusion is worth nothing.

However, as a percentage of income, the exclusion may also be viewed as progressive, as the exclusion represents greater savings for lower-income families than for higher-income families (Institute of Medicine, 1993). Again looking at Figure 20-2, for a \$5,000 health plan, the value of the exclusion is 5 percent of income for family one, 1.7 percent for family two, 1.3 percent for family three, and less than 1 percent for the other families.

Figure 20-2 shows that while the exclusion is greater in dollar amounts for the families with higher income, as a percentage of income the relative value of the exclusion falls as income rises. When examining the tax exclusion by the percentage of income, it should be noted that it is not progressive at all income levels. Families with no taxable income receive no tax exclusion because they pay no taxes. A refundable tax credit would result in a reduction in taxes for these families.

The analysis above includes only the impact of the federal income tax on employment-based health benefits. Additional savings are realized by employees and employers as a result of not having to pay employment taxes (e.g., Medicare taxes). In addition, states with individual tax liability laws may also exclude from state taxable income those amounts received in the form of employment-based health benefits.

## **Employee Participation**

Many employers cover all eligible employees under a single health plan, although different employee groups may have different plans (e.g., union members and nonunion employees may have separate plans). In Feb. 2001, 77.4 percent of workers ages 18–64 were offered health insurance by their employer, and 82 percent of these workers took the insurance (Fronstin, 2002). Claxton et al. (2004) found that, in 2004, 80 percent of workers (all ages) were offered insurance, and 82 percent of these workers took the insurance.

Most employees are covered at the time they are hired or after they satisfy a waiting or service period. In 2004, the average waiting period for health coverage was 1.6 months (Claxton et al., 2004). Workers in the retail industry were subject to, on average, a 2.8 month average waiting period, while those in the service sector were subject to, on average, a 1.5 month waiting period. In addition, the waiting period among small firms was longer than in large firms.

In addition to covering employees, many plans cover their dependents. Employers may pay all or part of the cost of the coverage for an employee or for his or her dependents. However, in many plans, the employer contribu-

tions for employee coverage may differ from the employer contribution for dependents' coverage. Employee and dependent costs for coverage are generally paid through payroll deduction and may be paid with pre-tax dollars under IRC Sec. 125(a). In 2004, employees paid an average of \$47 per month for employee-only coverage (16 percent of the premium), while they paid an average of \$222 per month for family coverage (28 percent of the premium) (Gabel et al., 2004).

## **Type of Health Insurance Administrators**

Employment-based health benefits may use any of a variety of administrators: commercial insurance programs, Blue Cross and Blue Shield plans, self-insured plans administered by third-party administrators (TPAs), or multiple employer welfare plan arrangements (MEWAs). Commercial insurance and Blue Cross and Blue Shield plans are primarily regulated by the states where they provide coverage. The federal government regulates self-insured plans exclusively.

**Commercial Insurance Plans**—Insurance companies are a major source of health insurance. The premium for such insurance protection is calculated to cover the benefits that will be paid, administrative costs, insurance sales commissions, state premium taxes, and surplus (e.g., profit). Generally, for employee groups of 50 or more, the insurer maintains separate claims records for the group and annually adjusts the premium to reflect the group's claims experience; these are called experience-rated plans. In contrast, a community-rated plan is an insurance plan in which the risk is shared among all members of the community and the premium is based on the community's health and the health of the individual plan members. Commercial insurance companies also offer and administer self-funded health plans.

**Blue Cross and Blue Shield Plans**—Blue Cross and Blue Shield plans were originally started in the 1930s. Blue Cross plans were developed based on the concept of a community-based, voluntary, nonprofit group hospitalization or prepayment plan for hospital services. Based on the same concept, Blue Shield plans cover physician services. Although many plans operate under the Blue Cross and Blue Shield name, each plan is independent, generally operates in a specific geographic area, and offers different benefit structures.

Blue Cross and Blue Shield plans must comply with certain standards established by the Blue Cross Blue Shield Association. In addition, in some states, Blue Cross and Blue Shield plans are required to enroll all applicants regardless of health status. In recent years, several Blue Cross Blue Shield plans have converted to for-profit status and merged into larger plans. These

plans are still required to comply with Blue Cross Blue Shield Association standards.

***Self-Insured Plans***—In a self-insured plan, the employer, or a trust to which the employer contributes, pays employee health care claims directly. Thus, the employer essentially acts as its own insurance company and bears the financial risk of making payments to providers. A limited number of employers self-insure and self-administer their medical plans with TPAs, commercial carriers, or Blue Cross Blue Shield. Other employers self-insure their plans but purchase administrative services contracts to take care of their administrative needs. Additionally, some insurers offer stop-loss insurance to employers, which covers catastrophic health expenses above a maximum and, therefore, limits a self-insured plan's liability.

The two main types of stop-loss coverage are individual stop loss (ISL) and aggregate stop loss (ASL). ISL, sometimes called specific stop loss, protects the employer against catastrophic claims by single individuals that exceed a dollar limit chosen by the plan sponsor. For example, if a covered participant incurs catastrophic injuries in an accident and has claims exceeding the contract's agreed-upon dollar limit (deductible), the ISL coverage would reimburse the plan for the covered expenses beyond that dollar limit. ASL, or excess risk insurance, insures against either noncatastrophic or all claims exceeding a total dollar amount for a plan year. This is usually 125 percent of the level of expected claims established by the carrier.

Employers that self-insure do so for a number of reasons. Some employers self-insure in order to retain control of the plan reserves while others self-insure in an attempt to manage health care costs more directly. Some employers prefer to self-insure because these plans are not subject to state mandated benefit laws and insurance premium taxes. In effect, by avoiding state mandated benefits, employers are able to provide a uniform set of benefits to all employees, regardless of where they live. For some employers it makes sense to self-insure because their population of workers is healthier and less costly than the community pool. The Employee Retirement Income Security Act of 1974 (ERISA) prohibits states from regulating self-insured plans.

***Multiple Employer Welfare Arrangements (MEWAs)***—A MEWA is an employee welfare benefit plan or any other arrangement that provides any of the benefits of an employee welfare benefit plan to the employees of two or more employers. MEWAs that do not meet the ERISA definition of employee benefit plan or are not certified by the U.S. Department of Labor may be regulated by states. MEWAs that are fully insured must meet state insurance laws regulating reserves.

## Managed Care

In 2004, 95 percent of Americans with employment-based health benefits were enrolled in some kind of managed care plan (Gabel et al., 2004). Health maintenance organizations (HMOs) and preferred provider organizations (PPOs) represent a great majority of that enrollment with approximately 80 percent. A managed care system typically provides, arranges for, and finances medical services using provider payment methods that encourage cost containment by contracting with select networks of providers.

Before the spread of managed care in the 1990s, insurance coverage was mostly based on a fee-for-service (FFS) system. Beneficiaries in the plan picked their doctors and hospitals at will. Payment was made by the beneficiary when service was rendered, or the health care provider accepted assignment of the claim from the beneficiary, and afterward claim forms were submitted to the insurance company (or self-insured plan sponsor) for reimbursement. Under managed care, enrollees are often required to follow utilization review and disease management procedures in order to secure coverage for services received.

## Reimbursing Health Providers

Health plans calculate payments to providers in different ways: fee-for-service (FFS), discounted fee-for-service, resource-based relative value schedule (RBRVS), per diem, diagnosis-related group (DRG), capitation, or a combination of these.

The traditional health care payment system (FFS), which dominated the marketplace from the 1950s through the early 1990s, used a method of reimbursement under which physicians and other providers received a payment, based upon prevailing charges, for services rendered. Most FFS systems today include consideration of usual and customary rate of charges (UCR). UCR means that the provider's usual fee for the service does not exceed the customary fee in that geographic area, and is reasonable based on the circumstances. A fee may be considered reasonable when special circumstances require extensive or complex treatment, even though it does not meet the standard UCR criteria. Today, many health plans arrange prices for services based upon a fee schedule agreed to in advance of services being rendered.

Discounted FFS is a reimbursement methodology in which the provider is paid a fixed percentage discount from full charges. Discounts may be made in a variety of ways such as package pricing, or established prices for specific items or services (i.e., fee schedules) or maximum price limits imposed through determination of reasonableness. Discounted FFS is commonly used by PPOs.

The RBRVS reimbursement methodology ranks physician services according to the resource inputs required to perform these services. The challenge in producing an RBRVS both properly and fairly requires that each of the resource inputs be defined accurately and that its measurement, weighting, and correlation be based on the best available data and a high level of validity. Medicare heavily relies on the RBRVS reimbursement methodology in order to determine payment amount to physicians.

A per diem is a set daily payment amount for hospital services, agreed to in advance, by a managed care organization (e.g., HMO or PPO) and the hospital. Per diem payment can be a single amount encompassing all levels of hospital treatment or there can be service-specific per diems (e.g., different amounts for medical/surgical, intensive care, maternity services, etc.).

Another reimbursement system, diagnostic-related groups (DRG), uses diagnosis information to establish hospital payments. Medicare uses the DRG approach, as do some other managed care organizations. This system groups patient needs into about 467 categories, based upon the coding system of the International Classification of Disease.

Capitation reimbursement stipulates a dollar amount established to cover the cost of health care services delivered to a person, usually expressed in units of per member per month (PMPM). The term usually refers to a negotiated per capita rate to be paid periodically—usually monthly—to a health care provider. The provider is responsible for delivering or arranging for the delivery of all health services to the covered person under the condition of the provider contract. Capitation is a fixed periodic prospective payment to a provider regardless of the number of services provided to each member. This payment is the same regardless of the amount of services rendered by the provider. Most commonly, capitation reimbursement is limited to HMOs and is confined to primary care services (e.g., it excludes specialty care, hospital care, etc.).

## **Beneficiary Out-of-Pocket Responsibilities**

Virtually all covered services in health care plans are subject to payment limitations and require the employee to share in the costs of coverage. These cost-sharing features generally include some combination of premiums, deductibles, coinsurance, copayments, and maximum caps on benefits. These plan features are intended to reduce plan costs, encourage employee cost consciousness, and lower administrative expenses.

A deductible is a specified amount of initial medical costs that would otherwise be treated as covered expenses under the plan, which each beneficiary must pay before any expenses are reimbursed by the plan. Deductibles typically range from \$100 to \$500 per person, though they can be higher. In

fact, high-deductible health plans associated with a health savings account (HSA) must have minimum annual deductibles of at least \$1,000 for self-only coverage and \$2,000 for family coverage in calendar year 2004.

Under a plan with a \$200 individual deductible, for example, a participant must pay the first \$200 in recognized expenses for covered health care services according to the plan provisions. Some plans have different deductibles for different types of health care services. For example, a plan can have one deductible for inpatient care and a different deductible for pharmaceutical benefits.

The deductible must be satisfied periodically (generally every calendar year) by each participant, sometimes with a maximum of two or three deductibles per family. However, some plans contain a three-month carry-over provision. In this case, any portion of the deductible that is satisfied during the last three months of the year can be applied toward the satisfaction of the following year's deductible.

Coinsurance provisions require the plan participant to pay a portion of recognized medical expenses; the plan pays the remaining portion. Commonly, the employee pays 20 percent, with the plan paying the remaining 80 percent of recognized charges. Most major medical plans include both deductibles and coinsurance provisions. Thus, once the plan participant pays the deductible (e.g., the first \$200 in medical expenses), the plan pays 80 percent of all other covered charges. Some services may have special coinsurance provisions.

Because 20 percent of a large medical claim may pose a significant financial burden for many individuals and families, most plans limit beneficiaries' out-of-pocket expenditures for covered services. In this case, once a beneficiary has reached the out-of-pocket maximum, covered expenses are reimbursed in full for the remainder of the year. The out-of-pocket limit may be renewed at the start of the calendar year for each individual beneficiary. In 2003, the median family out-of-pocket limit was \$3,000 for POS (point-of-service) plans, \$3,000 for PPOs, and \$3,300 for indemnity plans. The median employee-only out-of-pocket limit was \$1,450 for POS plans, \$1,500 for PPOs, and \$1,500 for indemnity plans in 2003 (Hewitt Associates LLC, 2003).

Most medical plans impose a maximum annual or lifetime dollar limit on the amount of health insurance coverage provided. Individual lifetime maximums are usually set at very high levels, such as \$1 million or more. Although less common, plans that impose limits may do so on an episodic (or per episode) basis, such as per hospital admission or per disability.

As health benefit costs continue to escalate, employers are increasingly changing the design of cost-sharing features. Employees are often required to contribute toward routine health benefit cost expenses such as premiums

and deductibles. However, a growing proportion of employees are protected against catastrophic loss by out-of-pocket limits on the overall amount they must pay toward health care costs.

## **Pre-existing Conditions**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) defines a pre-existing condition as a health care condition for which care or treatment was recommended or received during the six months prior to coverage under a health plan. Genetic information is not considered a pre-existing condition. Group health plans are allowed to exclude coverage for pre-existing conditions, but they are prohibited from applying pre-existing condition limits for periods longer than 12 months (or 18 months for late enrollees). The pre-existing condition limit cannot be applied in cases involving pregnancy or in cases involving newborns or newly adopted children, who become covered under the plan within 30 days of eligibility. HMOs are allowed to substitute a 60-day affiliation period (90 days for late enrollees) for a pre-existing condition limit.

When excluding a pre-existing condition from coverage, group health plans are required to take into account an individual's prior creditable coverage when determining the length of the limit. A plan must reduce the duration of its pre-existing condition limit by one month for every month of prior creditable coverage, so long as the individual does not have a break in coverage exceeding 63 days. Waiting periods and affiliation periods are not counted as a break in coverage.

## **Comparing Health Insurance Programs**

The term *health insurance* refers to a wide variety of insurance policies. These range from policies that cover the costs of doctors and hospitals to those that meet a specific need, such as paying for dental care. In the past, health insurance that covered medical bills, surgery, and hospital expenses was typically referred to as comprehensive or major medical policies. Today, when individuals talk about an insurance program, instead of using the term major medical, they are more likely to refer to FFS (e.g., indemnity), PPO, POS, HMO, or some other type of insurance program. These descriptions more accurately describe for consumers the type of health insurance coverage they have. In evaluating a health program, one should consider services covered; cost (premium, annual deductibles, coinsurance, and copayments); access (ease of obtaining appointments, waiting time in physicians' offices, telephone access to physicians); choice of physicians and hospitals, including referrals to specialists; continuity (do patients see the same physician each

time care is sought, what provision is made for changes in the program's coverage of certain specialists); convenience (location of doctors/hospitals and claim filing procedures); coordination (how is care between the primary care physician and specialists coordinated); flexibility (switching physicians, second opinions, denials of care); and quality. The following section discusses differences among health insurance programs in terms of services covered.

## Services Covered

Most insurance programs cover medical expenses for hospital and physician fees, surgical expenses, anesthesia, x-rays, laboratory fees, emergency care, and maternity care. Some programs cover physical exams; preventive care (e.g., vaccinations); health screenings (e.g., mammographies); chemical dependency treatment; prescription drugs; dental, vision, mental health or other psychiatric care; and home health, nursing home, and hospice care. In addition to reviewing what is covered, one should also consider any financial or other limitations on the coverage offered (e.g., the program may cover physical therapy expenses, but limit coverage to a certain number of visits annually).

Most health insurance programs do not cover treatment that is experimental or investigational. However, virtually every treatment is "experimental" when first introduced. In order to overcome an insurance program administrator's determination that a treatment sought is experimental, the administrator would need to be convinced of at least the following: experts in the field recommend the treatment, the patient will benefit from the treatment, and the treatment is not just for the purpose of furthering scientific research. Some health insurance programs allow access to high-quality clinical trials, while other programs may only pay for the patient care costs associated with participating in clinical trials.

Insurance programs typically cover only medically necessary care. A typical definition of appropriate and medically necessary care is the standard for health care services as determined by physicians and health care providers in accordance with prevailing practices and standards of the medical profession and community. For example, laetrile therapy to treat cancer may not be covered as appropriate and medically necessary because the treatment has not been shown to be safe and effective. The utilization review process evaluates requests for medical treatment and determines whether the treatment is medically necessary.

A typical insurance program has many restrictions on coverage. As mentioned above, most policies have a lifetime maximum on what they will pay. Some have a lifetime maximum per illness, per member, and/or per family. Many policies require pre-certification before hospitalization. Pre-

























































































































































































































