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Your Healthcare Terms Cheatsheet

We put together a list of terminology and added in helpful tips when exploring healthcare plans.

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Healthcare 101
The Basics

01 Health Insurance

A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium. The plans may have deductibles, co-pays, coinsurance and max - out-of-pocket amounts.

02 Cost-Sharing/Healthshares

The individual, family or small business pays a monthly subscription to become a member of a large group or community that shares in the cost of medical needs. The plans have initial unshareable amounts (IUA's), IUA's have annual caps and may have co-pays depending on the plan.

03 Premium

The monthly payment that you're going to make to keep your plan or policy active. The premium is for coverage.

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04 Membership/Subscription

If you have a cost-share or a healthshare, you might see this monthly payment called a membership or subscription. This membership provides access to the health plan benefits and services.

05 Deductible

The deductible is the amount that you're going to be responsible for before the insurance kicks in. You might have a deductible of $5,000 for an individual and $9,000 for a family. This is the minimum amount you must pay before the insurance will pay its portion of the balance of the claim. Deductibles follow the calendar year and restart in January.

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06 IUA- Initial Unshareable Amount

If you are a member of a cost-share or a healthshare, you might see a term called IUA-initial unshareable amount. This is a capped patient responsibility amount. An IUA is similar to a deductible. It represents the most you will pay for a major medical need and the maximum you will pay for the year for major medical, whereas, a deductible is the minimum you must contribute before insurance will pay. IUA's follow the medical need, if you are being treated consecutively for the same medical need you do not have to pay your IUA again in the new calendar year.

07 Co-Pay

A copay is a set amount you are going to be responsible for at the time of service - like an emergency room visit or a doctor's visit. A co-pay for an ER visit might be around *$250 - $500, while a primary care physician or a specialist visit could range, maybe, between *$25 to $75.

*co-pay rates vary depending on the plan

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Coinsurance

Coinsurance is a payment of a percentage of the charges you will split with the insurance company after you have paid your deductible, but, before the insurance company begins to pay on the balance of the claims for “allowable services.” You might see an 80/20 split or maybe even 50/50. **TIP: check to see if there is coinsurance for diagnostics or inpatient hospitalization.**

You might have a coinsurance of 50% after you have met your deductible and then you have a max- out- of- pocket, let's say of $10,000. So that means that you could still be responsible for coinsurance up to $10,000 in that calendar year.

Also, you may think, okay, I met my deductible, now it's $0 for the rest of the year. This leads to the next term we are going to talk about: Max-out-of-pocket.

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The Basics

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Max-Out-Of-Pocket

The max-out-of-pocket represents the most a healthcare policy holder will pay each year for covered healthcare expenses. It is meant to be the maximum amount that you will pay before the insurance company pays 100% of “allowable services” or “qualified expenses”. This number might be difficult to nail down because, for example, the plan may not cover certain procedures or services or may only cover up to a certain amount, so, if a facility or provider charges more than the allowable amount, then, it won’t be covered.

Tip:
Make sure to check your plan details to see if out-of-network care and services count towards the max-out-of-pocket costs.

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Healthcare 101 The Basics

10 Networks

A network is a group or providers or facilities contracted with an insurance company to offer their services for lower prices to the insurance company’s members in exchange for members exclusively using these providers and facilities.

For example, HMO’s and PPO’s are different types of plans that leverage a group of providers and facilities for purposes of servicing their members healthcare needs. If you use an HMO you will need to go through the primary care physician for referrals to specialists. They act as gatekeepers.

A PPO is another network-based approach that doesn’t require that you go through your PCP (primary care provider) to be referred to a specialist. So the difference is that, with an HMO, there are a few more steps, more process, but, less expensive. It's not as flexible of a plan as a PPO and that's probably why you're going to see that PPO’s are a little bit more expensive than an HMO.

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Healthcare 101
The Basics

11 ACA and MEC

The ACA (Affordable Care Act) specifies that certain kinds of care and coverage, or MEC (Minimum Essential Coverage) be provided for in insurance plans.

These plans typically provide preventative care/your annual wellness, prescription benefits, mental health and immunizations.

If you're looking for an ACA compliant plan, they're usually going to be those metal plans: bronze, silver, gold and platinum. When you go on healthcare.gov you will see these plans are ACA compliant because they will have specific preventive care services included for $0.

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Healthcare 101 The Basics

12 Health Savings Account

HSA’s or a Health Savings Account is a type of savings account that lets you set aside money on a pre-tax basis to pay for qualified medical expenses.

What that means is every month you could put away, let's just say, $100 into a health savings account and then use that money to pay for medical expenses. This is really a great option for people that like to visit chiropractors, acupuncturists or even naturopaths who rarely accept insurance. This is where you would use your HSA.

As of 2024, the max you can contribute to your HSA is $4,150 for and individual and $8,300 for a family.

The best part is - it rolls over to the next year if you don't use it. Again, for business owners, this is a really great option because it's pre-tax money.

We suggest speaking with your accountant to learn more about how this type of plan can work in your business.

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Differences Between Insurance and Cost-sharing

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Explore and Compare

- ELIGIBILITY
- ENROLLMENT
- STATES SERVED
- NETWORK
- PRE-EXISITING
- DEDUCTIBLE
- MATERNITY

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ELIGIBILITY

Cost-Shares:

- 18-64 years old with a US address
- part-timers, full timers, contractors/freelancers, small businesses
- rates are not based on employment status, location or earnings

Insurance:

- Based on employment status, location, age and earnings

ENROLLMENT

Cost-Share

- open enrollment all year
- Month to month subscriptions

Insurance

- Open enrollment from November 1 - January 1, unless you have a qualifying life event, ie; divorce, death, birth or re-location

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STATES SERVED

Cost Shares:

- *All 50 states and when traveling abroad
- Identical benefits state to state

**plans vary, indipop plans work in all 50 states.*

Insurance:

- Networks and care may be covered only in designated states, unless it is an emergency

NETWORK

Health insurance companies leverage networks, like PPO’s and HMO’s, depending on an individual's health insurance plan. Expenses incurred for services provided by out-of-network healthcare professionals or facilities may not be covered, or may only be partially covered by an individual's insurance company.

Depending on your health insurance plan, you may not be covered when receiving care outside your hospital network, state and country.

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PRE-EXISITING CONDITIONS

Under the Affordable Care Act, health insurance companies can't refuse to cover you or charge you more just because you have a “pre-existing condition” — that is, a health problem you had before the date that new health coverage starts. They also can't charge women more than men.

Cost-shares treat pre-existing conditions differently and many of the plans have this guideline: A condition is considered pre-existing, for you or a dependent, if symptoms or treatment have occurred within the *twelve months prior to joining the plan. Controlled diabetes, hypertension, high cholesterol, seasonal allergies and intermittent asthma will not be considered pre-existing when reported prior to the membership effective date, are medically managed, and, so long as the member has not been hospitalized for the condition in the past 12 months.

**read the plan, some plans look back more than 12 months.*

DEDUCTIBLES

Health insurers require annual deductibles that renew each year. For example, if you break your leg in December, you’ll probably need post-op care in January. That post-op care will be subject to a new deductible in the new year. As a result, you will pay two deductibles for the same medical event.

Cost-sharing plans don’t work that way. IUA’s are tied to specific medical events. If you break your leg, you will not have to pay the IUA again if you are being treated consecutively for the same medical need.

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MATERNITY

Cost-Shares
A majority of cost-shares offer pre and post-natal care as a healthcare benefit. Depending on the plan, the average cost is $2,000 for a regular vaginal delivery and for Caesareans, the average is $5,000. Some plans allow for midwives, doulas and home births.
Plans vary - so if you are thinking of growing your family this year, check the plan specifically for maternity guidelines.

Insurance:
All Health Insurance Marketplace® and Medicaid plans cover pregnancy and childbirth. This is true even if the pregnancy begins before the coverage starts.

Maternity care and newborn care — services provided before and after your child is born — are essential health benefits. This means all qualified health plans inside and outside the Marketplace must cover them.

Premiums and deductibles are individually based and can vastly range in cost by the plan, geographical location and hospital.

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Helpful tips:

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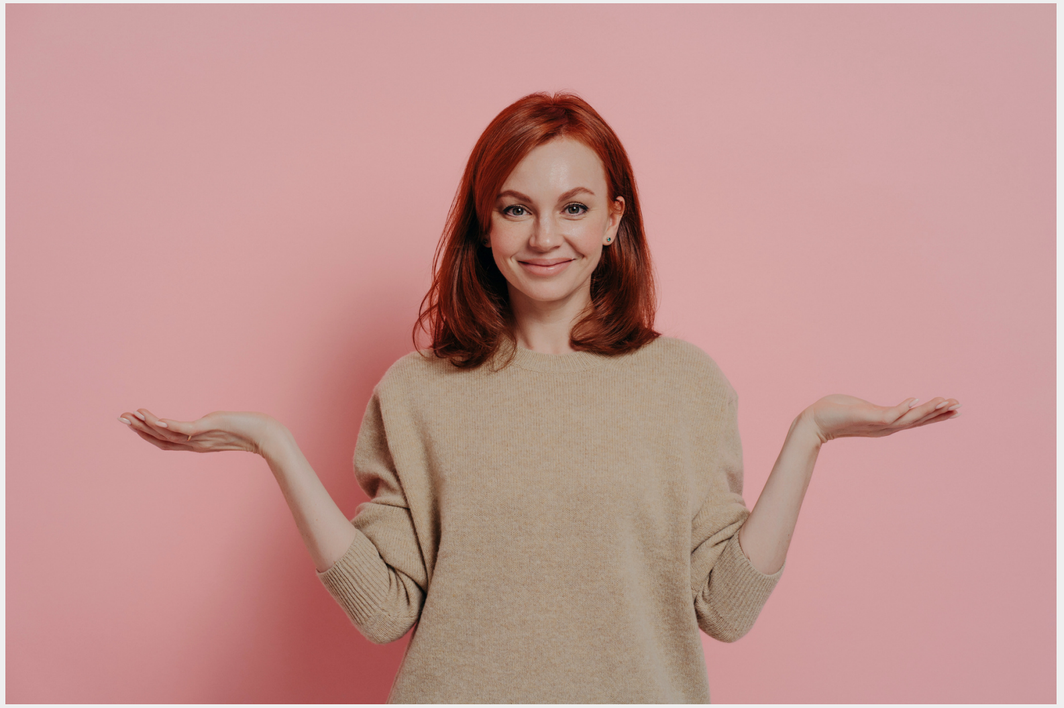
How to choose

Because healthcare is not a one size fits all, and plans can range in benefits, the plan that works best for you is a personal decision and based on your healthcare needs and priorities...



01 Medical Conditions

02 Insurance and the ER

03 Max-Out-Of-Pocket

04 What to look for

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PRE-EXISTING ON A COST-SHARE

If you have a chronic condition, a cost-share may not be the right fit as many of the plans have a look back period. For the first year they will not “share” in the expense of the condition. There are many medically managed conditions that are shareable, ie: diabetes, high cholesterol, high blood pressure. it is important to read the guidelines of the plan to understand what is included and excluded in the benefits. This is where insurance may be a better fit in addressing the members needs for that particular medical condition.

Another example: if you just had ACL surgery and are exploring becoming a member of a cost share, you may want to wait the full look back period to ensure the knee fully healed. If you joined a cost-share 6 months after surgery and it did not quite heal right, that condition is considered pre-existing and it would not be eligible for the $1000 IUA for the first year. If you broke your arm while on the plan, this injury is unrelated to your your knee injury and so it would be eligible.

INSURANCE AND ER

When researching health insurance, look at the premium, that is your monthly payment, then, the deductible, what would you owe if you have medical needs? Next, look at what is listed under the ER section. Is there a co-pay? If so, is it a co-pay + coinsurance? How much is the co-pay and what is the co-insurance split? What does it include? If there is no co-pay and no coinsurance does it say that an ER visit has a deductible?
That means you may have to pay your deductible for the ER visit. This can be a very expensive ER visit!

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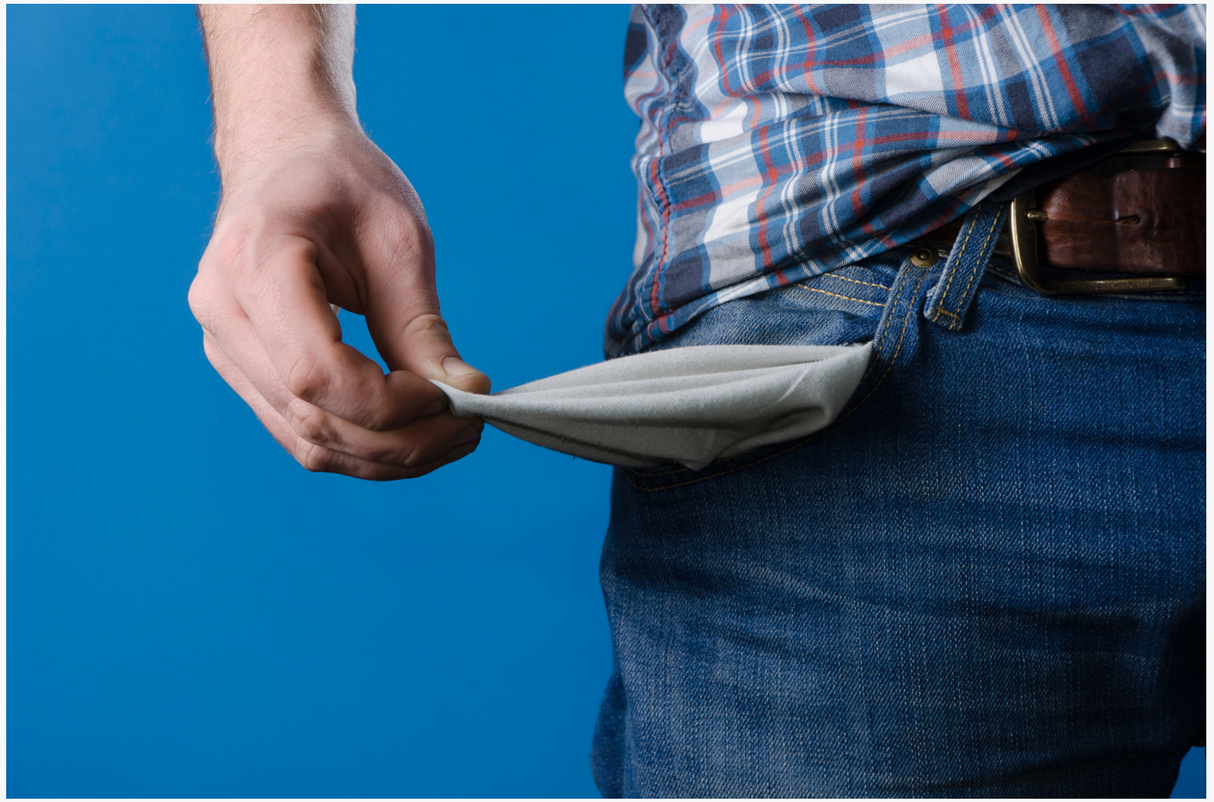
MAX-OUT-OF-POCKET

Max out of pocket, check to see if your max out of pocket has a **cap for out-of-network providers.** Just in case your provider is out-of-network and not included in your plan, you will want to know whether you have a cap for how much you will spend out-of- pocket for the year.

Keep your money in your pocket.



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WHAT TO LOOK FOR IN HEALTHCARE PLANS

URGENT CARE	IS THERE A CO-PAY OR DOES IT APPLY TO YOUR DEDUCTIBLE?
EMERGENCY ROOM	IS THERE A CO-PAY? COINSURANCE? DEDUCTIBLE?
PRIMARY CARE/SPECIALISTS	IS THERE A CO-PAY? HOW MANY VISITS? WHAT NETWORK?
DIAGNOSTICS/RX	IS THERE COINSURANCE, DOES IT APPLY TO YOUR DEDUCTIBLE?
NETWORKS	THE TOP QUESTION WE GET ASKED EVERYDAY, CAN WE KEEP OUR PROVIDER? (DOUBLE CHECK THAT YOU CAN!)
DEDUCTIBLE	IS THERE A DEDUCTIBLE PLUS COINSURANCE? WHAT IS THE MAX I WILL SPEND IN A YEAR FOR PLAN LIMITS?
MAX-OUT-OF-POCKET	DOES IT HAVE A CAP FOR OUT OF NETWORKS PROVIDERS?

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YOU HAVE OPTIONS

Each year healthcare is innovating and bringing more options to you with accessibility and affordability. You have choices!

Explore why you need healthcare-is it for the “what if” scenario of breaking a limb or hospitalization? Or do you frequent urgent care and specialists throughout the year? Each one of us has our personal reasons for needing a healthcare plan that will be there for us for the expected and unexpected health events.

Add it up.

If you see alternative providers and are willing to pay out-of-pocket, consider an HSA compatible plan. If you want to see various specialists, check a plan that offers reasonable co-pays. If you have a family, take notice of the deductible and max out-of-pocket. One or two sports injuries can start to add up.

For cost-shares, check:

- Is it religious based - do you have to sign a statement of faith?
- Is there a lifetime or annual cap?
- Do you have to pay for a medical service and wait to be reimbursed?
- Do you understand what you would pay for a surgery or hospitalization? Check the IUA and cap.
- What benefits are excluded?
- What is the look back period for pre-existing conditions?

Get familiar with your plan before you need it!

IMPORTANT

Health insurance and cost-sharing plans have different benefit guidelines, depending on the plan you enrolled in, you may see different benefits than what were discussed in this presentation.

The information provided is for purposes of explaining the meaning of common terms in healthcare plans and to point out terms to look for, what they mean and the differences between insurance and cost-sharing.

We encourage you to read through the guidelines and yes, the fine print to fully understand what you enrolled in.

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Thank You

Not quite sure which type of plan is a good fit, reach out!
We can review your current plan and do a side by side comparison.

www.indipop.co **hello@indipop.co** **480-818-5489**