

# HEALTH INSURANCE BASICS

**If health insurance feels like a foreign language, we get it.**

Understanding the basics is the first step toward being able to choose the best health insurance plan for your life (and your wallet).



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# PREMIUM

Let's start with your **health insurance premium**.  
This is what you pay every month to have health insurance coverage.

<b>INSURANCE PROVIDER</b>	<b>Plan Name</b> ★★★★☆	<a href="#">View Plan Details</a>
Monthly Premium: <b>\$133.97</b>	Annual Deductible: <b>\$7,500</b>	Out-of-pocket Limit: <b>\$10,000</b>

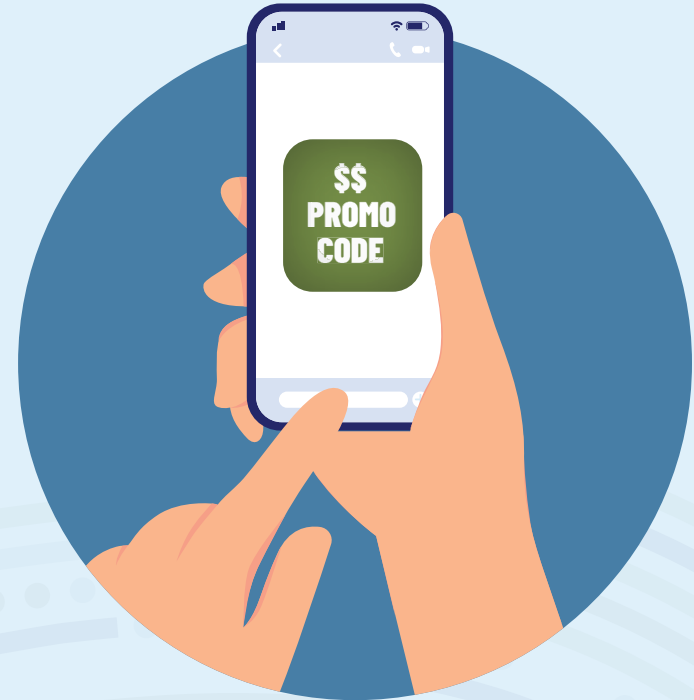
# PREMIUM

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When comparing health insurance premiums on [CoverME.gov](https://coverme.gov), most Mainers qualify for Premium Tax Credits. Premium Tax Credits are also known as subsidies or savings. These tax credits can significantly lower the cost of premiums. Make sure you enter your income in the online form when enrolling or comparing plans. You need to enter your income to see premiums with your Premium Tax Credit savings factored in.

## Think of the tax credits like a “promo code.”

There’s the “retail price” you see on the website, and then there’s the price you actually pay after all the discount codes are added at checkout. Your Premium Tax Credits are your “promo codes.” Everyone gets a different amount of Premium Tax Credits. The amount you get is determined by the county you live in, household income, number of household members covered by the plan, and their ages.

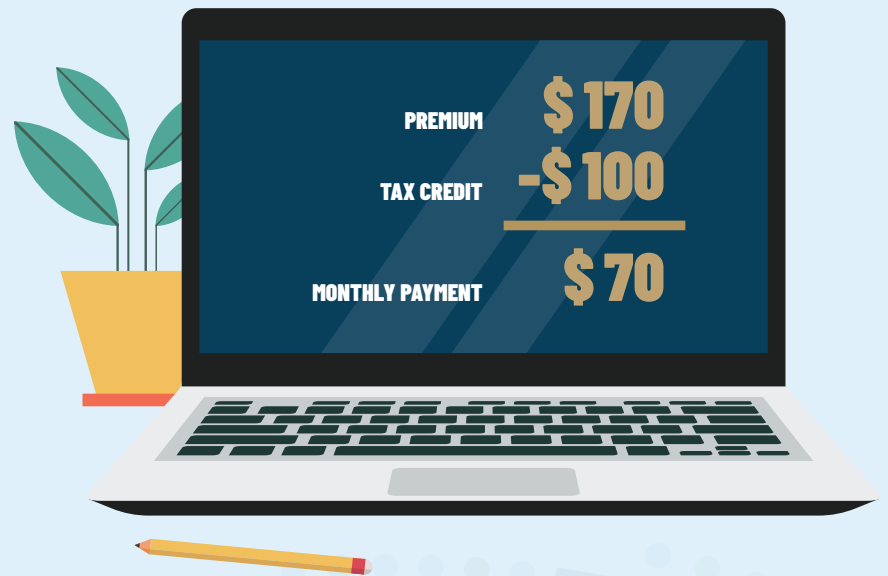


# PREMIUM

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**The premiums you see online might be the “retail price.” To see the price you would actually pay, enter your household income.**

After you enter your zip code, income, ages, and household size on [CoverME.gov](https://coverme.gov), your prices will adjust. You’ll see your **actual monthly payment** with the “promo code” applied.



# DEDUCTIBLE

Almost all health insurance plans offered through **CoverME.gov** include something called a deductible. A deductible is the dollar amount you need to pay towards your healthcare costs before your full coverage kicks in. Once you pay your full deductible, your insurance company will start paying for your care. They will pay for certain types of covered services. Paying your full deductible is also called “hitting,” “meeting,” or “reaching” your deductible. Until you reach your deductible, you are responsible for paying your healthcare bills. This includes the full bills for services like hospital visits and imaging. See the **“Pre-Deductible Coverage”** section for information on services covered before meeting your deductible.

**INSURANCE PROVIDER** **Plan Name** [View Plan Details](#)

★★★★☆

Monthly Premium: \$133.97    **Annual Deductible: \$7,500**    Out-of-pocket Limit: \$10,000

# DEDUCTIBLE

## Think of your deductible like a rewards card at your local coffee shop.

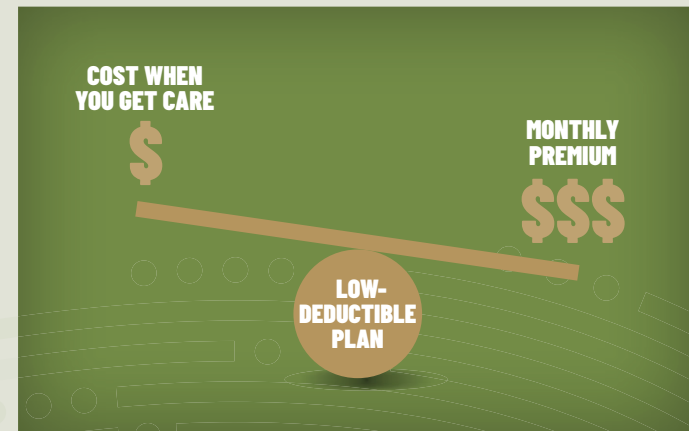
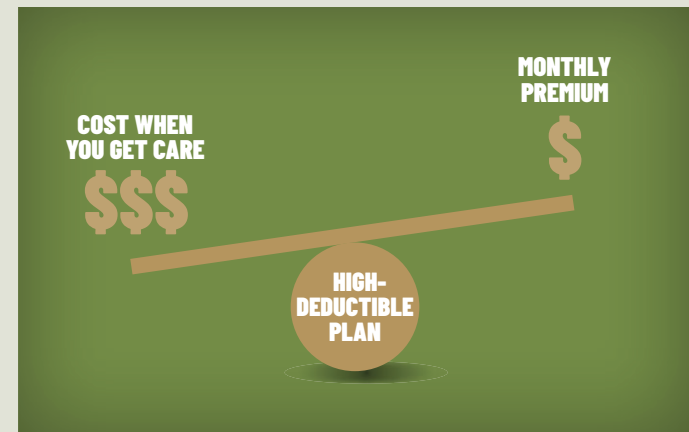
If you have a **low-deductible plan**, you'll only need to buy 5 coffees before you get a free or discounted one. If you have a **high-deductible plan**, you'll need to buy 10 coffees before you get a free or discounted one.



# DEDUCTIBLE

**If you have a plan with a high deductible, you'll pay more out-of-pocket before your health insurance will start covering services than if you have a low-deductible plan.**

The tradeoff is that **plans with lower deductibles have higher monthly premiums. Plans with high deductibles have lower monthly premiums.** If you use a lot of healthcare services throughout the year, explore lower-deductible options. If you rarely use your insurance, a high-deductible plan might be a better fit. A high-deductible plan might also be a good fit if you only use your insurance for things like annual check-ups and preventive care. Your deductible resets at the beginning of every plan year.



# PRE-DEDUCTIBLE COVERAGE

Some services are covered by your health insurance plan before you've paid your full deductible. This is called pre-deductible coverage.

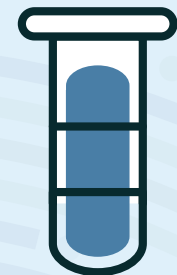
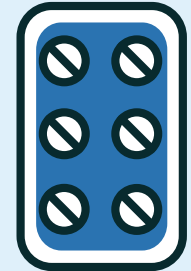
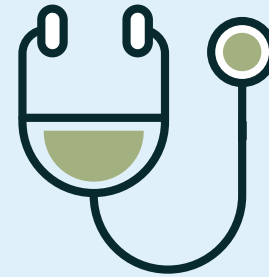


## PRE-DEDUCTIBLE COVERAGE

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**All health insurance plans on CoverME.gov include recommended preventive care at no extra cost beyond your monthly premium.**

Many things are covered in full, even before you've met your deductible. Some examples are wellness exams, mammograms, Pap tests, and immunizations. Some preventive prescriptions, such as birth control pills, are fully covered too. In most cases, you must receive the services from a provider that is in your plan's network. Some plans also cover office visits, urgent care visits, and some prescription medications with a copay of \$20-\$50. This is also considered pre-deductible coverage.



# PRE-DEDUCTIBLE COVERAGE

You can find out if a plan has pre-deductible coverage. Check the first page of the “Summary of Benefits and Coverage” document.

Look where it says, “Are there services covered before you meet your deductible?” If the document says “Yes,” great! You found a plan with pre-deductible coverage. The services or prescription drugs covered before your deductible will be listed in the box that says “Yes.”

Plans with lower premiums usually have less pre-deductible coverage. Plans with higher premiums likely have more. If having pre-deductible coverage is important to you, look for it before you enroll in a plan. Compare the details of your plan options. There are plans at every level that cover office visits and some prescription medications pre-deductible.

## Summary of Benefits and Coverage

Health Insurance Plan Name

Important Questions	Answers	Why This Matters
Are there services covered before you meet your deductible?	<b>Yes.</b> Preventive Care (as defined in your Member Benefit Agreement). For more information see below.	This <b>plan</b> covers some items and services even if you haven't yet met the <b>deductible</b> amount. But a <b>copayment</b> or <b>coinsurance</b> may apply. For example, this <b>plan</b> covers certain <b>preventive services</b> without <b>cost sharing</b> and before you meet your <b>deductible</b> . See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits">https://www.healthcare.gov/coverage/preventive-care-benefits</a> . Refer to your Member Benefit Agreement for more information.

# COPAY AND COINSURANCE

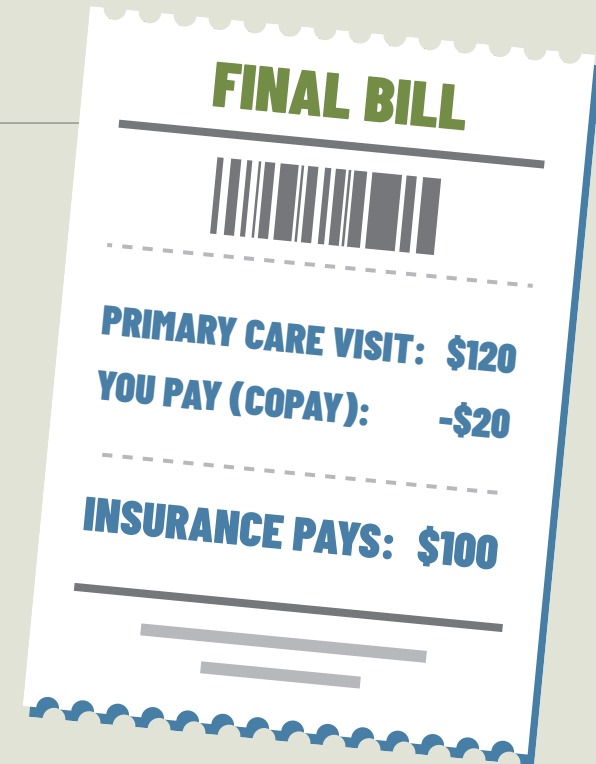
Some health insurance plans include even more pre-deductible coverage. You get this coverage in addition to preventive care. So, what might be covered? Services like specialist visits, prescriptions, telehealth, and behavioral health might be covered.



## COPAY AND COINSURANCE

**Sometimes you'll pay a flat fee for those services, called a copay, and your insurance will cover the rest of the bill.**

For example, if your copay to see your primary care provider is \$20, you will only pay \$20. Your insurance would pay the rest of the bill.



**If your primary care provider conducts a test, like a strep or flu test, during the office visit, you may receive an additional bill. This bill may have a different out-of-pocket cost arrangement.**



# COPAY AND COINSURANCE



**Sometimes, instead of paying a copay for a service, you might pay coinsurance.**

**Coinsurance means that you pay a percentage of your bill.** You pay a percentage of the total negotiated rate for services, and insurance will pay the rest. For example, if your coinsurance is 50% for hormone replacement therapy, that means you would pay half of the negotiated cost. Your insurance company would pay the other half. With coinsurance, it's important to remember that you often won't know how much services cost until you get the bill. This can make it difficult to know the dollar amount you'll be responsible for. If you want to know how much your coinsurance might be for a doctor's visit, you can ask your provider for an estimate of the costs before you go. Your provider's office is required to give you a "Good Faith Estimate" of expected charges for the visit.

# COPAY AND COINSURANCE

You can see which services require copays or coinsurance by checking your **“Summary of Benefits and Coverage.”** You can get this document from your insurance company, or from CoverME.gov’s Plan Comparison Tool. It’s important to know that copays and coinsurance don’t stop once you hit your deductible. You will keep paying when you use services with copays and coinsurance. You only stop paying copays and coinsurance when you reach your out-of-pocket maximum. Typically, every dollar you pay toward copays and coinsurance is counted towards reaching your out-of-pocket maximum.

**INSURANCE PROVIDER** **Plan Name** [View Plan Details](#)

★★★★☆

Monthly Premium: **\$133.97** Annual Deductible: **\$7,500** Out-of-pocket Limit: **\$10,000**

**Primary Care Visit to Treat an Injury or Illness:**  
Tier 1: \$40 Copay  
Tier 2: \$75 Copay

**Specialist Visit:**  
Tier 1: \$60 Copay  
Tier 2: \$130 Copay after deductible

**Urgent Care Centers or Facilities:**  
Tier 1: \$40 Copay  
Tier 2: \$40 Copay

**Preferred Generic Drugs:**  
Tier 1: \$25 Copay  
Tier 2: \$40 Copay

**Generic Drugs:**  
Tier 1: 30% Coinsurance after deductible  
Tier 2: 40% Coinsurance after deductible

**Preferred Brand Drugs:**  
Tier 1: \$50 Copay  
Tier 2: \$65 Copay

**Estimated Network Size**  
56% of 6,267 doctors within 10 mi who accept CoverME.gov plans are covered.

- In-Network, Tier 1 (Preferred): 51.35%
- In-Network, Tier 2 (Non-preferred): 4.05%
- Out-of-Network: 44%

# OUT-OF-POCKET MAXIMUM

All health insurance plans include something called an out-of-pocket maximum. This is a combination of your deductible, copays, and coinsurance. **It is the maximum amount you would ever pay for covered healthcare expenses in a single plan year** (aside from your monthly premium).

**INSURANCE PROVIDER**      **Plan Name**      [View Plan Details](#)  
★★★★☆

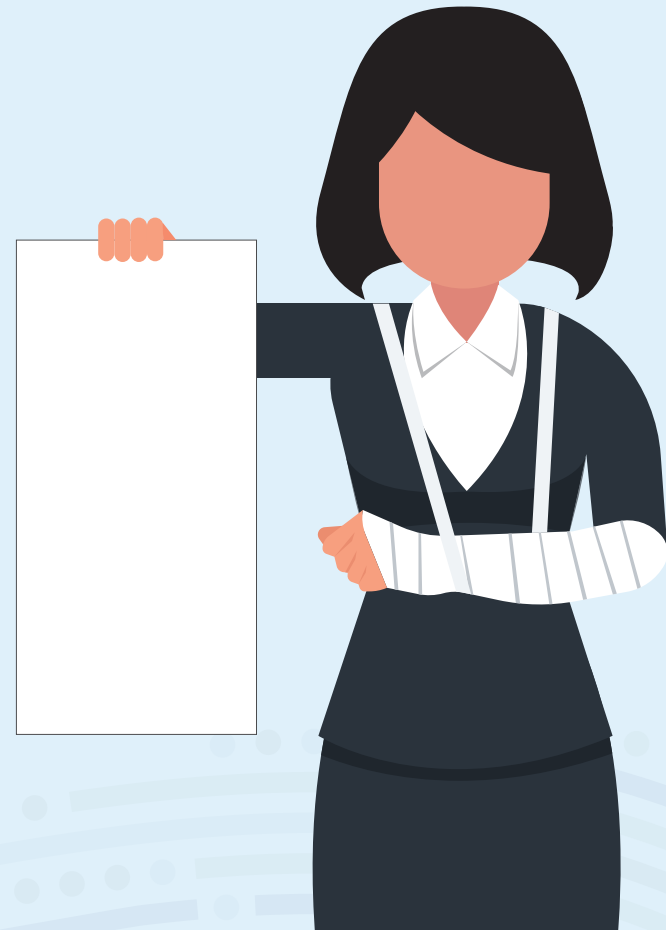
Monthly Premium: \$133.97      Annual Deductible: \$7,500      **Out-of-pocket Limit: \$10,000**

# OUT-OF-POCKET MAXIMUM

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## It's essentially a worst-case scenario.

Once you hit your out-of-pocket maximum, the insurance company pays 100% of your in-network care for the rest of the year. You won't pay any copays or coinsurance.



# IN-NETWORK VS. OUT-OF-NETWORK CARE

In-network care means the provider has a contract or agreement with your insurance company.

They have both agreed on a set cost for services.



# IN-NETWORK VS. OUT-OF-NETWORK CARE

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**If you choose to see a provider that is out-of-network, you might pay more.**

The service may not be covered by insurance at all. You can learn if a provider is in-network by visiting your insurance company's website or by asking the provider directly. Most insurance companies also have apps that include a search tool. You can use the search tool to find in-network care.



# IN-NETWORK VS. OUT-OF-NETWORK CARE

## Some plans also have what are called “tiered networks.”

In a tiered network, there are a group of preferred providers or prescription medications. These preferred providers or medications are in “Tier 1.” You will pay less out-of-pocket when you visit Tier 1 providers or take a Tier 1 medication. You will pay more with a Tier 2 (or Tier 3) provider or prescription medication. You may also have a lower deductible for Tier 1 providers. All tiers are in-network, but they have different costs.



# STILL UNSURE ABOUT WHO PAYS WHAT?

Contact Consumers for Affordable Health Care to get free support to understand your options, choose a plan that fits your life, or get help with the plan you currently have.

Phone: **1-800-965-7476**

Website: **MaineCAHC.org**

CoverME.gov | 1-866-636-0355 TTY: 711

 coverME.gov