

# Health Insurance Cheat Sheet

HMO – Health Maintenance Organization

EPO – Exclusive Provider Organization

HDEPO – High Deductible Exclusive Provider Organization

HDPPO – High Deductible Preferred Provider Organization

POS – Point of Service

**HMO** – These plans require that you choose a Primary Care Physician (PCP) who will coordinate all of your care within a network. Your PCP will treat or refer you to any specialists or lab services that you may need. Most HMO's require a referral for you to be treated by a specialist and for certain surgeries and testing. HMO's are popular because there is a set fee (co-pay) that you pay per visit. The co-pays may vary based on the type of service. No "Out-of-Network" (OON) services are covered.

**EPO & HDEPO** – These plans are consumer-driven plans; which means that in most cases the consumer is responsible for more of the cost of their health care. EPO plans give you the flexibility of choosing your doctors and specialists. Most often referrals are not needed except for certain high priced radiology services and certain types of surgeries. These plans often have a network of doctors outside of the subscriber's service area. EPOs may have co-pays and deductibles for services, as well as a coinsurance. HDEPO plans usually have a large deductible that must be met before benefits for services are covered.

**HDPPO** – Preferred Provider plans allow both an In and Out of Network of providers. As with an EPO you have the flexibility to choose your doctors. In network you will often pay a lower cost than going out of network. High deductible plans will often have a deductible over \$1000 per person which must be met before services are covered. Out of network deductibles and coinsurance are usually higher than the in network benefits. For OON services you must pay the doctor directly and submit the bills to your provider for reimbursement.

**POS** – Point of service is a combination of a HMO and a PPO plan. You will need to choose a PCP and you will have coverage for In Network services subject to co-pays. OON services are subject to a deductible and coinsurance. This plan is the most flexible of all the plans as you have the benefits of paying a co-pay for in network benefits with the option to choose an OON provider when necessary.

## Definitions and abbreviations associated with insurance plans:

**OON**- Out of Network

**Co-pay** – a set cost that the subscriber will pay for a service

**Coinsurance**- a percentage of cost the patient will pay for a service. Ex. A \$200 bill with a 20% coinsurance would mean the patient will pay \$40 out of their pocket.

**Deductible** – The amount set by the insurance company that a subscriber must pay before the insurance is responsible for any payment. This can range from \$100 to \$5000 or more.

**Out of Pocket (OOP)** – This is the amount a subscriber must pay out of their own pocket. The out of pocket expense is usually a combination of the deductible and coinsurance paid by an individual. Many EPO, HDEPO, POS AND HDPPPO plans have a maximum out of pocket expense attached to them. Once a subscriber meets the OOP their benefits are then paid at 100% by the insurance company.

**Embedded Deductible**- An embedded deductible is the amount needed by one member to meet their deductible before the insurance company starts paying. Often deductibles are listed showing a single or family deductible. For an embedded plan the deductible for a family can be met by multiple members of the family but no one person will be charged more than the single deductible.

**Aggregate or True Family Deductible** – An Aggregate or True Family deductible means that if more than one person is covered under the contract than the full amount of a family deductible must be met before the insurance company will pay any benefits.

**Health Savings Account (HSA)** – High deductible plans (\$1500 or more) offer the consumer an option to open an account called a Health Savings Account. This account allows the subscriber the flexibility to put money into a Money Market account to help offset the cost of their health care costs. HSA plans are non-taxable and can be carried forward from year to year. Only medical related expenses can be paid without penalty to the subscriber. The government has a list of medical expenses that are covered by this plan. The amount that can be put in a health savings account is often determined by the size of the deductible on your plan. Most banks handle these accounts or you can contact your insurance provider to set one up.

**Generic, Formulary and Non-Formulary** – This is the classifications for prescription drugs used by the insurance industry. Generic drugs are the preferred drugs that are no longer covered under a trademark agreement and can be manufactured by different companies. Formulary drugs are often referred to as Name-Brand drugs, which have been approved by the FDA and are under a trademark agreement. Non-Formulary drugs are often new drugs out on the market that are in the process of FDA approval or have been approved for limited uses. These drugs are usually the most expensive and have a higher co-pay and are not always covered by insurance companies.

**Preventive Care** – Preventive care is most often covered in full by your insurance coverage and applies to your routine physical care done by your PCP. The list of preventive care has grown with the inception of Health Care Reform. The government has indicated the services it feels fall under this category and these are the guidelines that the insurance companies must follow. For the guidelines on Preventive care you can check out the following website:

<http://www.healthcare.gov/center/regulations/prevention/taskforce.html>.