HEALTH INSURANCE TERMS

The purpose is to help explain and understand basic terms

Self-Funded - Self-funded employee health care insurance plans can enable employers to better manage and control their health care spending and improve cash flow while still being able to tailor the health coverage they desire for their workforce. In self-funded plans, the employer takes on the financial risk of funding their health plan from its assets and becomes responsible for managing and administering the benefit plan.

The following information is regarding In-Network situations

Copays – A copay is the amount you pay out of your own pocket for the office visit. This does not include labs, x-rays, surgeries, etc. that are done along with the office visit. Our copay is $30 per visit for general physician office visits and $40 specialist physician office visits. Routine/preventive visits are covered 100% with no copay. Copays do go towards co-insurance.

Deductibles - A Deductible is the amount you pay out of your own pocket before your insurance begins picking up any of the costs of health care. Any deductible met in October, November, and December will carry over for the next year.

> **Individual -** $1,500
> **Family –** x 3 = $4,500; Each person will not be responsible for more than $1,500. If there are only 2 on the plan then you would only have to reach $1,500 each with a limit of $3,000 total.

Co-Insurance - The basic concept of coinsurance, also known as **percentage participation**, is that you and your insurance plan share the risks. In health insurance, this usually translates into the insurance plan paying a certain percentage of your health care bills, while you pay the remaining percentage.

> **Individual -** $4,850
> **Family –** x 3 **=** $14,550; Each person will not be responsible for more than $4,850. If there are only 2 on the plan then you would only have to reach $4,850 each with a limit of $9,700 total.

Total Out of Pocket – covered expenses that you are responsible for before your health-plan benefits kick in at 100 percent coverage. This is the deductible amount and co-insurance added together. Once this is met, the insurance pays 100% for the rest of the calendar year.

> **Individual -** $6,350 ($1500 deductible + $4850 co-ins.)
> **Family –** x 3 = $19,050; Each person will not be responsible for more than $6,350. If there are only 2 on the plan then you would only have to reach $6350 each with a limit of $12,700 total.

Deductibles and Co-insurance run January 1 thru December 31 of each year

Provider Network – This is the network of providers we have contracts with. Our network is HealthLink. We have two options within our network. They are:

> **PPO –** This is paid at 70/30% meaning insurance pays 70% of the discounted bill and the member pays 30% of the discounted bill.
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> **Open Access –** This is the richer of the two so you might want to make sure the provider is an Open Access Provider. This is paid at 80/20% meaning insurance pays 80% of the discounted bill and the member pays 20% of the discounted bill.
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> **How to know if your provider is PPO or Open Access** – Go to www.healthlink.com. Select from the HealthLink Network dropdown "HealthLink Open Access III". Choose a Provider Type by specialty

or by name. Pick a Location by putting in the info here you want to check by. When you find your provider(s), at the top of this list will be Tier I/HMO which is 80/20% or Tier II which is 70/30%.

Adult Wellness/Preventive Care (age 19 and older) - Program of health care designed for the prevention and/or reduction of illnesses by providing certain services paid at 100% with no copay. For example, office visits, pap smears, mammograms, prostate exams, gynecological exam, routine physical examination, urinalysis, other cancer screenings and immunizations, etc. that are in conjunction with "Routine" diagnosis codes in the ICD-9 book or are preventive/screening services. These visits can not be for an injury or sickness. *You cannot combine injury or illness with a routine visit or a copay will be taken for the medical condition.*

Well Child Preventive Services (birth to age 18) Preventive service offered under well child care are paid 100% with no copy and includes periodic check ups, immunizations, and vaccinations that are in conjunction with "Routine" diagnosis codes in the ICD-9 book or are preventive/screening services. These visits cannot be for an injury or sickness. *You cannot combine injury or illness with a routine visit or a copay will be taken.*

Immunizations - Covered under wellness/preventive care at 100%

Routine immunizations
Shingles immunization - for ages 60 and over.
Flu Shots
Gardisil Shots - The age span for women who receive these are age 13-21 paid at 100%
Pneumonia shots
Hepatitis B shots
HPV shots

Counseling - It is covered for mental disorders. For instance, depression, grief, emotional, etc. fall under this category. You can go to a psychologist, psychiatrist, licensed clinical social worker or licensed professional counselor. You would check under www.healthlink.com to find an in network provider or make sure the one you may have is in the network. This would not have a co-pay and would go to deductible and then co-ins.

National Access Card – This card is for if you are outside of the PPO service area for continued medical benefits. Examples would be on vacation, traveling, away on business, college student, etc. Go to http://providers.nhbc.com, which is on your card, to find a list of participating providers. Or if you do not have computer access, call the toll-free number on the card. When going to the provider, use this card along with your Med-Pay insurance card. Show **BOTH** cards.

Benefit Plan Booklet – This can be found on our school website, www.camdentonschools.org under Staff Resources – Health Benefits – Health Plan. Or you can go by the Insurance office in the Administration for a hard copy. Plan booklet always takes precedence over this sheet.

Retirees

If a retiree (past employee) dies, can the spouse stay on the plan? – Yes, per plan document page 10, item 2 under Eligibility Requirements for Employee Coverage.
When is Medicare primary or secondary? – Medicare is secondary if you are an active employee. If you retire, then Medicare becomes primary.
Do you need to notify us when you go on Medicare while an active employee? – Yes, Med-Pay requires that we send a copy of the Medicare card to them.

These are general explanations. Please refer to your Benefit Plan booklet for a detailed description of benefits and limitation. All benefits are based upon medical necessity and eligibility at the time of occurrence.