A Guide to Health Insurance

YourWay ICHRA
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ONEBRIDGE BENEFITS

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Welcome

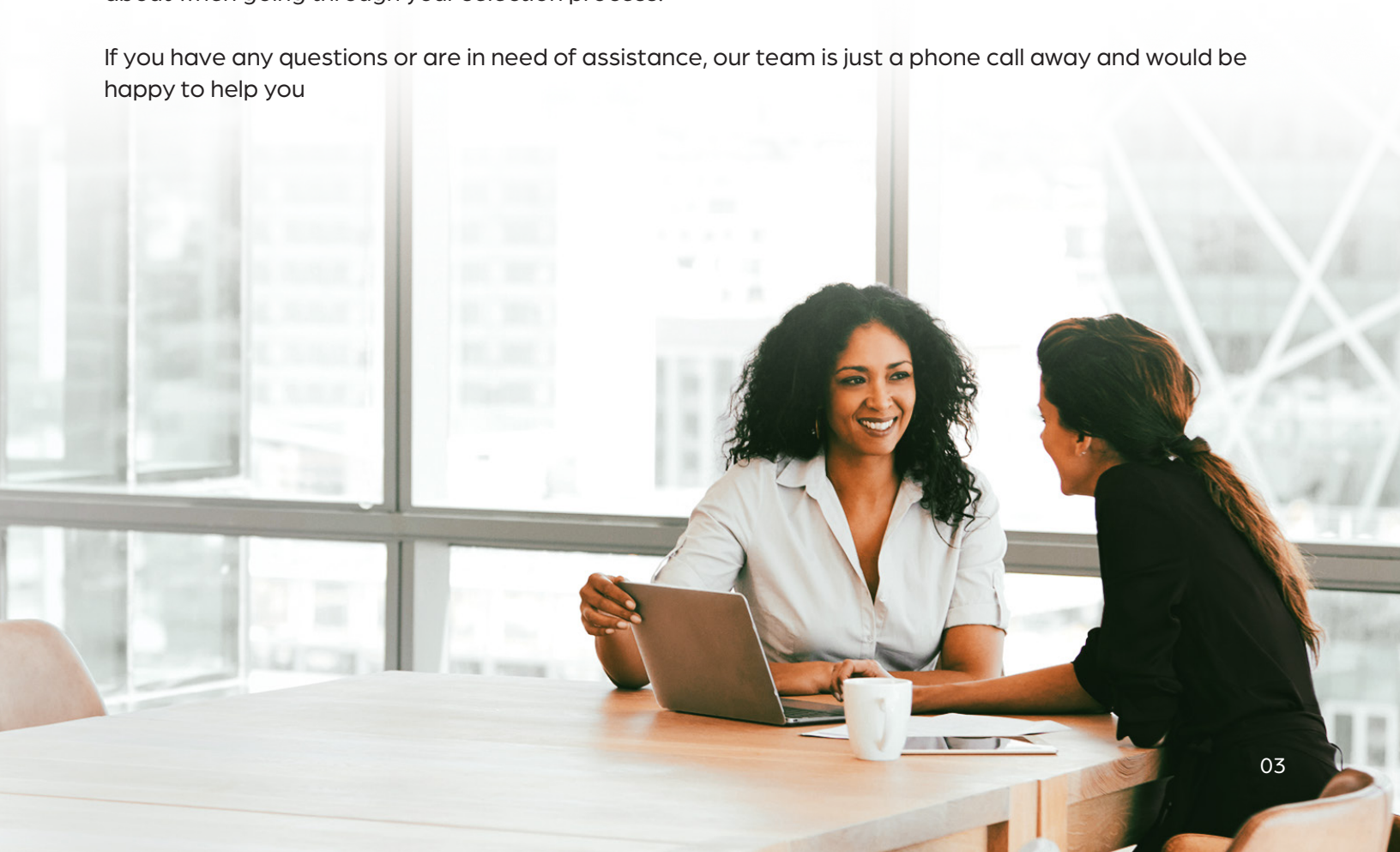
Congratulations! Your employer has made the choice to allow you, their valued employee, the ability to select the health insurance plan that works best for you and your family.

OneBridge Benefits is pleased to be part of this process!

This guide has been prepared to assist you with your health insurance plan selection process.

In addition to helping to clarify many of the common details and terms used in the world of health insurance, we have also included three items in the next Selecting a Plan section that you should think about when going through your selection process.

If you have any questions or are in need of assistance, our team is just a phone call away and would be happy to help you



Selecting a Plan

In addition to your specific budget and lifestyle needs, it is recommended that you consider the following three items when comparing all of the Health Insurance Plans available to you.

1

Your current health status
(and that of your dependents)

If you only see your doctor a couple times a year for simple check-ups and preventative care, you may want a plan that offers a lower monthly premium payment in exchange for basic coverage. Bronze and Silver plans are good examples of these.

However, if you see the doctor frequently and need to treat or manage a chronic illness, you may want a plan that offers a lot of health care benefits and allows you to see your doctor at an affordable price. Gold and Platinum plans best support these scenarios.

Additional details on these different "metal plans" (Bronze, Silver, Gold, and Platinum) are available in this guide to help you understand their differences.

2

The plan's network

Each health insurance plan comes with a group of nurses, doctors and hospitals that will provide you with care at a set price. This group is referred to as the plan's net ork.

It is important to note that different types of health plans will also provide different levels of coverage for the care you get inside and outside of a plan's network. Some plans require you to see a primary care physician for a referral before you're able to access specialized care.

A primary care physician is typically a Medical Doctor or Doctor of Osteopathic Medicine who directly provides or coordinates all of the health care services for you, their patient.

If you currently take certain prescription medications, you want to make sure that the plan you are considering covers these drugs. Also, if you and your family are particularly attached to the current group of doctors you see, you should confirm that they are in the plan's network.

Please refer to the provider plan networks section in this guide for additional details on this topic.

3

Your total estimated cost of care

When choosing a plan, it's a good idea to think about your total health care costs, not just the "premium" you pay to your insurance company every month. Other amounts, sometimes called "out-of-pocket" expenses, and include deductibles, copays, and coinsurance, and have a big impact on your total spending on health care – sometimes more than the premium itself.

In order to pick a plan based on your total costs of care, you'll need to estimate the medical services you'll use for the year ahead. Of course, it's impossible to predict the exact amount, so think about how much care you usually use, or are likely to use.

Health Insurance Basics

Health insurance helps you pay for health care services such as visits to the doctor or prescription drugs. When you buy a health insurance plan, you enter into an agreement with the insurance company. You pay a monthly payment called a "premium" and, in exchange, the insurance company agrees to help you pay a portion of your medical bills.

Health insurance helps reduce the financial risk off of your health care expenses, so if you get sick, you can get the care you need at a reasonable price.

What does health insurance cover?

Most health insurance plans are minimally required to cover certain or essential benefits, such as preventive care services. However, some plans offer additional benefits, like vision, dental, or medical management programs for specific needs or conditions, like weight management, back pain, and diabetes.

Every insurance plan is different. Some plans also include unique benefits and services like discounts on gym memberships.

Essential Health Benefits

1. Ambulatory patient services (outpatient care you get without being admitted to a hospital)
2. Emergency services (trips to the emergency room)
3. Hospitalization (like surgery and overnight stays)
4. Pregnancy, maternity, and newborn care (both before and after birth)
5. Mental health and substance use disorder services, including behavioral health treatment (this includes counseling and psychotherapy)
6. Prescription drugs
7. Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills
8. Laboratory services
9. Preventive and wellness services and chronic disease management, which includes basic vaccines, screenings, and doctor visits, as well as a variety of other items to meet your health care needs or to keep you healthy, including services like contraception, blood pressure screenings, aspirin use, and nutrition and diet counseling.
10. Pediatric services, including oral and vision care (note: adult dental and vision coverage aren't essential health benefits)

Health Insurance Plans must also include coverage for birth control and breastfeeding.

Note: specific services covered in each broad benefit category can vary based on your state's requirements.

Metal Tiers

Most health insurance plans are separated into four categories: Bronze, Silver, Gold, or Platinum. This metal tier grouping was created from the Affordable Care Act to make it easier for all of us to compare health insurance plans.

The category you choose will affect the amount you will likely spend on essential health benefits during the year, including premiums, deductibles, copayments, coinsurance, and out-of-pocket maximums.

You can use these metal tiers as a starting point to help you narrow down your search. For example, if you're a healthy individual who rarely gets sick or injured, you might want to focus your search on Bronze or Silver plans. Although they pay a smaller percentage of your health expenses, your total expenses might be too low to offset the higher premiums of a Gold or Platinum plan.

	Bronze	Silver	Gold	Platinum
Coverage	You Pay **40%** Insurance Pays **60%**	You Pay **30%** Insurance Pays **70%**	You Pay **20%** Insurance Pays **80%**	You Pay **10%** Insurance Pays **90%**
Monthly Payment	$	$$$	$$$	$$$$
Out-Of-Pocket Costs for Care	$$$$	$$$	$$	$
Deductible	**High**	**Moderate**	**Low**	**Lowest**
Fit For	Those who rarely get sick, **see a doctor 1-2x a year for checkups**, and avoid risky physical activity.	Those with **1-2 mild health conditions** that require some specialty visits or medications.	Those with **chronic health conditions** that require regular doctor visits.	Those with **costly, chronic health conditions** or who require emergency care more than once a year.

Catastrophic Plan

In addition to metal categories previously described, there is an additional plan category call Catastrophic. These plans are designed to pay less than 60% of the overall expected health care costs. You can only purchase a catastrophic plan if you are under 30 years of age or have a hardship exemption, which includes homelessness, eviction, or foreclosure in the past six months; a natural or human-caused disaster that caused substantial damage to your property, filing for bankruptcy in the last six months, or the death of a close family member.

Catastrophic plans have low monthly premiums but have very high deductibles that are equal to their Maximum Out of Pocket, which means the insurance company usually isn't going to pay for any care except Preventive Services until the Maximum Out of Pocket has been paid.

These plans are intended to protect consumers from worst-case scenarios, like serious accidents or diseases.

Provider Plan Networks

Most insurance plans have a separate group of doctors that participate in a Provider Plan Network. There are 4 major plan network types. Understanding the network type and making sure your doctor is "in network" are important factors when picking your health insurance plan.

> **What is the difference between in-network and out-of-network providers?**
> To help you save money, most health insurance plans provide access to a network of doctors, facilities, and pharmacies. These doctors and facilities must meet certain requirements and agree to accept a discounted rate for covered services under the health insurance plan in order to be part of the network. These providers are considered in-network. If a doctor or facility doesn't have a contract with the health insurance plan, they're considered out-of-network and can charge you full price, which is usually much higher than the in-network discounted rate.

The table below lists these different types of plan networks, as well as some of the key differences between them. Additional details on each of these network types can be found on the next page.

	PPO Preferred Provider Organization	EPO Exclusive Provider Organization	POS Point-of-Service	HMO Health Maintenance Organization
Primary Care Physician (PCP) **Required**	No	Yes	Yes	Yes
Referral Required to See a Specialist	No	No	Sometimes	Yes
"In-Network" Benefits	Yes	No	Yes	Yes
Non-Emergency "Out-of-Network" Benefits	Yes	No	Yes	No*
Emergency Coverage	Yes	Yes	Yes	Yes

1 — Insurance plans can't make you pay more in copayments or coinsurance if you get emergency care from an out-of-network hospital. They also can't require you to get prior approval before getting emergency room services from a provider or hospital outside your plan's network. However, you may have to pay some out-of-pocket costs, like a deductible.

PPO Preferred Provider Organization

- PPOs often have higher plan premiums but offer partial coverage if you go out-of-network.
- PPOs usually have a deductible in addition to copays, coinsurance, and a monthly premium.
- You usually have a higher deductible and pay a larger share of the cost if you see an out-of- network provider for care. You may also need to take care of any pre-certification paperwork that is typically handled by an in-network provider, as well as submit your out-of-network claims on your own.
- If you want the freedom to choose what doctors you see, consider a PPO plan. However, if your doctors are in-network and you do not anticipate needing out of network care, then an HMO or EPO might be your better option.

HMO Health Maintenance Organization

- HMOs only cover you if you stay in-network and require referrals to see specialists. An HMO delivers services exclusively through a network of doctors, nurses, and hospitals. You are also required to have a primary care physician who coordinates all of your care, including referring you to a specialist in your HMO network, when needed.
- HMOs are often less expensive than other plan types, and in some cases, they will not have a deductible, which means your insurance will begin paying most of your costs immediately. But, if you see a doctor that is not in-network, you will likely pay the full cost of care.
- HMOs can be great if you are satisfied with the providers that are included in the network.

EPO Exclusive Provider Organization

- EPOs are similar to HMOs as they only cover you within a specific network of providers and there is no out-of-network coverage, except in the case of emergencies.
- Like HMOs, EPOs often have lower premiums than PPOs and your annual spend may be less than in a PPO, assuming you avoid out-of- network care.
- If you are comfortable with using in-network providers, but want to see specialists without a PCP referral from your primary care physician, an EPO might be a good option. You will save money and, compared to an HMO, have a little more flexibility.

POS Point-of-Service

- A Point of Service (POS) health insurance plan provides access to health care services at a lower overall cost, but with fewer choices.
- A point-of-service plan (POS) is a hybrid of HMO and PPO plans. Like an HMO, you pick in- network physician to be your primary care provider. But like a PPO, you may go outside of the provider network for health care services.
- You pay less if you use doctors, hospitals, and other health care providers that belong to the plan's network. However, you're required to get referrals from your primary care physician to see specialists.
- When you do go out of network, you'll have to pay most of the cost, unless your primary care physician referred you to the out-of-network provider.
- When you do get out-of-network care and services, you may be responsible for all related paperwork, including managing the receipts and bill payments.

Some Common Health Insurance Terms

As you will share in the cost of your health care by paying a monthly premium, and out-of-pocket expenses, we wanted to provide you with a few key definitions to help you when you're comparing the main differences between health insurance plans.

1 Premium

You pay this amount each month to have your health insurance plan whether you use it or not. In general, the lower your monthly premium is, the higher your out-of-pocket costs will be if you do become ill or injured.

2 Out-of-Pocket Expenses

These are amounts you will pay, in addition to your premium, if you require medical care. There are four key terms that define how you'll pay for medical expenses throughout the year, which are **deductibles**, **copayments**, **coinsurance**, and **out-of-pocket maximums**. Each of these items are described below:

Deductibles

This is how much you have to spend for covered health services before your insurance company pays anything (except free preventive services). For example, if your deductible is $1,000, you will pay the first $1,000 in medical bills out of your own pocket. Each time you pay a medical expense, it will count towards your deductible, and once you've reached your deductible, your insurance will begin to pay the majority of the remaining medical expenses. Your deductible is reset at the beginning of each plan year.

Plans with low premiums generally have higher deductibles. People with high deductible plans should still put some money aside, so they're prepared to pay their deductible, if necessary.

Maximum Out-of-Pocket Amount

The most you have to spend for covered services in a year. After you reach this amount, the insurance company pays 100% for covered services.

The out-of-pocket maximum or limit doesn't include your monthly premiums. It also doesn't include anything you spend for services your plan doesn't cover like out-of-network care and services, and costs above the allowed amount for a specific service.

The out-of-pocket limit can't go over a set amount each year. For the 2022 plan year, the out-of-pocket limit for a Marketplace plan couldn't be more than $8,700 for an individual and $17,400 for a family.

Copayments

Copayments (or co-pays) are a type of coinsurance, only they are a flat fee rather than a percentage. You usually pay copayments when you check-in at a doctor's office or other medical facility unless you're receiving free preventive care services. A copay is often a small amount (like $20 for a typical doctor's visit).

Some plans allow you to pay a low copayment for certain types of care even if you haven't yet met your deductible. These plans often cost a bit more but might be a good choice if you know you'll go to the doctor a few times each year.

Coinsurance

This is the percentage of the expense that you are responsible to pay, after you met your deductible. For example, suppose your plan has 20% coinsurance, you've already paid your deductible, and you need a $10,000 surgery. You would pay a maximum of $2,000 and your insurance would pay the rest.

3 High Deductible Health Plan (HDHP)

An HDHP is a plan that has a higher deductible than a traditional health insurance plan. The monthly premium is usually lower, but you pay more health care costs yourself before the insurance company starts to pay its share (your deductible).

You can combine an HDHP with a Health Savings Account (HSA), which will allow you to pay for certain medical expenses with money free from federal taxes. The IRS defines a high deductible health plan as any plan with a deductible that meets a minimum annual amount for both individual and family plans for the specific plan year.

An HDHP's total yearly out-of-pocket expenses (including deductibles, copayments, and coinsurance) also has limits that are defined every year by the IRS for both individual and family plans (note: this limit doesn't apply to out-of-network services).

Need assistance? We're here to help.

If you have a question or need a little clarification about the different plan details, you can refer to the plan's Summary of Benefits Coverage for additional information or call us and one of our friendly Enrollment Specialists will be happy to assist you.

1.888.865.1628

Monday through Friday **8:00 AM to 8:00 PM** (Eastern Time)

Note: Certain information contained in this guide was referenced from: www.healthare.gov