Wisconsin Office of the COMMISSIONER OF INSURANCE

Guide to Health Insurance for Small Employers and their Employees

This guide helps small employers understand their health care insurance options and provides a comparison of premium rates available in the small employer health insurance market.

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Disclaimer

This guide is intended as a general overview of current law in this area but is not intended as a substitute for legal advice in any particular situation. You may want to consult your attorney about your specific rights. Publications are updated annually unless otherwise stated and, as such, the information in this publication may not be accurate or timely in all instances. Publications are available on OCI's website at oci.wi.gov/Publications. If you need a printed copy of a publication, use the online order form (oci.wi.gov/Pages/Consumers/Order-a-Publication.aspx) or call 1-800-236-8517. One copy of this publication is available free of charge to the general public. All materials may be printed or copied without permission.

File a Complaint

If you have a specific complaint about your insurance, refer it first to the insurance company or agent involved. If you do not receive satisfactory answers, contact the Office of the Commissioner of Insurance (OCI).

- Reach out to OCI (1-800-236-8517, ocicomplaints@wisconsin.gov) to speak with our staff. If sending an email, please indicate your name and phone number.
- File a complaint with OCI. You can file a complaint online at oci.wi.gov/complaints. If you would like to file your complaint by mail, visit oci.wi.gov/complaints, email ocicomplaints@wisconsin.gov, or call 1-800-236-8517 for a form.

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Introduction

(Ch. 635, Wis. Stat., and Ch. Ins. 8, Wis. Adm. Code)

Wisconsin small employers are not required by state law to offer employees health care benefits. However, many small employers do offer health benefits to their employees to attract and keep good employees. Small employer health insurance is available in Wisconsin from several insurers and managed care plans. This publication is meant to help small employers understand their options and to provide a comparison of premium rates available in the small employer health market.

In Wisconsin, a small employer is defined as one that employs at least two but not more than 50 employees. State law defines an eligible employee as one who works on a permanent basis and has a normal workweek of 30 or more hours. This includes a sole proprietor, a business owner (including the owner of a farm business), a partner of a partnership, and a member of a limited liability company if these individuals are included as an employee under a health benefit plan of a small employer. The term does not include an employee who works on a temporary or substitute basis or less than 30 hours a week.

Under the Affordable Care Act, every small group and comprehensive individual health insurance policy must include these essential health benefits as a minimum requirement.

The following are the 10 essential health benefit categories:

1. Ambulatory services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services
10. Pediatric services, including oral and vision care

Small group and comprehensive individual health insurance policies may not contain annual or lifetime dollar limits for these essential health benefits.

The following terms are important to understand for all types of insurance. A glossary is also included at the end of this document.

Deductible

The deductible is the initial dollar amount that must be paid out-of-pocket before the insurance company pays its share. For example, if there is a $3,000 annual deductible, the insured member will pay for the first $3,000 of covered expenses before the policy pays any benefits toward the claims.

When buying coverage for a family, ask how the family deductible works. Some family plans have both an individual deductible and a family deductible. In some instances, a family may be required to meet both deductibles before the plan begins to pay benefits.

Read the policy carefully. Some policies require a separate deductible for certain services, like prescription drugs.

Coinsurance

Coinsurance is the insured member's share or percentage of covered expenses that must be paid in addition to the deductible. For example, a common coinsurance arrangement is for the insurance company to pay 80% and the insured to pay 20% as coinsurance until a maximum out-of-pocket expense is reached. Coinsurance applies to each person and starts over again each plan or calendar year.

Copayment

A copayment is the insured member's share or a fixed amount that must be paid for covered expenses in addition to the deductible. The amount can vary by the type of covered medical expense.

Out-of-Pocket Limit

The out-of-pocket limit is the maximum dollar amount the insured member pays for covered services and supplies during a specified period, generally a calendar year. Once the out-of-pocket maximum is paid, benefits are paid at 100% of covered costs incurred until the end of the calendar or policy year.

Medically Necessary

All comprehensive health insurance policies contain provisions allowing insurance companies to evaluate whether a service or treatment is considered medically necessary and whether it could adversely affect a medical condition if it were omitted. Insurance companies can deny payment for a treatment that is deemed to be not medically necessary. Many health plans require a review before certain medical procedures are done.

Allowed Amount

Most insurance companies do not use an insured member's actual bills to calculate how much they will pay. Insurance companies have their own fee schedule or another claim payment methodology, which is described in the certificate of coverage. Allowed amounts are typical amounts paid for everything from a doctor's visit to heart surgery. In some instances, the insured member may be billed for any difference between what the provider billed and the insurance company's allowed amount.

However, the No Surprises Act bans the following:

- Surprise billing for emergency services;
- Balance billing and out-of-network cost-sharing (like out-of-network co-insurance or copayments) for emergency and certain non-emergency services;
- Out-of-network charges and balance billing for ancillary care (like an anesthesiologist or assistant surgeon) by out-of-network providers at an in-network facility; and
- Certain other out-of-network charges and balance billing without advance notice or consent.

Traditional Health Plans

With traditional fee-for-service health plans (also known as indemnity plans), an employer purchases a policy from an insurance company and pays a premium on a regular basis. A group health insurance policy is a contract between the employer and the insurance company. The employee does not receive a policy but only a certificate of

insurance under the employer's contract. In exchange for the premium, the insurance company agrees to pay for certain medically necessary services for the employees and dependent family members included as covered items under the policy.

Under a fee-for-service plan, insured members are free to seek necessary medical care from any physician. With a fee-for-service plan, the insurance company pays for part of the doctor and hospital bills.

The doctor often bills the insurance company directly for the services provided, and the insurance company pays for items covered by the policy. In some cases, an insured member may have to submit a completed claim form and an attending physician's statement. Fee-for-service health plans require an insured member to pay a deductible and coinsurance.

Defined Network/Managed Care Health Plans and Related Terms

A defined network plan (also known as a managed care plan) is the term used in Wisconsin insurance law to refer to any health benefit plan that has incentives for its members to use network providers. Some defined network plans will provide coverage only if the insured member use network providers; other plans will pay a larger portion of the charges for network providers. Health Maintenance Organization (HMO) plans, Point of Service (POS) plans, and Preferred Provider Organization (PPO) plans are examples of defined network plans.

Health Maintenance Organization

An HMO is a defined network plan providing comprehensive, prepaid medical care. An HMO may operate on a closed panel basis. This means you are required to seek care from a medical provider who is either employed by or under contract with the HMO.

Except for serious emergencies or the need for urgent care outside the service areas, the HMO will not pay for care received from a provider who is not part of the HMO's network unless the HMO physician refers an insured member tothat provider and the plan approves the referral before receiving services.

Point of Service

POS plans are essentially HMOs that allow members to use services provided outside of the network. POS plans may require a referral from a primary care doctor for a specialist. Visits outside the network normally require the payment of deductibles and coinsurance so you pay more if you seek care outside your provider network.

Preferred Provider Organization

A PPO is a form of managed care closest to a fee-for-service plan. A PPO has arrangements with doctors, hospitals, and other care providers to accept lower fees from the insurer for their services as part of the network agreement. A PPO pays a specific level of benefits if network providers are used and a lesser amount if non-network providers are utilized. A PPO must provide reasonable access to network providers in the service area. However, a PPO is not required to offer a choice of network providers in each geographic area. A PPO also does not require a referral to see a specialist.

PPOs may require coinsurance of up to 50% for services provided by non-network providers. Always read the policy carefully before seeking services from non-network providers.

A PPO operates in a specific geographic area and is limited to specific providers. A PPO that has a provider agreement with a hospital may not have an agreement with every provider who provides services at the hospital, such as anesthesiologists, pathologists, and radiologists.

Many insurers offering traditional health plans also offer some type of preferred provider plan. You may wish to ask your agent to provide you with information on preferred provider plans in your area.

Exclusive Provider Organization

An Exclusive Provider Organization (EPO) is a managed care plan where services are covered only if insured members go to doctors, specialists, or hospitals in the plan's network (except in an emergency).

Provider Directories

All defined network plans must make available to members a provider directory that lists hospitals, primary care physicians, and specialty providers from whom you may obtain services. These directories are generally available on the plan's website, but a paper copy must be provided upon request. Insured members should verify with the defined network plan before making an appointment that the provider is currently contracted with the defined network organization.

Continuity of Care

(s. 609.24, Wis. Stat.)

If a defined network plan indicates that a primary care physician (defined as a physician specializing in internal medicine, pediatrics, or family practice) is available during an open enrollment period, it must make that physician available with the same cost-sharing as in-network providers at no additional cost for the entire plan year. A specialist provider must be made available for the course of treatment or 90 days, whichever is shorter. If a member is in the second trimester of pregnancy, the provider must be available through postpartum care. The exceptions are for a provider who is no longer practicing in the defined network plan's service area or who was terminated from the plan for misconduct.

Referral Procedure

Some defined network plans require a referral from a primary care physician before an insured member can see another in-network provider. All HMOs require a referral approved by the network plan before going to an out-of-network provider. The certificate booklet includes information on the procedure to follow and any notification requirements.

A defined network plan may not require a referral from a physician for services from a plan chiropractor. The plan must also allow a woman to receive obstetrical and gynecological services from a plan physician who specializes in obstetrics or gynecology without requiring a referral from their primary care provider.

Defined network plans must have a procedure allowing for standing referrals. A standing referral authorizes insured members to be seen by a specialist provider for a specific duration of time or a specific number of visits without having to obtain a separate referral from the primary provider for each visit to the specialist.

If seen by a non-HMO provider without an approved referral, the claim for those services may not be reimbursed by the HMO. The insured member has the right to file a grievance when a referral is denied.

Second Opinions

Every defined network plan must cover a second opinion from another provider within the defined network plan provider network.

Disenrollment

An HMO must disclose in the policy and certificate any circumstances under which insured members may be disenrolled. Disenrollment proceedings may be initiated only for the following reasons:

- The insured member failed to pay the required premiums by the end of the grace period.
- The insured member moved outside of the geographical service area of the organization.
- The insured member filed fraudulent claims or committed any type of insurance fraud.

Insured members have the right to file a grievance when a disenrollment proceeding is initiated.

Requirements Applicable to Small Employer Health Benefit Plans

The requirements of the small employer health insurance law apply to group health insurance policies or certificates offered to small employers.

Important Note

Under Wisconsin insurance law, health insurers are required to provide insured members with a copy of the health insurance certificate. Health insurers may make this available in electronic format on their website but must also provide a paper copy of the certificate if an insured member requests it.

Special Enrollment Periods

Small employer plans must provide a special enrollment period:

- For individuals who become dependents by marriage, birth, or adoption. At that time, the employee or spouse may also elect coverage if not already covered.
- For employees/dependents who initially decline coverage because they were covered through their spouse and then lose that coverage.

A special enrollment period also allows individuals to purchase coverage in the individual market outside of open enrollment if they have a triggering event:

- Loss of minimum essential coverage
- Gain citizenship
- Become newly eligible for premium tax credits

Enrollment Participation

An insurer may establish minimum participation and employer contribution rules and requirements on a group health benefit plan offered to a small employer. An insurer offering a group health benefit plan to a small employer through a network plan may limit the small employers to those with eligible individuals who reside, live, or work in the service area of the network plan.

Special Provisions Relating to the Sale of Small Employer Health Insurance Policies

There are special provisions in the small employer health insurance law relating to the sale of group or individual health insurance policies to small employers.

- Small employer insurance plans are required to treat all eligible individuals equally concerning health status. For example, plans may not discriminate against individuals with an unfavorable medical history.
- Small employer insurers are required to automatically renew group coverage each year as long as the insurer is in the group market.
- Small employer insurers selling coverage to small employers are required to make all products available to any small employers who apply.

Exclusions and Limitations

All health insurance policies can exclude or limit coverage of specified conditions and services. A small employer plan is allowed exclusions and limitations as long as they are treated the same way under the insurer's other small group health benefit plans and the benefit design is not considered discriminatory.

Emergency Care

Every health plan offered in Wisconsin covering emergency care must cover, without prior authorization, services required to stabilize a condition most people would consider to be an emergency. Defined network plans are permitted to charge a reasonable copayment or coinsurance for this benefit.

Mandated Benefits

(s. 632.895, Wis. Stat.)

Health insurance policies sold in Wisconsin often include benefits that are required to be offered under state law or regulation. These are referred to as mandated benefits. These are benefits that an insurer must include in certain types of health insurance policies. Except for HMOs organized as cooperatives under Ch. 185, Wis. Stat., HMOs are required to provide the same benefits as traditional health plans.

For more information on mandated benefits, see the Fact Sheet on Mandated Benefits in Health Insurance Policies publication available on the OCI website at oci.wi.gov/Pages/Consumers/PI-019.aspx.

Coverage Limits

If a health insurance plan limits coverage of an experimental treatment, procedure, drug, or device, the insurer is required to clearly disclose those limitations in the policy. Additionally, the insurer must have a process to request a timely review of a denied experimental treatment.

If the health insurer limits coverage of drugs to those on a preapproved list, often called a formulary, the insurer must have a process for a physician to present medical evidence to request coverage of a drug not on the approved list.

Health insurance plans must provide at least the minimum mandated coverage but may provide benefits greater than those mandated by law.

Grievance Procedure

(s. 632.83, Wis. Stat., and Ch. Ins. 18, Wis. Adm. Code)

All health insurance plans are required to have an internal grievance procedure for those who are not satisfied with the service they receive. The procedure must be set forth in the insurance contract and must also be provided by written notice.

The defined network plan must provide insured members with complete and understandable information about how to use the grievance procedure. Insured members have the right, but are not required, to participate in person before the grievance committee and present additional information.

Insured members may wish to first contact the health plan with a question or complaint. Many complaints can be resolved quickly and require no further action. However, filing a complaint with the plan first is not required. Complaints may be filed with the appropriate state agency instead of, before, or at the same time as filing with the defined network plan.

Health plans are required to have a separate expedited grievance procedure for situations where the medical condition requires immediate medical attention.

Defined network plans are required to file a report with OCI listing the number of grievances they received in the previous year. A summary of this information is included in the Consumer's Guide to Managed Care Health Plans in Wisconsin publication available at oci.wi.gov/Pages/Consumers/PI-044.aspx

Independent Review

(s. 632.835, Wis. Stat., and Ch. Ins. 18, Wis. Adm. Code)

If an insured member is not satisfied with the outcome of the grievance, they may have an additional way to resolve some disputes involving medical decisions. The insured member or their authorized representative may request that an Independent Review Organization (IRO) review the health plan's decision.

In most cases, an insured member needs to complete the health plan's internal grievance procedure before seeking an independent review. The insurer's final written decision on a grievance should include a notice explaining how to request an independent review. Send a written request for independent review to the address provided in the insurer's final written decision within four months of the date the grievance procedure was completed.

The dispute must involve a medical judgment. An insured member may request an independent review whenever a health plan denies coverage for a treatment because it maintains the treatment is not medically necessary or is experimental, including denial of a request for out-of-network services when the insured believes that the clinical expertise of the out-of-network provider is medically necessary. The treatment must otherwise be a covered benefit under the insurance policy.

An insured member may also request an independent review if the coverage has been rescinded because the insurer maintains that health questions on the application for insurance were not answered completely and accurately.

If you and your insurer disagree about whether your dispute is eligible for independent review, you may request that it be sent to the IRO. The IRO will decide if it has the authority to do the review.

The independent review process provides an opportunity for medical professionals with no connection to the particular health plan to review the dispute. The IRO assigns the dispute to a clinical peer reviewer who is an expert in the treatment of the medical condition. The clinical peer reviewer is generally a board-certified physician or other appropriate medical professional. The IRO has the authority to uphold or reverse the health plan's decision.

For more information on the independent review process, see the Fact Sheet on the Independent Review Process in Wisconsin publication available on the OCI website at oci.wi.gov/Pages/Consumers/PI-203.aspx

Continuation

Both state and federal law give certain individuals, who would otherwise lose their group health care coverage under an employer or association plan, the right to continue their coverage for a period of time. The two laws are similar in some ways but also have very different provisions. Most employers having 20 or more employees must comply with the federal law, while most group health insurance policies providing coverage to Wisconsin residents must comply with the state law. When both laws apply to the group coverage, it is the opinion of OCI that the law mostfavorable to the insured should apply.

COBRA (Federal Law)

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law allowing most employees, spouses, and their dependents who involuntarily lose their health coverage under an employer's group health plan (i.e., when you leave your job) to continue coverage, at their own expense, for a period of time. This law applies to both insured health plans and self-funded employer-sponsored plans in the private sectorand those plans sponsored by state and local governments. However, COBRA does not apply to certain church plans, plans covering less than 20 employees, and plans covering federal employees.

Under federal law, an employee, who terminates employment for any reason other than gross misconduct or who loses eligibility for group coverage because of a reduction in work hours, and the covered spouse and dependents of the employee may continue the group coverage for up to 18 months. A spouse and dependents may continue coverage for up to 36 months if they lose coverage due to the death of the

employee, divorce from the employee, loss of dependent status due to age, or due to the employee's eligibility for Medicare. If within the first 60 days of COBRA coverage an individual or dependent is determined by Social Security to be disabled, the disabled individual and other covered family members maycontinue coverage for up to 29 months.

For questions about the federal COBRA law, contact:

U.S. Department of Labor
Regional Office Employee Benefits Security Administration (EBSA)
230 South Dearborn Street, Suite 2160
Chicago, IL 60604
(312) 353-0900
dol.gov/general/topic/health-plans/cobra

Wisconsin Law (s. 632.897, Wis. Stat.)

Wisconsin's continuation law applies to most group health insurance policies providing hospital or medical coverage to Wisconsin residents. The law applies to group policies issued to employers of any size. The lawdoes not apply to employer self-funded health plans or policies that cover only specified diseases or accidental injuries.

Employees have 30 days from the date they are notified of their continuation rights to make a decision andpay the initial premium required. There is no grace period to make subsequent payments.

For more information on continuation, see the Fact Sheet on Continuation Rights in Health Insurance Policies publication which describes both state and federal law and is available on the OCI website at oci.wi.gov/Pages/Consumers/PI-023.aspx.

Small Employer Plan Premiums

In general, how much premium a health insurance company charges for a specific small employer plan depends on:

- Each employee's age and the age of any family member(s) insured by the plan. Older individuals usually have more expensive and more frequent health-related claims. The older the workforce, the more the plan will cost.
- Whether or not each individual 21 or older uses tobacco. Federal law allows health insurance companies to charge tobacco users up to 50% more than non-tobacco users.
- The network of doctors and hospitals accessed. More choice is usually more expensive, while narrower networks can result in cost savings.
- The covered services and cost-sharing amounts in the health plan. Plans providing more benefits will generally cost more than plans providing less benefits.
- The geographic location of the employer. Health care costs vary by region because of differences in the cost of living and the number of providers in the area.

A health insurance company cannot vary the group's premium based on the "health status" of employees or their family members.

Small Business Health Options Program (SHOP)

SHOP is a Marketplace designed for small employers with 50 or fewer full-time equivalent employees. It allows small employers to get the information they need in one location by using the tools available at HealthCare.gov.

If you are a small employer enrolling in SHOP insurance for the first time, you can use HealthCare.gov to verify your eligibility for SHOP insurance. You then work with your SHOP-registered agent or broker or with an insurance company to choose a plan, enroll, and pay premiums.

Small Business Health Tax Credit

Small businesses providing health care for employees may apply for a federal tax credit through the SHOP Marketplace. You may qualify for employer health care tax credits if you have fewer than 25 full-time equivalent employees making an average of approximately $56,000 a year or less. To qualify for the small business health care tax credit, you must pay at least 50% of your full-time employee's premium costs. You do not need to offer coverage to your part-time employees or dependents.

The credit is available only if you get coverage with a SHOP Marketplace plan. You can find out more about the amount of and eligibility for the potential tax credits by visiting IRS.gov.

Coverage Options

Similar to the market-at-large, the SHOP Marketplace provides four plan categories based on how your employees and the plan expect to share the costs for health care:

- Bronze covers 60% of the total average costs of care
- Silver covers 70% of the total average costs of care
- Gold covers 80% of the total average costs of care
- Platinum covers 90% of the total average costs of care

The amount your employees can expect to pay for things like deductibles and copayments, and the total amount they spend out-of-pocket for the year if they need a lot of care, depends on which plan category you choose.

If you are self-employed with no employees, you can get coverage through the individual health insurance marketplace, but not through SHOP. Small employers are not required to purchase insurance through the SHOP Marketplace, but you may want to compare plans available on and off the Marketplace. You may find more information at HealthCare.gov.

Consumer Tips

- Shop around. Health insurance can be expensive. Check with several agents and companies or the SHOP Marketplace before making a final choice.
- The Checklist for Small Employers and the Health Care Coverage Worksheet at the back of this publication will give you a more accurate idea of what your actual policy premium may be.
- Be sure to request and review your Schedule of Benefits. This is a brief explanation of specific benefits and benefit limitations for covered services provided under the terms of the Certificate of Insurance.
- Buying several limited policies can be very expensive and may not provide the coverage you need.

- When you apply for coverage, fill out the application accurately and completely. If you knowingly give incorrect or misleading information or fail to disclose relevant information, your coverage could be canceled, or benefits may be denied.
- Never sign a blank application. Verify any information filled in by the agent.
- Make payments by check or money order payable to the insurance company or HMO, not to the agent. Insist on a signed receipt on the company's letterhead. Pay no more than two months' premium and fees until you have received the policy, group certificate, or HMO subscriber certificate.
- Make sure you have the full name, address, and phone number of both the agent and the insurance company or HMO.
- Be careful about mail order policies, those sold door-to-door, and over the internet. You may need a local agent to help you with claims.
- Avoid duplicate coverage. Insurance companies often coordinate benefits so you may collect on only one policy.

Problems with Your Insurance Company

If you have a specific complaint concerning your insurance, you should first attempt to resolve your concerns with your insurance agent or with the company involved in your dispute. If you do not get satisfactory answers from the agent or company, file a complaint with OCI. A complaint form is available on the OCI website at oci.wi.gov/complaints.

Glossary

Actuarial Value
The percentage of total average costs for covered benefits a plan will cover. For example, if a plan has an actuarial value of 80%, on average, you would be responsible for 20% of the costs of all covered benefits. However, you could be responsible for a higher or lower percentage of the total costs of covered services for the year, depending on your actual health care needs and the terms of your insurance policy.

Certificate of Insurance
The formal document received by an employee describing the specific benefits covered by the policyholder's health care contract with the insurance company. The certificate contains copayment and/or deductible requirements, specific coverage details, exclusions, and the responsibilities of both the certificate holder and the insurance company.

Closed Panel
A type of health plan requiring members to seek care only from a medical provider who is either employed by or under contract to the health maintenance organization or limited service health organization.

Coordination of Benefits (COB)
A provision in a health insurance policy applying when a person is covered under more than one health plan or another type of policy such as an automobile insurance policy. It requires the payment of benefits to be coordinated by all insurers who cover the person to eliminate over insurance or duplication of benefits.

Drug Formulary
A list of prescription drugs the plan considers medically appropriate and cost effective. The defined network plan will provide coverage for only those prescription drugs named in the list. However, your doctor may present medical evidence to the insurer to obtain an exception allowing coverage for a prescription drug not routinely covered by the plan.

Essential Health Benefits (EHB)
The minimum level of covered services insurers must offer in the individual and small group markets.

Exclusion
A specific situation, condition, or circumstance listed in the insurance policy as not covered. Although you may purchase a plan covering most medical, hospital, surgical, and prescription drug expenses, no health plan will cover every conceivable medical expense you may incur. Examples of typical exclusions include vision care (eye exams, glasses, contacts, etc.), hearing aids, dental care, cosmetic surgery, experimental treatments, etc.

Exclusive Provider Organization (EPO)
A health plan requiring the use of a specific network of providers participating in the plan. EPOs do not cover care outside the network chosen by the enrollee except for emergency medical condition treatment.

Fee-for-Service
The traditional health care payment system under which physicians and other providers receive a payment for each service provided. Under a fee-for-service insurance plan, insureds usually may choose to go to any provider they want. However, providers are not required to accept the insurance company's payments as payment in full.

Grace Period
A period of time after a premium becomes due in which you can still pay for the insurance and keep it in force. Wisconsin law requires at least 31 days for group health insurance.

Guaranteed Renewable Policy
A small employer or individual policy which must be continued in force, and must be renewed regularly, if the premium is paid on time.

Health Maintenance Organization (HMO)
A health care financing and delivery system providing comprehensive health care services for members in a particular geographic area. HMOs require the use of specific plan providers.

Indemnity Plan (see Fee-for-Service)

Point-of-Service (POS)
A type of managed care plan providing financial incentives to encourage enrollees to use network providers but allows enrollees to choose providers outside the plan.

Preferred Provider Organization (PPO)
An organization contracting with insurers and other organizations to provide health care services at a discounted cost by providing incentives to members to use physicians and other health care providers contracting with the PPO.

Primary Care Provider
A physician, nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law, who provides, coordinates, or helps a patient access a range of health care services. Insurance plans may provide a list of providers who are contracted with the plan, that you can choose from and designate as your primary care provider.

Provider Network
A provider network is a list of the doctors, other health care providers, and hospitals a plan has contracted with to provide medical care to its members. These providers are also called network providers or in-network providers.

Urgent Care
Medically necessary care for an accident or illness needed sooner than a routine doctor's visit.

Checklist for Small Employers – Evaluating Your Small Business Health Insurance Needs

Small businesses have special needs because they generally do not have a personnel department or benefits manager. If you are a small business, you need to think of your insurance agent as your benefits manager. Make sure the agent you choose has experience in working with small employer insurance and the insurance options available because of the Affordable Care Act (ACA).

Number of employees currently eligible for coverage	
Number of dependents	
Number of individual or family plans	individual
	family
Age of employees and age of dependents	under age 19
	age 19 or older
Number of employees insured elsewhere	
How is the rate calculated?	
Is the rate guaranteed? For how long?	
Will the agent/broker or a customer service representative meet with employees and dependents?	
Will the agent/broker or a customer service representative describe the enrollment process?	to employer
	to employees
How long will it take to process a claim?	
How often will the employer be billed?	
Was the agent or broker knowledgeable and able to answer my questions about small-group insurance and SHOP (ACA)?	
How much is the employer required to contribute to the cost of premiums for its employees?	
Will provider network cover health care providers and facilities used by my employees?	

Health Care Coverage Worksheet

This chart may be used to compare policies. This comparison is not intended to be a complete analysis of the plan's benefits. The certificate of coverage provides a detailed description of the policy benefits. Please check your own policy for variations and further details.

Plan Name					
Employer Premium	Monthly Annual				
Employee Premium	Monthly Annual				
Annual Deductible	Single Family				
Deductible for Specific Services	Single Family				
Coinsurance Percentage					
Copayments					
Annual Out-of-Pocket Limit					
What Is not Included in the Out-of-Pocket Limit?					
Provider Network					
Preventive Care • Preventive Services Subject to Cost-sharing					
• Colonoscopy Cost-sharing if Diagnostic					
Hospital Services* • Inpatient Services					
• Outpatient Services					
Emergency Services • Emergency Room Care (including Physician Charges and Misc. Expenses)					
• Ambulance Services					
Professional Services** • Primary Care Office Visits					
• Specialist Office Visits					

* Some services may require precertification or prior approval. Financial penalties could apply if an approved precertification or prior approval is not in place for services received.

** The exclusions section of the certificate lists the services, treatments, equipment or supplies that are excluded (meaning no benefits are payable under the plan benefits) or have some limitations on the benefit provided. Some of the listed exclusions may be medically necessary but still are not covered under the plan, while others may be examples of services which are not medically necessary or not medical in nature, as determined by the plan.

Professional Services** (continued) • Maternity Services				
• Medical Supplies and Durable Medical Equipment				
• Occupational, Physical, and Speech Therapy				
• Anesthesiologist, Pathologist, and Radiologist Services				
• X-Ray and Lab Services				
Home Health Care**				
Skilled Nursing Care**				
Health Care Services** • Breast Reconstruction (following a covered mastectomy)				
• Diabetic Equipment, Supplies, and Self-Management				
• Smoking Cessation Programs				
• Temporomandibular Joint (TMJ) Disorders				
• Treatment for Autism Spectrum Disorders				
Transplants (prior approval may be required)**				
Alcoholism, Drug Abuse, and Nervous or Mental Disorders • Inpatient				
• Outpatient				
• Transitional				
Prescription Drug Coverage • Generic Drugs				
• Preferred Brand Drugs				
• Non-Preferred Brand Drugs				
• Specialty Drugs				
Additional Benefits • Adult Dental Care				
• Adult Vision Exams				
• Hearing Exams				

** The exclusions section of the certificate lists the services, treatments, equipment or supplies that are excluded (meaning no benefits are payable under the plan benefits) or have some limitations on the benefit provided. Some of the listed exclusions may be medically necessary but still are not covered under the plan, while others may be examples of services which are not medically necessary or not medical in nature, as determined by the plan.

Additional Benefits (continued) • Employee Wellness Program				
• Other				
Exclusions**				
• Bariatric Procedures				
• Fertility Treatment and Services				
• Other				

** The exclusions section of the certificate lists the services, treatments, equipment or supplies that are excluded (meaning no benefits are payable under the plan benefits) or have some limitations on the benefit provided. Some of the listed exclusions may be medically necessary but still are not covered under the plan, while others may be examples of services which are not medically necessary or not medical in nature, as determined by the plans.