Health Insurance Terminology and Frequently Asked Questions

Types of Plans

HMOs - HMO Plans typically offer the smallest network of participating providers and do not provide coverage when you seek services from non-networked physicians, hospitals, out-patient facilities and labs. To receive covered benefits, always make sure you review the provider network for your plan and seek services ONLY from participating providers. Some plans will allow you to self-refer, while others will require a referral to see a specialist. Your plan summary will indicate whether a referral from a primary care physician is required to see a specialist.

PPOs - PPO plans typically offer the largest network of participating providers, and they offer some coverage should you wish to seek services from a non-networked provider. However, your out-of-pocket costs will be higher when you use a nonnetworked health care provider, so this is not recommended. In-network physicians, hospitals and pharmacies have contracts with the insurance companies they work with, and you cannot be "balanced billed" beyond the contracted rates when you use a participating health care provider. On the other hand, outside of the network, you can be “balance billed” if the cost of the service exceeds the "allowed" amount. Outside of the network, deductibles and copayments may be separate and higher than deductibles and copayments inside of the network. For the best coverage, always make sure that you use a participating provider. Your insurance company's website will always have a link to view participating doctors, hospitals and facilities online.

EPOs – EPOs are a hybrid of the PPO and the HMO. EPOs often offer a large network of participating providers (like a PPO), however, they may not offer coverage outside of the network (like an HMO). EPOs do not require you to receive a referral from a primary care physician to see a specialist

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Covered vs. Not Covered

Covered means the service is payable AFTER your deductible is met or it is payable AFTER a copayment is paid. A few services, such as preventive care (immunizations, paps, mammograms, prostate screenings, etc) must be covered at 100% with no cost sharing as a requirement of Federal Health Care Reform. Many people mistake deductible expenses as expenses that are not covered. For example, if your PPO plan's annual deductible has not been met yet, a trip to the lab for bloodwork might result in a deductible expense, an expense that reduces your calendar year deductible. In this case, you will be required to pay the network discounted fee for the blood test. This service is considered a covered expense, even though you must pay for it.

Not Covered - If a service is "not covered", it will not reduce your calendar year deductible.

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What is a Deducible?

A deductible is the amount you must pay out of your own pocket before health insurance benefits kick in for certain services. Most health care products and/or services are subject to a deductible, except preventive care and in many cases, routine sick visits and prescription drugs. Plan deductibles are almost always tracked by calendar year, however some plans do track by plan year (renewal to renewal). Your summary will tell you if you have a calendar year deductible or a plan year deductible.

Some plans have an embedded, "per person" deductible, while other plans have an aggregate, "family" deductible.

- **Embedded Family Deductible** - If you see the word “embedded” next to the family deductible and maximum out of pocket, that means each person in the family has their own deductible, and an individual family member will begin to receive coverage once the individual family member’s deductible is met. Once the family deductible is met, then all family members receive coverage for the remainder of the calendar year, regardless of the size of the family.
- **Aggregate Family Deductible** - If you see the word “aggregate” next to the family deductible and maximum out of pocket, that means that the entire family deductible must be met before coverage kicks in for any one family member.

Typically, insurance plans are less expensive when you choose a higher deductible plan. In terms of healthcare reform, Bronze Plans will have the highest deductibles and lowest premiums, while Silver, Gold and Platinum Plans will be more expensive and have lower out-of-pocket costs.

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What is Co-Insurance?

Co-insurance is the percentage of healthcare costs that you will split with the insurance carrier after your calendar year deductible is met. Like the deductible, co-insurance is also typically tracked by calendar year and starts over again each calendar year. However, some plan do track these out-of-pocket-costs by “plan year” (renewal to renewal). Your plan summary will tell you if deductibles and co-insurance are tracked by calendar year or by plan year. Typical Coinsurance splits are 80/20, 70/30, 60/40 and 50/50. You will continue to pay your portion of the co-insurance until your coinsurance maximum (out-of-pocket maximum) is met. The plan summary will always tell you what your co-insurance maximum is. Once the co-insurance maximum is met, your insurance carrier will pay 100% of covered expenses.

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What is a Copayment (Copay)?

Office Visit Copayment - An office visit copay is the flat dollar amount that you pay for a routine visit to either a primary care physician or a specialist, Coverage is 100% after the copay. Some catastrophic plans do not offer an office visit copay. Instead, the cost of a routine office visit can apply towards a plan deductible. Do not assume that your health plan includes an office visit copay. Be sure to read your plan description to verify coverage for a routine office visit. When you pay a copay, your deductible IS NOT reduced by the amount of that copay, however, all plans count copayments towards the plan's maximum out-of-pocket limit.

Prescription Copayment – A prescription copay is the flat dollar amount you must pay for the "tier" of prescription you are purchasing. Typically, prescription tiers fall into the following categories:

- Generic
- Preferred Brand
- Non-Preferred Brand
- Specialty

Generally, the higher the tier, the more expensive your copayment is going to be. All insurance companies have a prescription drug formulary you can look at online to determine which tier your prescription falls into.

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Primary Care Physician

Some insurance plans, typically HMOs, require you to designate a Primary Care Provider (PCP). When a plan requires you to designate a primary care physician, this physician is the physician you are going to use to get referrals to see specialists or to have a procedure pre-approved. When it is required for you to designate a Primary Care Provider, you will not be able to enroll in your plan until you specify who you would like this doctor to be. It must be:

- A doctor that is either a generalist, a family practitioner or an internist
- A doctor that participates in the plan's network (navigate to the insurance company's website to find a participating provider).
- Cannot be a PA, NP or Gynecologist
- Accepting new patients – If you are a current patient with this physician, that is OK too.

If you do not have a Primary Care Physician, you can ask your account manager to auto assign one for you, if you don't feel that you are able to make this decision on your own.

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Maternity Coverage

We get a LOT of questions about maternity coverage. The State of Colorado requires all plans to cover maternity. Maternity is not considered to be a "pre-existing condition", so it will be covered regardless of whether you are currently expecting. Even so, please understand that most plans cover maternity subject the plan deductible and maximum out-of-pocket amounts. Therefore, be sure that you clearly understand what your out-of-pocket costs are likely to be for prenatal care, labor and delivery before enrolling.

Once the baby is born, the baby is his or her own person and will have his or her own deductible and out-of-pocket maximum. You should expect that there will be additional out-of-pocket costs for the baby's medical expenses, on top of your own deductible and out-of-pocket maximum. We don't typically see babies reaching their out-of-pocket maximum, but if there are complications, it is possible, so that is something that should be considered when choosing your plan.

The State of Colorado requires baby to be covered under mom's plan for the first 30 days of life, regardless of whether the parent formally adds the baby to coverage. HOWEVER, once the baby is formally added, the effective date will be the baby's date of birth, and coverage will be billed based on that effective date. You cannot choose your baby's coverage effective date. The effective date is always the date of birth. If you do not formally add your baby to coverage by filling out and turning in an enrollment form, coverage will automatically terminate after the state mandated 30 days, so if you want to add your baby to coverage be sure to contact the insurance company or your HR department and turn in a formal signed application to add your baby to your policy

Short Term Disability Coverage for Maternity Leave – If you are enrolled on a short-term disability plan, you can file a maternity leave claim. Coverage typically spans 6 weeks for a normal delivery and 8 weeks for a C-Section. Call your insurance company for specifics. Coverage will not extend past that time frame unless there is a complication. You must complete the appropriate claim forms and turn them into your broker or HR department to begin the process of short-term disability leave for maternity.