



ABCs of Health Insurance

Health insurance has its own language and it can be tough to decipher. Here are some basic terms that you'll see as you consider which health plan is best for you and your family.

Co-insurance -- The percentage of your bill the insurer will pay. A typical co-insurance is 80 percent (you pay the remainder). Depending on your coverage, your portion could be higher if you use doctors who are not on the plan's list of approved providers.

Co-payment -- The set amount of money you'll pay for basic services such as office visits, emergency room visits or prescriptions. A typical co-pay for a doctor's office visit is \$20-\$25. For prescriptions, normal co-pays are \$15 for generic drugs and \$35 for formulary brand drugs.

Deductible -- The amount of expenses you pay on your own before coverage begins. It might be \$500, \$1,000 or more. Like other kinds of insurance, if you take a higher deductible, your premium will be lower.

Excluded or restricted services -- Some plans may not cover or may limit coverage of maternity care, chiropractic services and mental health services. Common exclusions include normal dental and vision services and cosmetic surgery, for example.

Lifetime benefit -- The total amount of coverage available over a lifetime. It could be \$2 million or more.

Maximum out-of-pocket expense -- The most you will pay out of your pocket during a year, including your deductible and your portion of the bill.



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Network -- The group of health care providers contracted to provide services to members of the plan. There are four basic types of networks:

- **Health Maintenance Organization (HMO)** -- It will be the least expensive and offer the least amount of flexibility. The concept behind an HMO is to keep you from getting sick, so it's more likely to pay for items such as annual physicals, vaccinations and programs to help you quit smoking. In an HMO, your entry point into the system is a primary care physician (PCP). You see that doctor first, and he/she may or may not refer you to a specialist, who is a member of the same network. If you sidestep your PCP or use a doctor or hospital that isn't in the network, you may pay the entire cost yourself.
- **Point-of-Service Plan (POS)** -- It's an HMO that will provide coverage if you go outside the network. You may have to pay a higher deductible and the reimbursement will be at a lower level.
- **Preferred Provider Organization (PPO)** -- Unlike an HMO or a POS plan, PPOs don't have PCPs. The insurer has negotiated fees with a broad range of doctors, and your coverage is good with anyone on the list. You can also go outside the network and still have coverage, although at a lower level.
- **Indemnity Plan** -- This is traditional health insurance. You can go to any licensed health care provider anywhere you want. Because the insurance company has very little control and few opportunities to reduce costs, they charge the most for this kind of coverage for similar benefits.

For most people, the top issues when deciding which type of network they use are the cost and the health care providers in the network. For those with a family doctor they like, or an ongoing medical condition, changing doctors can be a significant concern. If those aren't issues, it comes down to how much coverage you can afford and how much control you want.

Premium -- The monthly cost of the coverage.

Riders -- While the base insurance policy may have exclusions, many include the option to buy coverage at an additional premium. It is common to have maternity, mental health and accident care riders.

