Perceiving beforehand - Providing with care

CA Insurance License #0H31978

HEALTH INSURANCE DEFINITIONS:

1. **ACA Plans** – the Affordable Care Act (ACA) standardized coverage that insurance plans must offer. It packaged these coverages into four Metal Tiers: Bronze, Silver, Gold, and Platinum. The four levels have standardized coverages that remain the same regardless of which insurance company is providing the service. All plans provide preventive coverage at $0 cost to you and have a maximum out of pocket limit.
    a. ***Bronze*** – designed to cover approximately 60% of your medical expenses. It has a high deductible that must be met before the insurance begins to cover medical services or medications. It is the lowest cost plan available.
    b. ***Silver*** – designed to cover approximately 70% of your medical expenses. Most services may be obtained by paying a modest copay (fixed dollar amount) prior to satisfying a deductible. The deductible is generally applicable to larger expenses, i.e. hospitalization; however, this can vary depending on which Silver plan you choose. Larger expenses may be subject to a 30% coinsurance rather than a specific copay. This level of coverage seems to be the most popular.
    c. ***Gold*** – designed to cover approximately 80% of your medical expenses. Most Gold plans have no deductible, and their copays for services are a little less than that of the Silver plans. Larger expenses may be subject to a 20% coinsurance. This may be an option if you have need for higher use of medical services.
    d. ***Platinum*** – designed to cover approximately 90% of your medical expenses. There is no deductible, copays are less than those of the Gold plans, and larger expenses are subject to a 10% coinsurance. If you have high medical expenses, this might be a good choice, although it will be the most expensive to purchase.
2. **Health On-Exchange** – If your household income falls below 600% of the Federal Poverty Level (see chart), then you will want to choose an "On-Exchange" plan. The Exchange is the ONLY place where you can receive an Advance Premium Tax Credit (APTC) that lowers the cost of your monthly premium.
3. **Health Off-Exchange** – If your household income is greater than 600% of the Federal Poverty Level, or you otherwise do not qualify for an APTC, then you probably want an 'Off-Exchange' plan. This is a plan obtained directly through the insurance company of your choice. Quite often, you will have more choices Off-Exchange than those offered On-Exchange.
4. **Subsidy** – This is another word for Advance Premium Tax Credit or APTC. It is the portion of your premium that is paid by the Federal and State governments.

5. **Deductible** – A deductible is a specific dollar amount that you must spend in the calendar year before specific services are covered under your plan. The amount of the deductible can vary from plan to plan, as well as the services that are subject to the deductible.
6. **Copay** – a fixed dollar amount that you pay to receive service (i.e.: $45 to see the doctor).
7. **Coinsurance** – a percentage that you pay to receive service (i.e.: 30% of a hospital bill).
8. **Max Out of Pocket** – The most you will pay in one calendar year for medical services. This amount consists of your deductible and any coinsurance you pay. Typically, it does not include copays or prescription medications.
9. **Phases of coverage**:
    a. ***Deductible phase*** – you pay for all costs at 100% until you have spent the amount equal to the deductible in your plan during that calendar year.
    b. ***Sharing phase*** – After you have met your deductible, then you share costs with the insurance company. During this phase, you will be paying either a copay (fixed dollar amount) or coinsurance (a percentage) and the insurance company will be paying the balance.
    c. ***Full Coverage phase*** – Once the amount of your deductible plus the amount you have spent in coinsurance payments equals the amount of the out of pocket limit in your plan, the insurance company pays for everything 100%.
10. **HMO** – Health Maintenance Organization: Their focus is on keeping you healthy, although they will treat you if you become ill or injured. It has a CLOSED Network of providers, meaning that you can only receive treatment from doctors and facilities that are specifically contracted with them. You are also required to have a Primary Care Physician (PCP) who monitors and administrates all of your care. Your PCP must refer you to any specialist you may need.
11. **EPO** – Exclusive Provider Organization: Similar to an HMO in that they also have a CLOSED Network of providers. However, you are not required to have a Primary Care Physician (although it is encouraged) and do not need a referral to see a specialist, as long as the specialist is in the Network of providers.
12. **PPO** – Preferred Provider Organization: They also have a specific network of providers that they PREFER you use; however, you do have coverage if you see a provider outside of the network. Coverage outside of the network is less than inside the network, so you will have more out of pocket expense using a doctor outside of the network. You also are not required to have a Primary Care Physician, although it is encouraged. No referrals are needed to see a specialist.