



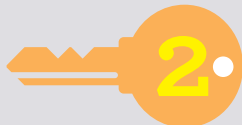
# to Understanding Your Health Insurance Costs

**H**health insurance plans can be complex and intimidating. Understanding the basics of how a health insurance plan works and learning the terms used can be beneficial. We then ask better questions, make better insurance decisions and get the most from our health insurance plan. This publication will take you through five keys to gain a better understanding of your health insurance costs.



## 1 Know Your Health Insurance Terms and Definitions

Knowing the terms used in talking about health insurance will help you be more comfortable when talking about your health insurance with your medical providers. Knowing the language makes asking questions easier.



## 2 Know Your Network

Using network health providers saves you money. A network is made of the different health-care providers, including doctors, clinics, hospitals and pharmacies, with whom an insurance company has contracts to deliver health-care services at negotiated fees.



## 3 Know Your Costs

The four types of costs you may pay when using health insurance are premiums, deductibles, copayments and coinsurance. You need to be aware of what they are and how and when they are paid.



## 4 Know Your Preventive Care Options

Preventive care is regular health care intended to keep you healthy and avoid disease. Many preventive health-care services are fully covered by your health insurance plan at no cost to you. Accessing these preventive services ensures you get the most from your health insurance.



## 5 Know your Prescription Drug Benefits

All qualified health insurance plans include a prescription drug benefit plan. These benefits can help in paying for prescription drugs your family uses. Each health plan covers prescription drugs differently. Know your plan!



# Know Your Health Insurance Terms and Definitions

**Bold blue text** indicates a term also defined in this glossary.

## Allowed amount

Maximum amount on which payment is based for covered health-care services. This may be called “eligible expense,” “payment allowance” or “negotiated rate.” If your **provider** charges more than the allowed amount, you may have to pay the difference. A preferred provider may not charge for the difference.

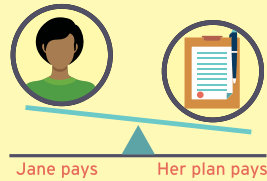
## Balance billing

When a **provider** bills you for the difference between the provider’s charge and the **allowed amount**. For example, if the provider’s charge is \$100 and the allowed amount is \$70, the provider may bill you for the remaining \$30. A **preferred provider cannot charge you** the balance of the bill for covered services.

## Coinsurance


Your share of the costs of a covered health-care service, which is calculated as a percent (for example, 20 percent) of the **allowed amount** for the service.

You pay **coinsurance** plus any **deductibles** you owe. For example, if the health insurance or plan’s allowed amount for an office visit is \$100 and you’ve met your deductible, your coinsurance payment of 20 percent would be \$20. The health insurance or plan pays the rest of the allowed amount.



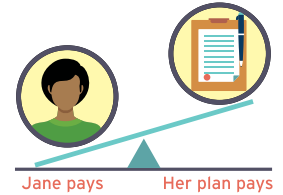
## Copayment (copay)

A fixed amount (for example \$15) you pay for a covered health-care service, usually when you receive the service. The amount can vary by the type of covered health-care service.

 Insurance Company Name: _____	
Plan Type: _____	Member Name: _____
	Member ID Number: _____
Prescription <b>Copay</b> :	
Generic: \$ _____	Office Visit <b>Copay</b> : \$ _____
Name Brand: \$ _____	Emergency Room <b>Copay</b> : \$ _____

## Deductible

The amount you will pay for health-care services your **health insurance** covers before your health insurance begins to pay. For example, if your deductible is \$1,000, your plan won’t pay anything until you’ve met your \$1,000 deductible for covered health-care services subject to the deductible. The deductible may not apply to all services.



## Deductible is waived

Some health insurance plans waive the deductible for some medical services. For these medical services only, the plan will pay any charges over the amount of the **copay**, even if the **deductible** has not been met.

## Excluded services

Health-care services that your **health insurance** or plan doesn’t pay for or cover.

## Formulary

A list of prescription drugs, generic and brand name, covered by a prescription drug plan or an insurance plan offering prescription drug benefits.



## Nonformulary

Any drug not listed on the **formulary**. These drugs will not be covered by the health plan’s prescription drug plan.

## Health insurance

A health insurance policy is a legally binding contract between the insurance company and the insured. The policy describes how much your health insurer will pay for your health-care costs in exchange for a monthly **premium**.

## In-network coinsurance

The percent (for example, 20 percent) you pay of the **allowed amount** for covered health-care services to **providers** who contract with your **health insurance** or plan. **In-network coinsurance** usually costs you less than **out-of-network coinsurance**.

## In-network copayment

A fixed amount (for example \$15) you pay for covered health-care services to **providers** who contract with your **health insurance** or plan. **In-network copayments** usually are less than **out-of-network copayments**.

## Network

The facilities, **providers** and suppliers your health insurer or plan has contracted with to provide health-care services.

## Nonpreferred provider

A **provider** who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a nonpreferred provider. Check your policy to see if you can go to all providers who have contracted with your **health insurance** or plan or if your health insurance or plan has a "tiered" **network** and you must pay extra to see some providers.

## Out-of-network coinsurance

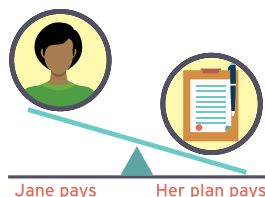
The percent (for example, 40 percent) you pay of the **allowed amount** for covered health-care services to providers who do not contract with your **health insurance** or plan. **Out-of-network coinsurance** usually costs you more than **in-network coinsurance**.

## Out-of-network copayment

A fixed amount (for example \$30) you pay for covered health-care services from providers who do not contract with your **health insurance** or plan. **Out-of-network copayments** usually are more than **in-network copayments**.

## Out-of-pocket limit

How much you must pay for medical services during a policy period (usually a year) has a limit. Once that out-of-pocket limit has been reached, your **health insurance** begins to pay 100 percent of the **allowed amount** for each service. This limit never includes your **premium**, **balance-billed charges** or health care your health plan doesn't cover. Some health plans don't count all of your **copayments**, **deductibles**, **coinsurance** payments, **out-of-network** payments or other expenses toward this limit.



## Pre-authorization

A decision by your health insurer or plan that a health-care service, treatment plan, prescription drug or durable medical equipment is medically necessary.

## Preferred provider

A **provider** who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your **health insurance** or plan has a "tiered" **network** and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who also are "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

## Premium

The amount that must be paid for your **health insurance** or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

## Prescription drug coverage

**Health insurance** or plan that helps pay for prescription drugs and medications.

## Provider

A physician (M.D., medical doctor, or D.O., doctor of osteopathic medicine), health-care professional or health-care facility licensed, certified or accredited as required by state law.



## Primary care provider

A physician (M.D., medical doctor, or D.O., doctor of osteopathic medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health-care services.

## Summary of benefits

**Health insurance** companies must provide you with a short document detailing in plain language information about their health plan benefits and coverage. It will summarize the key features of the plan, such as the covered benefits, cost-sharing provisions, and coverage limitations and exceptions.

## Tiers

Within a plan's **formulary** list of medications covered, each medication will be placed in a tier, as in Tier 1, Tier 2, etc. Lower-level Tier 1 medications will be less expensive; higher-level tiers will cost you more.

*This glossary has many commonly used terms but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan.*



# Know Your Network

When selecting a health insurance plan, one of the most important features to consider is the **network**.

## What Is a network?

A network is made up of the different health-care providers with whom an insurance company has contracts to deliver health-care services at negotiated fees. Most insurers contract with all types of providers: physicians, surgeons, therapists, hospitals, pharmacies and labs, to name the most common.

## Who is in your network?

Your insurance company will provide you with a list of all of the current **providers** in its network. Reviewing the list of network providers is important to see if the doctors, hospitals and other health-care providers you already see for health care, or would like to see for health care, are on that list.

Your health plan also may have a preferred network and a nonpreferred network of providers. The plan may provide more cost assistance with the preferred network, although you still can choose a **nonpreferred provider** and pay a higher portion of the cost.

## In-network vs. out-of-network

If a **provider** is under contract, that provider is considered “**in-network**.” If the provider is not under contract, that provider is considered “**out-of-network**.”

## How does a network work?

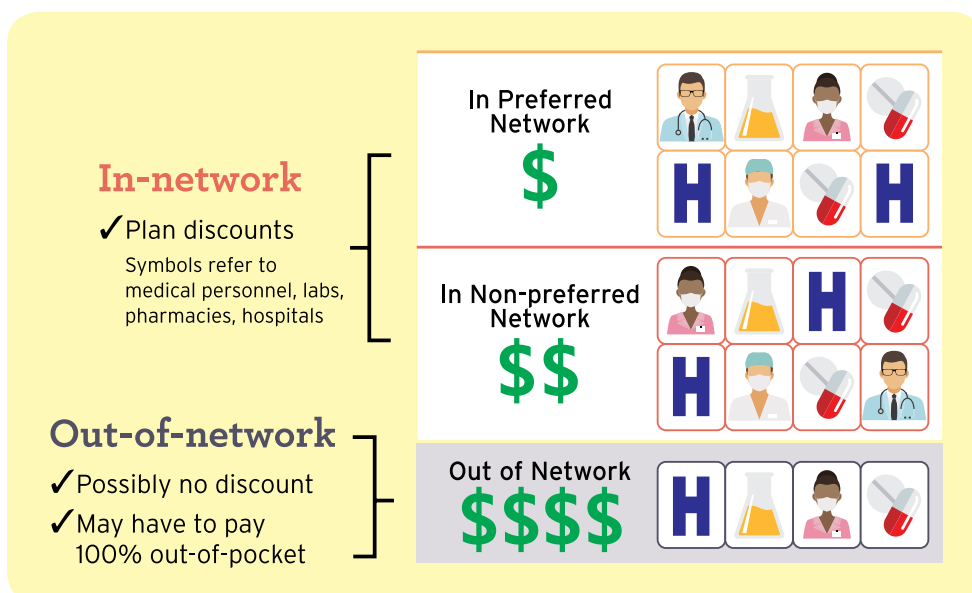
The most important difference between using an **in-network** provider and an **out-of-network** provider is cost. Many insurance plans encourage you to use in-network providers by offering lower **deductible, coinsurance** and **copay** amounts when you use network providers.

That does not mean that you cannot use other providers. But if you do choose to use an out-of-network provider, the insurance plan’s share of the costs will be less than if you used an in-network provider. You will pay more for services. Some health plans may not cover any of the costs when you see an out-of-network provider. Use in-network providers to keep your health-care costs lower.

When you call to make an appointment, ask if the provider is still in your insurance plan’s network.

## What about seeing a specialist?

Some plans instruct you to visit a **primary-care provider** (usually an internist or a family doctor) before seeking a consultation from a specialist. In those plans, the primary-care provider is the one who gives you a formal referral to a specialist if you need specialty care. A visit to a specialist may have a higher **copay** or **coinsurance**. Also determine if the specialist is **in-network** or **out-of-network**.



## What if I travel a lot during the year?

Because most networks feature local health-care providers, you will be faced with an added **out-of-network** expense if you need medical care while you travel. Some plans allow you to use out-of-network providers in a medical emergency. Ask your insurance provider how it handles medical expenses incurred when you travel away from home.

Source: This material was adapted from a publication authored by Elizabeth Kiss, Ph.D., et al., *Finding a Network Provider, Fact Sheet*, Kansas State University, April 2015.

Image adapted from: Health Insurance Literacy for the Marketplace, 2014



# Know Your Costs

You have four types of **costs** you may pay when using health insurance.

## Premium

If your plan has a **premium**, you or your employer must prepay your premium each month. For example, the January premium is paying for February's **health insurance** coverage. If you don't pay your premium every month, you will lose your health insurance. Make sure to pay on time every month. Keep records of each payment.

## Deductible

Your **deductible** is an amount of money you have to pay for health services you use each year. After you have paid your deductible, your **health insurance** will pay its share for any other health services you need during the year. Some of the health services you may have to pay for until you reach your deductible are doctor visits, lab work or a visit to the emergency room. Your health plan also may waive the deductible for some services. You do not have to pay anything for services that are preventive, such as flu shots and birth control.\*


**\$**

Do you have a premium, deductible, co-pays or co-insurance with your health plan? If yes, how much are they?

If you don't know, call the member services line for your health plan. The number is on your insurance card.

Then, your health plan starts paying.

You pay your deductible first.

 Insurance Company Name: \_\_\_\_\_

Plan Type: \_\_\_\_\_ Member Name: \_\_\_\_\_

Member ID Number: \_\_\_\_\_

Prescription **Copay**:

Generic: \$ \_\_\_\_\_ Office Visit **Copay**: \$ \_\_\_\_\_

Name Brand: \$ \_\_\_\_\_ Emergency Room **Copay**: \$ \_\_\_\_\_

## Copay

The **copay** is a fixed amount you pay when you get a health service that is **not preventive**. A health service could be a doctor visit, a laboratory test, a prescription medicine or a visit to the emergency room.

Different types of health services have different copays. For example, a doctor's office visit may have a \$25 copay. You must pay this at the doctor's office.

Your copay for prescription drugs could be \$15 for some medicines and more for others. You must pay this copay at the drug store.

## Coinsurance

After you have paid your **deductible** for the year, you may have to pay **coinsurance** for certain health services that are **not preventive**.

This charge is a part or percentage of the total cost for these health services.

*Here's an example:* Sonya has a **deductible** of \$1,000 and **coinsurance** of 20 percent. After she paid her deductible for the year, she had an accident and needed an X-ray. The X-ray cost \$100. Her insurance paid \$80 and she paid \$20.



## Out-of-Pocket Limits

All qualified **health insurance** plans now must have an out-of-pocket limit. This is the most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100 percent of the **allowed amount**. This limit never includes your **premium**, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your **copayments**, **deductibles**, **coinsurance** payments, **out-of-network** payments or other expenses toward this limit.

Source: Adapted from *My Health My Voice* publication developed by Raising Women's Voices for the Health Care We Need.

\* Some health insurance plans were grandfathered into the Affordable Care Act regulations and may not cover all of these preventive-care services at no cost. Check with your insurance provider to determine if it is a grandfathered plan.



# Know Your Preventive Care

“Preventive care” is regular health care intended to keep you healthy and avoid disease. Many preventive health-care services are fully covered by your **health insurance** plan at no cost to you.

## Preventive services that are **no additional cost** to you with your health insurance\*:

### For women only

- Well-woman visits
- Birth control
- Test for cervical cancer
- Tests and counseling for sexually transmitted infections such as chlamydia, gonorrhea, syphilis and HPV
- Mammograms (after age 40)
- Osteoporosis tests (after age 60)
- Help if you are the victim of domestic violence
- Tests during pregnancy for anemia, gestational diabetes, hepatitis B, Rh incompatibility, urinary tract infections
- Breastfeeding support, counseling and supplies
- Folic acid supplements
- Breast cancer genetic test counseling (BRCA)
- Breast cancer chemoprevention counseling



### For adults

- Tests
  - Blood pressure
  - Cholesterol
  - Colorectal cancer (after age 50)
  - Depression
  - Diabetes (Type 2) test (if you have high blood pressure)
  - Hepatitis B (if you have higher risk)
  - Hepatitis C (if you have higher risk)
  - HIV
  - Lung cancer (if you are a heavy smoker aged 55-80)
- Vaccines
  - Hepatitis A
  - Hepatitis B
  - Influenza (flu)
  - HPV
  - Measles, mumps, rubella (German measles)
  - Meningitis
  - Pneumonia (pneumococcal)
  - Shingles
  - Tetanus, diphtheria, pertussis (whooping cough)
  - Chicken pox
- Weight loss counseling (if you are obese)
- Diet counseling (if you have high risk of disease)
- Help for alcohol abuse
- Help quitting smoking (smoking cessation)



### For children

- Autism screening
- Behavioral assessments
- Blood pressure screening
- Cervical dysplasia screening
- Depression screening
- Developmental screening
- Dyslipidemia screening
- Fluoride chemoprevention supplements
- Gonorrhea preventive medication
- Hearing screening
- Height, weight and body mass index measurements
- Hemoglobin screening
- Sickle cell screening
- HIV screening
- Hypothyroidism screening for newborns
- Immunization vaccines
  - Diphtheria, tetanus, pertussis
  - Hemophilic influenza Type B (Hib)
  - Hepatitis A
  - Hepatitis B
  - Human papillomavirus
  - Inactivated poliovirus
  - Influenza (flu)
  - Measles, mumps, rubella
  - Meningococcal
  - Pneumococcal
  - Rotavirus
  - Varicella
- Iron supplements for children
- Lead screening for children at risk of exposure
- Medical history for all
- Obesity screening and counseling
- Oral health risk assessment
- Phenylketonuria (PKU) screening
- Sexually transmitted infection (STI) prevention counseling and screening for adolescents at higher risk
- Tuberculin testing for children



*\*Some health insurance plans were grandfathered into the Affordable Care Act regulations and may not cover all of these preventive-care services at no cost. Check with your insurance provider to determine if it is a grandfathered plan.*



# Know Your Prescription Drug Coverage

All qualified **health insurance** plans include a prescription drug benefit plan. These prescription drug benefits will vary depending on the type of health plan you have.

## Prescription drugs

Medications that are prescribed by a doctor to treat an illness or condition. “Over the counter” (OTC) drugs usually are not covered, even if a doctor writes you a prescription for them.

## The Basics of Prescription Drug Coverage

Each **health insurance** plan has a list of covered medicines called the formulary. Each health plan may have different medications in its **formulary**. The formulary lists each brand and generic name of medicines that the plan includes. Formularies can change. Medicines can be added or removed.

If your doctor prescribes a medication that is not on your health plan’s formulary list, you will be responsible for the entire cost of that medication.

Formularies may have two or more cost levels, called **tiers**. The **copayment** and/or **coinsurance** for each tier will be different. Higher-level tiers cost you more. For instance, a third-tier medicine will cost you more than a first-tier one.

Many health plans have three or four tiers of costs:

- **Tier 1:** Generic medicines, which cost the least
- **Tier 2:** Preferred, brand-name medicines
- **Tier 3:** Nonpreferred, brand-name medicines
- **Tier 4:** Specialty medicines, which often are costly, brand-name medicines

Your prescription benefits may have a **copay** and/or a **coinsurance** that you are responsible for when purchasing a medication. Your health plan’s **summary of benefits** will tell you if you have a copay and coinsurance and how much they are. Your **health insurance** card also may list your prescription co-pay.

**Note:** You may have a separate **deductible** for prescription drugs. You may need to pay it as well as a deductible for medical services. Look at your health plan’s **summary of benefits** about prescription medicines to see what you are responsible for paying.



Contact your health insurance **provider** for a list of medications in your health plan’s **formulary**.



Insurance Company Name: \_\_\_\_\_

Plan Type: \_\_\_\_\_ Member Name: \_\_\_\_\_

Member ID Number: \_\_\_\_\_

Prescription **Copay:**

Generic: \$ \_\_\_\_\_ Office Visit **Copay:** \$ \_\_\_\_\_

Name Brand: \$ \_\_\_\_\_ Emergency Room **Copay:** \$ \_\_\_\_\_



## to Understanding Your Health Insurance Costs

### Additional resources

#### **Federal Government Health Insurance Exchange**

[www.HealthCare.gov](http://www.HealthCare.gov)

#### **A Woman's Step-by-Step Guide to Using Health Insurance**

[www.myhealthmyvoice.com/](http://www.myhealthmyvoice.com/)

#### **ND Insurance Department**

[www.nd.gov/ndins/consumers/health/](http://www.nd.gov/ndins/consumers/health/)

#### **Understanding Health Insurance**

<http://kff.org/understanding-health-insurance/>

#### **Sample Summary of Benefits**

[www.cms.gov/CCIIO/Resources/Files/Downloads/sbc-sample.pdf](http://www.cms.gov/CCIIO/Resources/Files/Downloads/sbc-sample.pdf)

#### **Grandfathered plans**

[www.healthcare.gov/health-care-law-protections/grandfathered-plans/](http://www.healthcare.gov/health-care-law-protections/grandfathered-plans/)

### Sources

Elizabeth Kiss, Ph.D., et al., *Finding a Network Provider, Fact Sheet*, Kansas State University, April 2015.

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