Understanding Your Health Insurance

Your health insurance policy may seem complex at first, yet understanding your health insurance coverage may be just as important as getting covered. In that effort, the District of Columbia Department of Insurance, Securities and Banking (DISB) developed this fact sheet to highlight common health insurance terminology. Reviewing this fact sheet may help you better understand what services are covered by your policy, and what you will need to pay for each month and for certain services.

PREMIUM

This is the amount you pay every month for your health plan to keep your health insurance coverage active. If you stop paying your monthly premium, your coverage may be cancelled.

COPAYMENT (COPAY)

This is a fixed amount you pay for certain covered services, like doctor visits, and your insurance plan pays the rest. Depending on your health plan and the service, you may need to pay the full amount until you reach your full deductible, before visits thereafter will only require the specified copayments.

Preventive care lets your doctor find potential health problems BEFORE you feel sick. You will not be charged a copay for preventive care services, like annual check-ups, cancer screenings and immunizations, when delivered by a doctor or other provider in your network.

DEDUCTIBLE

This is the fixed amount some plans require you to pay before the plan begins to pay its share for covered services, like a hospital stay or other specialist doctor visits.

Occasionally, health plans may use the term **per occurrence deductible** for specific services. This usually acts like a copay for a more advanced service, like complex imaging (e.g. an MRI). A per occurrence deductible is also typically a higher dollar amount than your average copay, often more than $100.

COINSURANCE

This is when you and your health plan split the cost of the covered service, calculated as a fixed percentage for each. For example, maybe the health plan will pay 80% of an allowable amount and you need to pay the remaining 20%. Like copayments, you may need to pay your full deductible before coinsurance kicks in for your next visit.

OUT-OF-POCKET LIMIT (MAXIMUM OUT OF POCKET OR MOOP)

This is the maximum you will pay per year for medical services before your health plan begins to pay for 100% of remaining services. This limit helps to protect you and your family from very high medical expenses. Most of your copayments, deductibles and coinsurance payments will be counted towards this limit.

Premiums usually do not count towards your deductible or your maximum out-of-pocket limit. It is also important to note that you may have separate and unique deductibles or maximum out-of-pocket limits for individuals versus the whole family together, or for in-network versus out-of-network services.

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UNDERSTANDING YOUR DEDUCTIBLE

The example below uses information for an individual, standard silver plan that is sold on DC Health Link. Be sure to check your plan documents to better estimate your actual costs.

IMPORTANT: For each medical service, the deductible may or may not apply. Check your plans contract language and Summary of Benefits and Coverage (SBC).

For example, the SBC states that for Primary Care Visits ($25 co-payment) "Deductible does not apply." Therefore, you will not be required to reach your deductible for this service, and will simply pay $25 for your visit. Conversely, for other services the deductible will apply. For example, for emergency medical transportation you must reach your deductible before the coverage kicks in.

District of Columbia
Standard Silver Plan
Deductible: $2,000
Coinsurance: 20%, 50%
Copayment: $15, $25, $45, $50, $70, $65, $90, $250
(depending on the service rendered) Check your SBC to see how much each service costs
Out-of-Pocket Limit: $6,250

GREEN LIGHT: (FIRST MONTH OF COVERAGE)

Each year your deductible resets, so no matter how much you paid the last plan year, your deductible contribution will start at $0. At this point, you are responsible for all medical costs until you reach your deductible (spend $2,000 on medical costs).

Example: You are rushed to the Emergency Room via ambulance, the bill costs $700. Since the deductible applies to both emergency medical transportation and emergency room services and you have yet to spend any money on medical costs this year, you will be responsible for the full cost of the bill. The remaining deductible would be $1,300.

Disclaimer: Regardless of whether you reach your deductible, starting the first day of coverage, all preventive services, such as annual wellness visits and immunizations, do not require any payment from you (other than your monthly premium to maintain coverage).

YELLOW LIGHT: (3 MONTHS HAVE GONE BY)

Since your first $700 bill from the trip to the Emergency Room, you have spent an additional $1,300 on medical care over the past three months. In total, you have spent $2,000 out of-pocket. At this point, your have reached your deductible and you will only be responsible to pay for the designated copayments and/or coinsurance which can be found in your health plan policy documents and SBC.

RED LIGHT: (9 MONTHS HAVE PASSED)

Unfortunately, you have faced significant medical costs throughout the year; luckily, there is an out-of-pocket maximum. After you spend $6,250 out-of-pocket in a given plan year, you have reached your out-of-pocket maximum. At this point, if you are in need of any medical services that are covered under your plan, your insurance company will pay the entire bill when you use an in-network provider. You will not be required to pay any co-payments or coinsurance.

IMPORTANT: Although you have reached your out-of-pocket maximum, it is important that you continue to pay your monthly premium. If you do not pay your monthly premium, your coverage may be terminated.

CONCLUSION

Understanding health insurance may seem difficult, but these concepts are important to consider during plan selection to ensure that you are making the right financial decisions related to your personal health.

If you still have questions about your coverage, contact DC Health Link at 855-532-5465 or call the number on the back of your insurance card.

If you are having an issuing with your insurance coverage, please file a complaint with the Consumer Services Division within the District of Columbia Department of Insurance, Securities and Banking. To file a complaint, please email disbcomplaints@dc.gov or call 202-727-8000.