Glossary of Health Coverage and Medical Terms

- This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- **Bold blue** text indicates a term defined in this Glossary.
- See page 4 for an example showing how **deductibles**, **co-insurance** and **out-of-pocket limits** work together in a real life situation.

Allowed Amount

Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your **provider** charges more than the allowed amount, you may have to pay the difference. (See **Balance Billing**.)

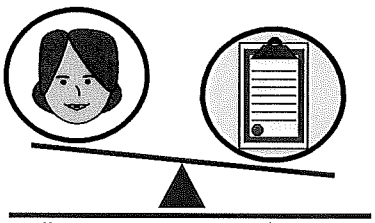
Appeal

A request for your health insurer or **plan** to review a decision or a **grievance** again.

Balance Billing

When a **provider** bills you for the difference between the provider's charge and the **allowed amount**. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A **preferred provider** may ***not*** balance bill you for covered services.

Co-insurance



Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the **allowed amount** for the service. You pay co-insurance ***plus*** any **deductibles** you owe. For example, if the **health insurance** or **plan's** allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

(See page 4 for a detailed example.)

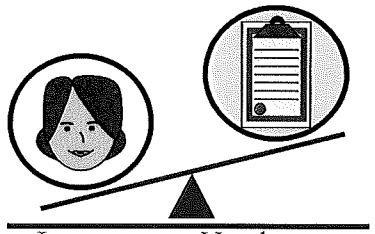
Complications of Pregnancy

Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

Co-payment

A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible



The amount you owe for health care services your **health insurance** or **plan** covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

(See page 4 for a detailed example.)

Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care **provider** for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition

An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation

Ambulance services for an **emergency medical condition**.

Emergency Room Care

Emergency services you get in an emergency room.

Emergency Services

Evaluation of an **emergency medical condition** and treatment to keep the condition from getting worse.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

Excluded Services
Health care services that your **health insurance** or **plan** doesn't pay for or cover.

Grievance
A complaint that you communicate to your health insurer or **plan**.

Habilitation Services
Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance
A contract that requires your health insurer to pay some or all of your health care costs in exchange for a **premium**.

Home Health Care
Health care services a person receives at home.

Hospice Services
Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization
Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care
Care in a hospital that usually doesn't require an overnight stay.

In-network Co-insurance
The percent (for example, 20%) you pay of the **allowed amount** for covered health care services to **providers** who contract with your **health insurance** or **plan**. In-network co-insurance usually costs you less than **out-of-network co-insurance**.

In-network Co-payment
A fixed amount (for example, $15) you pay for covered health care services to **providers** who contract with your **health insurance** or **plan**. In-network co-payments usually are less than **out-of-network co-payments**.

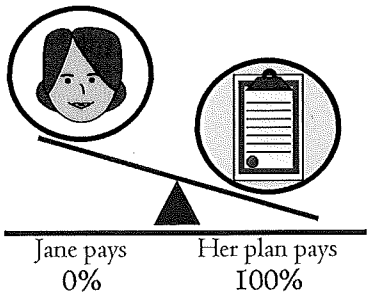
Medically Necessary
Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Network
The facilities, providers and suppliers your health insurer or **plan** has contracted with to provide health care services.

Non-Preferred Provider
A **provider** who doesn't have a contract with your health insurer or **plan** to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your **health insurance** or plan, or if your health insurance or plan has a "tiered" **network** and you must pay extra to see some providers.

Out-of-network Co-insurance
The percent (for example, 40%) you pay of the **allowed amount** for covered health care services to providers who do ***not*** contract with your **health insurance** or **plan**. Out-of-network co-insurance usually costs you more than **in-network co-insurance**.

Out-of-network Co-payment
A fixed amount (for example, $30) you pay for covered health care services from providers who do ***not*** contract with your **health insurance** or **plan**. Out-of-network co-payments usually are more than **in-network co-payments**.

Out-of-Pocket Limit


The most you pay during a policy period (usually a year) before your **health insurance** or **plan** begins to pay 100% of the **allowed amount**. This limit never includes your **premium**, **balance-billed** charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your **co-payments**, **deductibles**, **co-insurance** payments, out-of-network payments or other expenses toward this limit.

(See page 4 for a detailed example.)

Physician Services
Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan
A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization
A decision by your health insurer or **plan** that a health care service, treatment plan, **prescription drug** or **durable medical equipment** is **medically necessary**. Sometimes called prior authorization, prior approval or precertification. Your **health insurance** or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider
A **provider** who has a contract with your health insurer or **plan** to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your **health insurance** or plan has a "tiered" **network** and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium
The amount that must be paid for your **health insurance** or **plan**. You and/or your employer usually pay it monthly, quarterly or yearly.

Prescription Drug Coverage
Health insurance or **plan** that helps pay for **prescription drugs** and medications.

Prescription Drugs
Drugs and medications that by law require a prescription.

Primary Care Physician
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), 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.

Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Reconstructive Surgery
Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitation Services
Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care
Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist
A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a **provider** who has more training in a specific area of health care.

UCR (Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what **providers** in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the **allowed amount**.

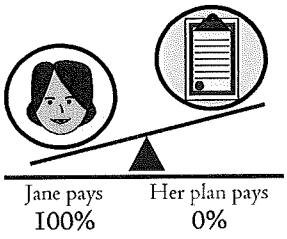
Urgent Care
Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require **emergency room care**.

How You and Your Insurer Share Costs - Example

Jane's Plan Deductible: $1,500 **Co-insurance:** 20% **Out-of-Pocket Limit:** $5,000

January 1st
Beginning of Coverage Period

December 31st
End of Coverage Period

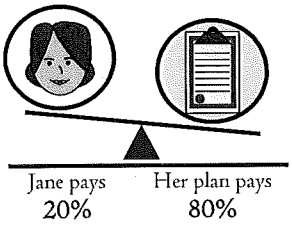


Jane hasn't reached her $1,500 deductible yet

Her plan doesn't pay any of the costs.

Office visit costs: $125
Jane pays: $125
Her plan pays: $0

more costs

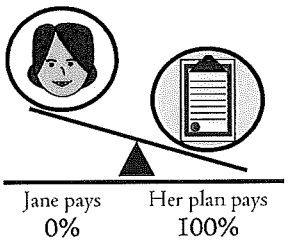


Jane reaches her $1,500 deductible, co-insurance begins

Jane has seen a doctor several times and paid $1,500 in total. Her plan pays some of the costs for her next visit.

Office visit costs: $75
Jane pays: 20% of $75 = $15
Her plan pays: 80% of $75 = $60

more costs



Jane reaches her $5,000 out-of-pocket limit

Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

Office visit costs: $200
Jane pays: $0
Her plan pays: $200

Actual Charge: The actual dollar amount charged by a physician or other provider for medical services rendered, as distinguished from the allowable charge.

Actuary: A person professionally trained in the mathematical and statistical aspects of the insurance industry.
Actuaries frequently calculate premium rates, reserves and dividends and assist in estimating the costs and savings of benefit changes.

Administrative Services Only (ASO) Agreement: A business contract under which an insurance company agrees to perform specific administrative duties for the maintenance of a self-funded health insurance plan.

Allowable charge: sometimes known as the "allowed amount," "maximum allowable," and "usual, customary, and reasonable (UCR)" charge, this is the dollar amount considered by a health insurance company to be a reasonable charge for medical services or supplies based on the rates in your area.

Ancillary Fee: An extra fee sometimes associated with obtaining prescription drugs which are not listed on a health insurance plan's formulary of covered medications.

Attending Physician Statement (APS): A physician's assessment of a patient's state of health as outlined in office notes and test results compiled by the physician. An APS may be requested by an insurance company in lieu of a medical examination in order to determine the state of a health insurance applicant's health for underwriting purposes.

Balance Billing: The amount you could be responsible for (in addition to any co-payments, deductibles or coinsurance) if you use an out-of-network provider and the fee for a particular service exceeds the allowable charge for that service.

Benefit: the amount payable by the insurance company to a plan member for medical costs.

Benefit level: the maximum amount that a health insurance company has agreed to pay for a covered benefit.

Benefit year: the 12-month period for which health insurance benefits are calculated, not necessarily coinciding with the calendar year. Health insurance companies may update plan benefits and rates at the beginning of the benefit year.

Broker: Though sometimes used in a sense synonymous with the term agent, a broker typically works to match applicants with a health insurance company or plan best matched to their needs. The broker is paid a commission by the insurance company, but represents the applicant rather than the insurance company itself.

Centers for Medicare and Medicaid Services: Formerly known as the Health Care Financing Administration, the Centers for Medicare and Medicaid Services (CMS) is part of the federal government's Department of Health and Human Services, and is responsible for the administration of the Medicare and Medicaid programs. The CMS establishes standards for healthcare providers that must be complied with in order for providers to meet certain certification requirements.

Certificate of Coverage: A document given to an insured that describes the benefits, limitations and exclusions of coverage provided by an insurance company.

Chronic: In healthcare and insurance terminology, a chronic condition is one that is permanent, recurring or long lasting, as opposed to an acute condition.

Claim: a request by a plan member, or a plan member's health care provider, for the insurance company to pay for medical services.

COB (Coordination of Benefits): This is the process by which a health insurance company determines if it should be the primary or secondary payer of medical claims for a patient who has coverage from more than one health insurance policy. See also, Non-duplication of Benefits.

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985): Federal legislation allowing an employee or an employee's dependents to maintain group health insurance coverage through an employer's health insurance plan, at the individual's expense, for up to 18 months in certain circumstances. COBRA coverage may be extended beyond 18 months in certain circumstances. COBRA rules typically apply when an employee loses coverage through loss of employment (except in cases of gross misconduct) or due to a reduction in work hours. COBRA benefits also extend to spouses or other dependents in case of divorce or the death of the employee. Children who are born to, adopted, or placed for adoption with the covered employee while he or she is on COBRA coverage are also entitled to coverage. All companies that have averaged at least 20 full-time employees over the past calendar year must comply with COBRA regulations.

Coinsurance: the amount you pay to share the cost of covered services after your deductible has been paid. The coinsurance rate is usually a percentage. For example, if the insurance company pays 80% of the claim, you pay 20%.

Coordination of benefits: a system used in group health plans to eliminate duplication of benefits when you are covered under more than one group plan. Benefits under the two plans usually are limited to no more than 100% of the claim.

Copayment (Copay): one of the ways you share in your medical costs. You pay a flat fee for certain medical expenses (e.g., $10 for every visit to the doctor), while your insurance company pays the rest.

Date of Service: The date on which a healthcare service was provided.

Deductible: the amount of money you must pay each year to cover eligible medical expenses before your insurance policy starts paying.

Department of Health and Human Services: A department of the federal government responsible for certain social service functions, such as the administration and supervision of the Medicare program.

Dependent Coverage: Health insurance coverage extended to the spouse and unmarried children of the primary insured member. Certain age restrictions on the coverage of children may apply.

Dependent: any individual, either spouse or child, that is covered by the primary insured member's plan.

Drug Formulary: A list of prescription medications selected for coverage under a health insurance plan. Drugs may be included on a drug formulary based upon their efficacy, safety and cost-effectiveness. Some health insurance plans may require that patients obtain preauthorization before non-formulary drugs are covered. Other health insurance plans may require that a patient pay a greater share or all of the cost involved in obtaining a non-formulary prescription.

Drug Maintenance List: A list of commonly prescribed drugs intended for patients' ongoing or long-term use.

Drug Utilization Review (DUR): The process by which health insurance companies evaluate or review the use of prescription drugs for appropriateness in the treatment of a patient.

Effective date: the date on which a policyholder's coverage begins.

Eligibility Date: The date on which a person becomes eligible for insurance benefits.

Eligibility Requirements: Conditions that must be met in order for an individual or group to be considered eligible for insurance coverage.

Eligible Dependent: A dependent (usually spouse or child) of an insured person who is eligible for insurance coverage.

Eligible Employee: An employee who is eligible for insurance coverage based upon the stipulations of the group health insurance plan.

Eligible Expenses: Expenses defined by the health insurance plan as eligible for coverage.

Eligible Person: This term is used to designate a person who is eligible for insurance coverage even though he or she may not be an employee, but rather a member of an organization or union.

Emergency Room: Typically, emergency room services include all services provided when a patient visits an emergency room for an emergency condition. An emergency condition is any medical condition of recent onset and severity, including but not limited to severe pain, that would lead to a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of bodily organ or part.

Employee Contribution: The portion of the health insurance premium paid for by the employee, usually deducted from wages by the employer.

Employer Contribution: The portion of an employee's health insurance premium paid for by the employer.

Enrollee: An eligible person or eligible employee who is enrolled in a health insurance plan. Dependents are not referred to as enrollees.

Enrollment: The process through which an approved applicant is signed up with the health insurance company and coverage is made effective. This term may also be used to describe the total number of enrollees in a health insurance plan.

Enrollment Period: The period of time during which an eligible employee or eligible person may sign up for a group health insurance plan.

Exclusion or limitation: any specific situation, condition, or treatment that a health insurance plan does not cover.

Explanation of benefits: the health insurance company's written explanation of how a medical claim was paid. It contains detailed information about what the company paid and what portion of the costs you are responsible for.

Extended Coverage: A provision of some health insurance plans allowing for coverage of certain healthcare services after the member is no longer covered on the plan. For example, a member's maternity benefits may be extended beyond the expected end of coverage if the woman was already receiving covered maternity services.

Extension of Benefits: A provision of some health insurance plans allowing for coverage to be extended beyond a scheduled termination date. The extended coverage is made available only when the member is disabled or hospitalized as of the intended termination date, and continues only until the patient leaves the hospital or returns to work.

Generic Drug: A drug which is exactly the same as a brand name prescription drug, but which can be produced by other manufacturers after the brand name drug's patent has expired. Generic drugs are usually less expensive than brand name drugs.

Grace Period: A time period after the payment due date, during which insurance coverage remains in force and the policyholder may make a payment without penalty.

Grievance Procedure: The procedure by which a member or healthcare provider is allowed to file a complaint with a health insurance company and seek a remedy.

Group health insurance: a coverage plan offered by an employer or other organization that covers the individuals in that group and their dependents under a single policy.

Health maintenance organization (HMO): A health care financing and delivery system that provides comprehensive health care services for enrollees in a particular geographic area. HMOs require the use of specific, in-network plan providers.

Health savings account (HSA): a personal savings account that allows participants to pay for medical expenses with pre-tax dollars. HSAs are designed to complement a special type of health insurance called an HSA-qualified high-deductible health plan (HDHP). HDHPs typically offer lower monthly premiums than traditional health plans. With an HSA-qualified HDHP, members can take the money they save on premiums and invest it in the HSA to pay for future qualified medical expenses.

HIPAA (Health Insurance Portability and Accountability Act of 1996): Legislation mandating specific privacy rules and practices for medical care providers and health insurance companies, designed to streamline the healthcare and insurance industries and to protect the privacy and identity of healthcare consumers. HIPAA also provides additional protections for consumers, designed to help them obtain or retain health insurance coverage in certain circumstances. For more information on HIPAA rules and regulations, visit the Centers for Medicare and Medicaid Services website at http://www.cms.hhs.gov.

HMO: HMO means "Health Maintenance Organization." HMO plans offer a wide range of health care services through a network of providers that contract exclusively with the HMO, or who agree to provide services to members at a pre-negotiated rate. As a member of an HMO, you will need to choose a primary care physician ("PCP") who will provide most of your health care and refer you to HMO specialists as needed. Some HMO plans require that you fulfill a deductible before services are covered. Others only require you to make a copayment when services are rendered. Health care services obtained outside of the HMO are typically not covered, though there may be exceptions in the case of an emergency.

Home Health Agency: A certified healthcare agency that provides home health care services. See, Home Health Care.

Home Health Care: Part-time care that is provided by medical professionals in the home setting rather than in a hospital or skilled nursing facility.

Hospice Care: Care rendered either on an inpatient basis or in the home setting for a terminally ill patient. Often referred to as "palliative" or "supportive" care, hospice care emphasizes the management of pain and discomfort and the emotional support of the patient and family. See also, Respite Care.

HSA (Health Savings Account): A tax advantaged savings account to be used in conjunction with certain high-deductible (low premium) health insurance plans to pay for qualifying medical expenses. Contributions may be made to the account on a tax-free basis. Funds remain in the account from year to year and may be invested at the discretion of the individual owning the account. Interest or investment returns accrue tax-free. Penalties may apply when funds are withdrawn to pay for anything other than qualifying medical expenses. Click here for more information on HSAs.

In-network provider: a health care professional, hospital, or pharmacy that is part of a health plan's network of preferred providers. You will generally pay less for services received from in-network providers because they have negotiated a discount for their services in exchange for the insurance company sending more patients their way.

Individual health insurance: health insurance plans purchased by individuals to cover themselves and their families. Different from group plans, which are offered by employers to cover all of their employees.

LAB TEST: Covers X-rays, blood tests, MRIs and other health-related tests.

Medicaid: a health insurance program created in 1965 that provides health benefits to low-income individuals who cannot afford Medicare or other commercial plans. Medicaid is funded by the federal and state governments, and managed by the states.

Medicare: the federal health insurance program that provides health benefits to Americans age 65 and older. Signed into law on July 30, 1965, the program was first available to beneficiaries on July 1, 1966 and later expanded to include disabled people under 65 and people with certain medical conditions. Medicare has two parts; Part A, which covers hospital services, and Part B, which covers doctor services.

Medicare supplement plans: plans offered by private insurance companies to help fill the "gaps" in Medicare coverage.

Network: the group of doctors, hospitals, and other health care providers that insurance companies contract with to provide services at discounted rates. You will generally pay less for services received from providers in your network.

Out-of-network provider: a health care professional, hospital, or pharmacy that is not part of a health plan's network of preferred providers. You will generally pay more for services received from out-of-network providers.

OUT-OF-POCKET COSTS: **Costs you pay personally when you get health services or prescriptions. These include deductibles, copays, and coinsurance for covered services.**

Out-of-pocket maximum: the most money you will pay during a year for coverage. It includes deductibles, copayments, and coinsurance, but is in addition to your regular premiums. Beyond this amount, the insurance company will pay all expenses for the remainder of the year.

OUTPATIENT (AMBULATORY) SERVICE: **Health care that does not require hospital admittance. This could be care received at a doctor's office, clinic or same-day ("outpatient") surgery center. It also includes home health services**.

Payer: the health insurance company whose plan pays to help cover the cost of your care. Also known as a carrier.

Pre-existing condition: a health problem that has been diagnosed, or for which you have been treated, before buying a health insurance plan.

Preferred provider organization (PPO): a health insurance plan that offers greater freedom of choice than HMO (health maintenance organization) plans. Members of PPOs are free to receive care from both in-network or out-of-network (non-preferred) providers, but will receive the highest level of benefits when they use providers inside the network.
Premium—the amount you or your employer pays each month in exchange for insurance coverage.

PRIMARY CARE PROVIDER (PCP): The health care professional who provides most of your basic care. A PCP can be a doctor who practices in family, general, internal or pediatric medicine. Or, a certified registered nurse practitioner.

Provider: any person (i.e., doctor, nurse, dentist) or institution (i.e., hospital or clinic) that provides medical care.

REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES: Services and devices to help people recover physical and mental skills. This could be from injuries, disabilities, or chronic conditions. Includes physical therapy, occupational therapy, speech therapy, prosthetics and other medical equipment.

SPECIALIST: A doctor who limits his or her practice to a single branch of medicine or surgery.

TOTAL MAXIMUM OUT-OF-POCKET: The most you could pay in a plan year for covered services before your plan pays 100%. Your deductible, coinsurance and copays all go toward meeting it. You still need to pay your monthly premium.

Waiting period: the period of time that an employer makes a new employee wait before he or she becomes eligible for coverage under the company's health plan. Also, the period of time beginning with a policy's effective date during which a health plan may not pay benefits for certain pre-existing conditions.

HOW HEALTH PLANS WORK

Health plans vary, but most follow a simple formula with 3 phases that affect the cost of your care.

1

Before you meet your deductible...

You pay for all or most of your care.

Each plan year begins with a new deductible. You pay out of pocket for your medical care until your expenses total the amount of your deductible. Copays are usually not included. Think of them as an added fee. Some in-network care, such as preventive services, may not be subject to a deductible.

IN-NETWORK EXAMPLE

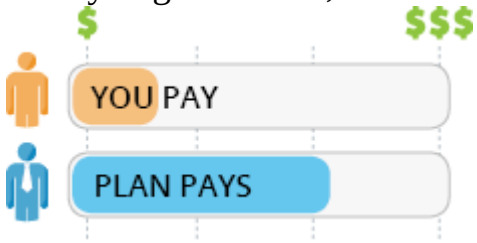
Say your plan has a $1,000 deductible and you pay $800 for covered medical services. You must spend $200 more in medical fees to meet your deductible. (Copays are extra. They usually do not go toward meeting your deductible.)

2

After you meet your deductible...

You only pay for part of your care.

After you meet your deductible, you pay a percentage (coinsurance) of some medical costs. And/or a flat fee (copay) for others. Your plan takes care of the rest when you get covered, in-network services.



IN-NETWORK EXAMPLE

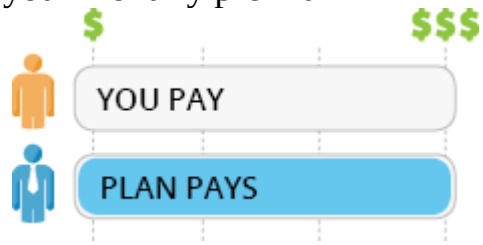
Let's say you visit the doctor after you've met your deductible. And your plan has a $20 office visit copay and 20% coinsurance. That means you pay a fixed $20 fee (your copay) for your appointment. If your doctor performs a special service, such as a blood test, you may also pay 20% of that cost (your coinsurance.)

3

If you reach your total max out-of-pocket

We pay 100% of your covered, in-network care

Your plan has a total maximum out-of-pocket. It's the most you could pay for covered, in-network care in a plan year. After that your plan pays 100%. Your deductible, coinsurance and copays all go toward meeting it. You still need to pay your monthly premium



IN-NETWORK EXAMPLE

Say your plan has a $6,000 max. If your family spends $6,000 in covered medical care during a plan year, your plan pays for 100% of your covered in-network services for the rest of the year. All you need to pay is your monthly premium.

WHAT'S A PPO? PPO (Preferred Provider Organization) plans have both in-network and out-of-network benefits. You pay less when you see in-network providers.

Who are in-network providers? They are doctors, hospitals, labs, and other health care professionals and facilities who have a contract with the health plan to accept discounted rates.

HOW NETWORKS COMPARE

	In-Network	Out-of-Network

Deductibles	$	$$$
Copays	$	$$$
Coinsurance	$	$$$
Emergency Care		$
Preventive Care*	$	$$$
Balance Billing	X	✓
Provider Files Claims	✓	X
Total Max-Out of-Pocket	$	**No maximum amount**

*Many plans cover in-network preventive services 100% with no deductible.