Small Group Health Questions & Answers

Q: What is a small group?

A: In Illinois, a small group is defined as having 2-50 full time employees. Most insurance companies define full time as working 30 or more hours weekly. Some will allow as low as 20 hours weekly. If your spouse works full time in your business, he/she will usually be considered as a separate employee rather than your dependent. At least 75% of all eligible full time employees must be on the plan. Employees covered on a spouse's group health plan don't have to be counted for this rule, nor do employees covered under Medicare. You also need at least 50% participation of all full time employees. Union employees aren't counted since they have their own plan.

Q: Does the employer have to pay the entire premium?

A: No. You don't have to pay for any of the dependent premium, but you do have to pay for some of the employee's premium. Most insurance companies require that the employer pay for at least 50% of the employee's premium. Some insurance companies will let you pay a flat amount per employee like $80, $100, $125, etc.

Q: Does every employee have to take the same plan, or do they have a choice?

A: Many insurance companies will allow the employer to choose two plans (two different PPO plans, or one PPO and one HMO plan) to offer to their employees. Some companies will allow the employer to add an HSA High Deductible Plan to the mix as well. Unicare allows each employee to choose from all of their PPO plans.

Q: Will we be accepted if there are health problems in our group?

A: In Illinois, groups of 2-50 full time employees cannot be declined due to health conditions.

Q: Are pre-existing conditions covered when our business applies for a new group health plan?

A: In Illinois, when a group of 2-50 full time employees applies for a new group health plan, pre-existing conditions are covered for any eligible employee or dependent that had continuous health insurance for the prior 12 months. Those with less than 12 months immediately preceding coverage can receive credit for time covered toward meeting the initial 12 month preexisting condition waiting period. Credit for prior coverage will not apply if there is a 63 day or more lapse in the prior coverage just before the new plan starts.

Q: Do we have to wait till our next annual renewal date to change?

A: Not usually. Health insurance isn't like property and casualty insurance where you are penalized for canceling midterm. You pay monthly, and most companies will let you cancel monthly with no penalty.

Q: What is a PPO?

A: A PPO (Preferred Provider Organization) is a network of doctors and hospitals that the insurance company has contracted with to provide services to its health insurance plan members at a discounted rate. A PPO plan gives you full control over which providers you use and when you use them, but will give you incentives to use its network. You'll want to save money with the PPO's huge discounts, and lower out of pocket costs (smaller deductible and coinsurance).

Unlike an HMO, you typically won't be required to pick a primary care physician, and will be able to see doctors and specialists within the network at your own discretion.

You will probably have a calendar year deductible to pay before the insurance company starts covering your medical bills, although charges for doctor visits and certain minor services may be covered with just a small co-payment. Once your deductible has been met, you will usually have to pay a percentage of the next $5,000 or $10,000 (or more). For example, let's say you've met your deductible of $1,000. You may then have to pay 20% of the next $10,000 before the insurance company pays 100%. This is called coinsurance.

With a PPO plan, services rendered by an out-of-network provider are typically covered at a lower percentage than services rendered by a network provider, and may require a higher or separate deductible. For example, when comparing to the network benefits in the sample above, the out of network charges may be subject to a $2,000 deductible, and before the company pays 100%, you'll have to pay 40% of the next $25,000.

Q: What is an HMO?

A: Though there are many variations, HMO (Health Maintenance Organizations) plans typically enable members to have much lower out-of-pocket healthcare expenses, but also offer less flexibility in the choice of physicians or hospitals 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 healthcare 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 healthcare services than you would through another type of plan. You may not be required to pay a deductible before coverage starts, and your co-payments will likely be minimal. However, keep in mind that you'll probably have no coverage whatsoever for services rendered by non-network providers or for services rendered without a proper referral from your PCP. Usually an exception to this restriction is treatment for a true emergency.