HEALTH INSURANCE Basics

KNOW YOUR PLAN. EMPOWER YOUR HEALTH.

Health insurance can seem confusing because it uses a lot of unfamiliar words. It doesn't have to be that way.

We're here to make it easier to understand.

Maine women deserve clear, easy-to-read information that helps them choose a health insurance plan that meets their reproductive and maternal health needs. That's why we created this quick guide. It explains the basics, starting with five important topics.

1 HEALTH INSURANCE BASICS: PREMIUM

What is a premium?

A premium is the amount you pay each month to have health insurance.

When you pay your premium, you can use your health insurance to help cover the cost of medical care. Many preventive health services are covered at no extra cost when you see a doctor in your plan's network.

If you get health insurance through CoverME.gov, you may qualify for help paying your monthly premium.

Your premium is different from the amount you may pay when you go to the doctor or get medical care.

Think of Premium Tax Credits like a coupon.

When you shop online, you might use a coupon to lower the price. A Premium Tax Credit works in a similar way. It lowers your monthly premium.

The amount you save depends on:

- The county where you live
- Your household income
- How many people are on your health plan
- The ages of people on your health plan

If you are planning to have a baby, are pregnant, or will add a baby to your health plan, make sure your family information is correct. This helps determine how much you need to pay each month.

The price you see at first may not be the price you pay. Enter your Zip code, income, ages, and family size. Then you'll see your estimated monthly premium after any savings are applied.

2 HEALTH INSURANCE BASICS: DEDUCTIBLE

What is a deductible?

A deductible is the amount you pay for many health services before your insurance starts paying part of the cost.

The good news is that many preventive health services for women are covered before you meet your deductible as long as you see a provider in your plan's network.

These preventive services may include:

- Yearly well-woman visits
- Breastfeeding support and breast pumps
- Pregnancy diabetes screening
- Mammograms and cervical cancer screenings
- Screening and counseling for domestic violence
- STI screenings and other preventive services
- HIV screening and prevention counseling
- Recommended vaccines

If your visit includes tests or treatment that are not considered preventive, you may have to pay your deductible or other costs.

If you expect to need pregnancy or reproductive healthcare, your deductible is important.

If you think you'll need prenatal visits, labor and delivery, fertility care, pelvic care, or other reproductive health services, compare the deductibles for each plan.

Plans with lower deductibles often have higher monthly premiums, but you may pay less when you get care.

3 HEALTH INSURANCE BASICS: COPAYS AND COINSURANCE

What are copays and coinsurance?

A copay is a set amount you pay for some healthcare visits. Coinsurance is **a part** of the bill after you meet your deductible.

For example, if your plan has 20% coinsurance, you pay 20% of the bill and your insurance pays the other 80%.

Many preventive health services for women do not have a copay or coinsurance.

You may have extra costs if:

- You get treatment for a health problem.
- Your doctor orders extra tests that are not preventive.
- You see a doctor who is not in your plan's network.

If you are not sure if a service is preventive, ask your health insurance company before your appointment.

If you are planning a procedure, having a baby, or getting another reproductive health service, ask your provider for a cost estimate before your visit.

You may receive more than one bill if your visit includes services like lab work, an ultrasound, or genetic testing.

4 HEALTH INSURANCE BASICS: OUT-OF-POCKET MAXIMUM

What is an out-of-pocket maximum?

Your **out-of-pocket maximum** is the most you will have to pay in one year for covered health care from providers in your plan's network.

This includes money you pay on:

Deductibles **Copays** **Coinsurance**

Many preventive health services for women are covered at no extra cost, so they usually do not count toward your out-of-pocket maximum.

If you need surgery, stay in the hospital, or have a serious health problem, your out-of-pocket maximum helps protect you from very high medical bills.

After you reach your out-of-pocket maximum, your insurance pays 100% of the cost for covered care from providers in your plan's network for the rest of the year.

5 HEALTH INSURANCE BASICS: IN-NETWORK VS. OUT-OF-NETWORK CARE

What does in-network mean?

In-network doctors, hospitals, and other providers have an agreement with your insurance company. This usually means you pay less.

Choosing an in-network provider can help you save money.

If you are planning a pregnancy or need reproductive healthcare, make sure your:

- OB-GYN
- Nurse-midwife
- Hospital or birth center
- Baby's doctor
- Lactation consultant
- Specialists

are all in your health plan's network.

Out-of-network care may cost much more or may not be covered at all.

Some plans have tiers.

Some health plans have different levels, called tiers. A tier is a group of in-network providers or medications that have different costs.

TIER 1 (lower cost) > **TIER 2** (higher cost)

For example, one hospital may be in Tier 1 and another may be in Tier 2. Both are covered by your plan, but Tier 1 usually costs less.

If you are planning to have a baby or are pregnant, check that your doctor, midwife, hospital, or birth center is in your plan's network. Also check which tier they are in. This can help you understand what your care may cost.

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