Health Insurance Terms

Health Maintenance Organization (HMO)

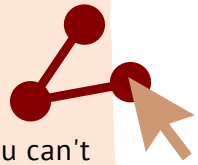
An HMO plan might give you the least number of choices of which care providers you can see. If you go to a care provider that is not part of your HMO, plan to pay the entire medical bill, unless it's a medical emergency.

Medicaid/BadgerCare Plus plans are HMOs.

Preferred Provider Organization (PPO) Plan

With a PPO plan, your insurer may pay part of your bill if you visit a doctor or specialist outside of your plan network. You won't need a referral from your primary care provider to do so, but you may pay more. To keep costs lower, try to see providers within your service network. Call membership services to learn who is in your network.

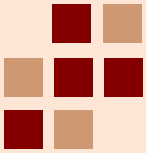
Point of Service (POS)



Under a POS plan, you can't receive care from a specialist without a referral from your primary care provider. You will likely have more choices of who you can see than you would with an HMO plan. Your medical costs may be higher if you choose a care provider outside of your network.

High Deductible Health Plan (HDHP)

A care plan with lower-than-normal premiums but higher deductibles and out-of-pocket spending caps.
Out-of-pocket spending caps means you pay more before your health insurance kicks in to pay their part. This care plan can be good for young healthy people who don't expect high healthcare costs.



Health Savings Account (HSA)

A health saving account that lets you put aside money, pre-tax, toward future medical costs. What you put aside helps to reduce your taxes owed. If you use the money for qualified medical expenses your withdrawals for those bills will be tax free.

An HSA is different from a Flexible-Spending Account (FSA), which a person may have through their employer. Unused funds in an HSA remain in your account until you need them, whereas FSA funds must be depleted before the plan year ends as they do not tend to roll over.

Member Services

The number found on your insurance card or insurance website. It is the number you call when you have questions. These questions may be about what your insurance covers, costs, or when you need a referral. Other questions may be what doctors are in your network, or what medicines are covered by your plan.

Network

Who your health insurer works with to provide services. This can be hospitals, doctors, and suppliers. It is generally more cost-effective (less cost to you) to see a provider "**in-network**" than "**out-of-network**".

Premium

Your premium is what you will pay your health insurance company to keep covering you. You will usually pay your premium monthly, but sometimes you will pay quarterly or yearly.



Medicaid or BadgerCare Plus plans will generally not require a premium. There are tax credits you can get to offset the premiums. These can be bought through the Affordable Care Act Marketplace. If you get health insurance coverage through work, your employer will usually pay some of your premium.

Deductible

The yearly cost of your health services before your health insurance company pays. For example, you may have a $2,000 deductible. In this case, your health insurance might not start paying until you've paid $2,000 for healthcare in a given plan year. Medicaid plans generally do not have a deductible except in special situations.

Pro tip: Plans often cover the cost of some things before you meet your deductible. Contact your plan's member services to get the details of your plan.

Copayment

Your copayment, or copay, is the amount you owe each time you receive medical services. Copays depend on the type of services you receive. Examples could be visiting your primary care provider or having blood tests done.

Pro tip: In most cases you can't use copays toward your deductible. This varies from one health insurance plan to another. Check with your plan's member services.

Coinsurance

After you've met your deductible for the year, you may still be responsible for part of your healthcare costs. This percentage amount that you're responsible for is your coinsurance. For example, you may meet your deductible amount in April. After that your coinsurance is 25%. If your insurance company is billed $100 for a service in May, insurance will pay $75, and you will pay $25.

Out-of pocket maximum

Your out-of-pocket maximum is the most you will have to pay toward your medical costs in a given plan year. For example, your out-of-pocket-maximum may be $3,000. Once you have paid this amount, your insurance will pay any remaining medical costs (if they are medically necessary). These costs include deductible, copays, and coinsurance. Premiums are not included.

Pro tip: Costs may vary between in-network and out-of-network providers. Insurance companies may not include out-of-network providers in your out-of-pocket maximum. Your plan may have different maximums depending on the type of provider. Check with your plan's member services.



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