

Health Insurance Basics:

Key Words and Phrases You Need to Know



Shopping for insurance can be confusing, but the Affordable Care Act (ACA) makes it easier to understand. This simple guide will help you make smarter choices for you and your family.

What You Pay

There are different costs associated with health insurance. When choosing a plan, it is important to take into account all of the costs for each plan.

Premium

The money you pay the insurance company to buy the plan. You usually pay this monthly or every pay period. If you get coverage through your job, your employer may also pay a part of the premium.



Deductible

The amount you have to pay for your health care each year before your insurance starts paying for care. Similar to car insurance, many health plans require you to pay a certain amount “out of pocket” before their coverage kicks in.



For example, if your deductible is \$300, you have to pay the first \$300 of your medical costs yourself before the insurance starts paying.

In some plans, the deductible applies only to services that you get outside their “provider network.” Also, some plans have a separate deductible for prescription medications. Usually, the deductible does not apply to preventive services.

What You Pay

Copayment/Co-insurance

The money that you may have to pay “out of pocket” for each service you receive. This could include an office visit with a doctor, a prescription medicine, an x-ray, or a hospital stay.



If the money you pay is a set amount (for example, a \$15 payment to a doctor), it is called a copayment (or copay).

If the money you pay is a percentage of the cost of the service (for example, 20 percent), it is called co-insurance.

Copayments and co-insurance can vary depending on the kind of service it is and whether you receive it from a provider that is in the plan’s network or not. Many preventive services now do not require copayments or co-insurance.

Out-of-Pocket Limit

The most you will have to pay each year for care covered by your plan. Once you hit that limit, your insurance starts paying for all of your covered costs.



Getting the Health Care You Need

Different plans have different rules about how you can get the health care you need and still have your plan cover your medical costs. You should know these rules to make sure you get the benefit of your plan's coverage and save money.

Provider Network

The doctors and other health care providers who have agreed to work with your health insurance company.

Different kinds of plans have different rules about their provider networks. Most will require higher out-of-pocket costs if you go outside their network, and some won't cover any care outside of their network at all.

There are two types of provider networks:

- Preferred Provider Organizations (PPOs) and Point of Service (POS) plans
- Health Maintenance Organizations (HMOs) and Exclusive Provider Organizations (EPOs)

Preferred Provider Organizations (PPOs) and Point of Service (POS) Plans

Plans that usually cover some of the cost of services you get outside their preferred provider network. However, you will probably have to pay higher deductibles and/or copayments or co-insurance if you go outside the network.



Getting the Health Care You Need

Health Maintenance Organizations (HMOs) and Exclusive Provider Organizations (EPOs)



Plans that usually cover only care that is provided within their network. They also often require you to pick a “primary care doctor” to go to for your regular visits (like a family physician, an internist, or a pediatrician) who has to give you permission, or a “referral,” to see a specialist.

Preauthorization

A requirement that certain services, treatments, medications, and equipment be approved in advance by the insurance company, except in emergencies. While getting preauthorization doesn’t guarantee that the service will be covered, not getting it when you need to will likely cause you to pay more than you could have if you had gotten preauthorization.

TIP: To get the most out of your insurance, know your plan’s rules. To save the most money, try to stay in its preferred provider network (if it has one) and get the proper referrals and preauthorizations if you need them.

Picking the Right Plan

To make the best health insurance choice for you and your family, you can't look just at the "sticker price"—the premium. Consider all the costs related to the insurance, as well as what you are actually getting for your money. Keep these things in mind when choosing a plan:

- **Usually, a lower premium means a higher deductible, and a higher premium means a lower deductible.** The choice you face is whether you want to pay less per month but pay higher medical costs out of pocket if you get sick, or you can pay more each month but pay lower medical costs when you need care. (Don't worry about preventive care like check-ups, vaccinations, and mammograms—deductibles usually won't apply to these services.)
- **Some plans have separate deductibles for different services.** For example, a plan might have one deductible for medications and a separate deductible for other services.
- **Remember that there may also be differences in copayments and co-insurance that you should consider.** However, these likely won't apply to preventive care.
- **Don't assume that deductibles and copayments or co-insurance are the only differences between plans—even when plans are offered by the same company with similar names.** Be sure to check whether all the same health services are covered, and be aware of any

Picking the Right Plan

limits on coverage of these services. (For example, the plan might cover only a specific number of days in the hospital or visits to physical therapy.)

- **Be sure to check that the plan covers the prescription drugs you take and at what price.** Many plans have different copayments or co-insurance for different drugs, and some drugs may be much more expensive than others.
- **Remember that most plans have provider networks you need to use to get the lowest-cost care.** Make sure the plan's network works for you. And if you already have a provider you want to keep seeing, make sure she is part of the network.

Where can I find a plan for me?

Enrollment in coverage for 2017 runs from November 1, 2016, through January 31, 2017. You can shop for an affordable health insurance plan and apply for financial assistance to help pay for the plan you choose. In fact, most people receive financial assistance.

You can sign up any time during the year if you experience a major life change like getting married, having a baby, or losing your job. And don't forget that Medicaid enrollment is open year-round.



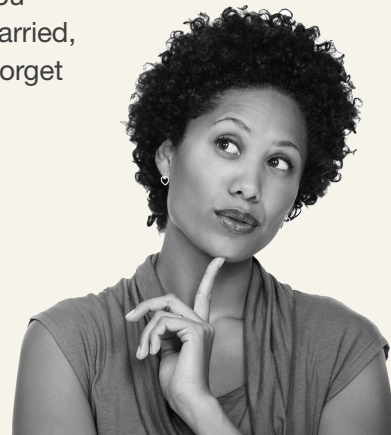
Go to www.healthcare.gov to connect to your state's marketplace.



You can also call **1-800-318-2596**.



Local, in-person assistance is available to help you sign up, just call **1-800-318-2596** or go to localhelp.healthcare.gov.





202-628-3030

info@familiesusa.org

www.familiesusa.org

 FamiliesUSA

 @FamiliesUSA



NATIONAL COUNCIL OF LA RAZA

202-785-1670

policy@nclr.org

www.nclr.org

 Nationalcounciloflaraza

 @ NCLR