

Understanding Health Insurance Terms

Make Sense of Your Coverage

We know that health insurance can sometimes feel like it has its own language. This guide is here to help you understand the key terms you'll see when choosing and using your health plan. We've broken them down into simple, easy-to-understand explanations with practical examples.



Top Important Concepts

ICHRA (Individual Coverage Health Reimbursement Arrangement)

What it is: Instead of a one-size-fits-all group plan, your employer is offering an Individual Coverage Health Reimbursement Arrangement (ICHRA). This IRS-approved benefit gives you more freedom, flexibility, and control over your healthcare, all while your company helps cover the cost.

HSA (Health Savings Account)

What it is: A Health Savings Account allows employees with High-Deductible Health Plans (HDHPs) to put money away and withdraw it tax free for qualified medical expenses, like deductibles, co-payments, and co-insurance.

Plan Types: Common Network Structures

HMO (Health Maintenance Organization)

How it works: With an HMO, you must use providers within the HMO's network (except in emergencies). You also usually choose a Primary Care Physician (PCP) who acts as your main doctor and will refer you to any needed specialists.

Best for: People who want lower monthly premiums and are comfortable with their main doctor coordinating their care.

PPO (Preferred Provider Organization)

How it works: PPOs offer the most flexibility. You can see any doctor, specialist, or hospital, whether they are in-network or out-of-network, without needing a referral. However, you'll save a lot of money by staying in-network.

Best for: People who want the most flexibility, want to see specialists without a referral, and are willing to pay a higher monthly premium for that freedom.

EPO (Exclusive Provider Organization)

How it works: An EPO is a balance between an HMO and a PPO. You must use doctors and hospitals within the network (except in emergencies), but you usually don't need a referral to see a specialist.

Best for: People who want a balance of lower costs (by staying in-network) but also want the freedom to see specialists directly without a referral.

POS (Point of Service)

How it works: A mix of HMO and PPO. You choose a main doctor who refers you to specialists within the network. You have the option to go out-of-network for care, but it will cost you more.

Best for: People who like having a main doctor to coordinate their care but still want the option to go out-of-network if needed.

Key Cost Terms: Understanding What You Pay

Premium	What it is: Think of this as your monthly subscription fee to keep your health plan active. You pay this amount whether you see a doctor or not.	How it works: Your employer may cover some of this cost, and your portion is typically deducted pre-tax from your paycheck.
Deductible	What it is: This is the amount of money you need to pay for your medical care out-of-pocket each year before your insurance plan starts to share the costs.	Example: If you have a \$2,000 deductible, you pay for the first \$2,000 of your medical bills for things like hospital stays or surgeries. After that, your plan helps pay.
Family Deductible	What it is: When you have a family plan, there are two types of deductibles: individual and family. Each person has their own deductible, and all of those payments also count toward a larger, single family deductible.	How it works: Once the family deductible is met, the insurance plan starts helping pay for everyone on the plan for the rest of the year, even if some members haven't met their individual deductible.
Co-Pay (Co-Payment)	What it is: A flat fee you pay for certain medical services, like a doctor's visit or a prescription.	Example: If you have a \$50 co-pay for a specialist visit, you'll pay \$50 at the office, and your insurance covers the rest of the visit's cost, even if you haven't met your deductible.
Co-Insurance	What it is: After you've met your deductible, you'll start sharing the cost of your medical care with your insurance plan. Co-insurance is the percentage of the cost that you are responsible for.	Example: If your co-insurance is 20%, and a medical service costs \$100 after your deductible is met, you would pay \$20, and your plan would pay the remaining \$80.
Out-of-Pocket Maximum (or Out-of-Pocket Limit)	What it is: This is the absolute most you will have to pay for your covered medical care in a plan year. This is your financial safety net.	How it works: All of your payments for deductibles, co-pays, and co-insurance count toward this limit. Once you hit your out-of-pocket maximum, your insurance plan pays 100% of all your covered medical expenses for the rest of the plan year.

Network Types: Where You Can Get Care

In-Network

What it means: These are the doctors, hospitals, and clinics that have a contract with your insurance company to provide care at a negotiated, lower price. Your plan will cover a much larger portion of the bill when you see in-network providers.

Out-of-Network

What it means: These are providers that do not have a contract with your insurance company. You can sometimes still see them, but you will have to pay much more out of pocket, and some plans may not cover out-of-network care at all (except in emergencies).

Understanding Plan Categories: Metal Tiers

Health plans are categorized into "metal tiers" based on how costs are shared between you and the carrier. The higher the metal tier, the more the carrier pays when you get medical services (but you typically have a higher monthly premium).

Bronze Plans	Cost sharing: Your carrier pays about 60%, and you pay about 40% when you get medical services.	Best for: Healthy individuals who don't expect to need many medical services, or those who want the lowest monthly premium and are comfortable with a higher deductible.
Silver Plans	Cost sharing: Your carrier pays about 70%, and you pay about 30% when you get medical services.	Best for: Individuals who need medical services occasionally or want a moderate deductible. Many people find this to be a good balance.
Gold Plans	Cost sharing: Your carrier pays about 80%, and you pay about 20% when you get medical services.	Best for: Individuals who expect to need a fair amount of medical services, have chronic conditions, or prefer more predictable costs with a lower deductible.
Platinum Plans	Cost sharing: Your carrier pays about 90%, and you pay about 10% when you get medical services.	Best for: Those who anticipate needing frequent medical services, have significant ongoing health needs, or want the lowest out-of-pocket costs when they receive care.

Prescription Drug Coverage

What it is: This is the list of prescription drugs that your health plan will help cover. It's important to check this list to make sure your medications are included.

How it works: The formulary is usually broken into tiers. The lower the tier, the less you'll pay for the drug.

Drug Tiers

Tier	Drug Type	Cost
1	Preferred Generic	\$
2	Generic	\$
3	Preferred Brand	\$\$
4	Non-Preferred Brand	\$\$\$
5	Specialty Drugs	\$\$\$\$

*Plans may not have identical drug tiers, so it's important to review the Summary of Benefits and Coverage to see how many tiers the plans you're considering offer.



Preferred Generic Drugs: The most affordable option. These typically work the same way as brand-name drugs but at a lower cost.

Generic Drugs: Still a great value, these are often older brand-name drugs that are now available as generics.

Preferred Brand Drugs: These are brand-name drugs that your plan has agreed to cover at a lower cost than other brand-name drugs.

Non-Preferred Brand Drugs: You'll pay more for these brand-name drugs. Often, a generic or preferred brand alternative is available.

Specialty Drugs: These are high-cost drugs used to treat complex or chronic conditions. They often require special approval from your insurance carrier.

Plans may also include rules like:

Prior Authorization: Your doctor must get approval before the plan will cover the medication.

Step Therapy: You must try a lower-cost drug first before “stepping up” to a more expensive one.

Quantity Limits: Restrictions on how much you can get at once.

These can affect not only what you pay, but how soon you can access your meds.