Health Insurance Terminology

As you begin to review your benefit choices, consider the following before selecting a plan:

Types of Plans

Before applying for health insurance coverage you will want to make sure that your favorite physicians and local facilities are in the network. Links to Doctor Directories can be found here.

- **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 non-networked 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.

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

Deductibles

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.

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 co-insurance 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.

Office Visit Co-Payments
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.

Maternity Coverage - In Colorado, all insurance plans must cover maternity subject to the plan deductible and co-insurance.