
Sutter Health
What to Know About
Your Health Plan

Given the ever-changing nature of healthcare, it's no surprise many people have a difficult time understanding their health benefits. However, learning the basics of health plans is key to navigating your care and being a strong advocate for your health. While this guide doesn't cover every plan type, it's designed to help simplify and explain the fundamentals the most common types of health plans.

All health plans are different, so we encourage you to call the number on your member ID card and speak with a customer service representative about your health plan benefits. They should be able to answer questions and provide information about your coverage. Take time to learn about your health plan benefits through additional resources, such as their website or member materials.

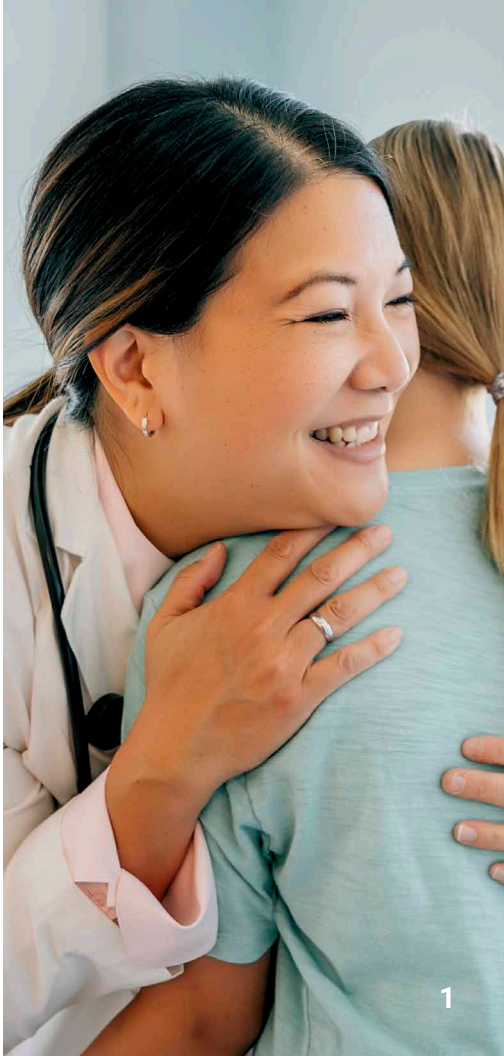
Table of Contents

HMO or PPO

Health Maintenance Organization (HMO) and Preferred Provider Organization (PPO) plans are the two most commonly purchased types of health plans. HMO plans provide access to a select network of providers at a lower cost than PPO plans; PPO plans feature a broader network of providers and tend to have higher monthly premiums and out-of-pocket costs.

When you enroll in an HMO plan, you must select a primary care physician (PCP). A PCP is your healthcare advocate. They provide care like routine exams, preventive care and treatment for illnesses and minor injuries. When you have an HMO plan and you choose a PCP, you also select your PCP's medical group. Your PCP refers you to providers within the medical group for specialty care, X-ray, laboratory and other medical services. Coverage for these specialty care services typically depends on prior authorization from your medical group.

A PPO plan allows you to visit any in-network physician or healthcare provider without a referral from your PCP. PPO plans may allow you the flexibility to visit providers outside the network at a higher cost share.



Coverage Basics

Preventive Care

Early prevention helps protect against disease and may provide early detection of certain health conditions when they may be the most treatable. Your health plan may cover a variety of preventive care services at no additional out-of-pocket cost*, including:

- Comprehensive preventive medical and counseling visits, including routine physical exams, well-child and well-woman preventive exams, vaccines and immunizations
- Maternity and newborn care
- Routine preventive imaging services (such as mammograms) and laboratory tests
- Screening tests, such as blood pressure screenings for adults, colorectal cancer screenings, and cholesterol tests for adults at certain ages or at higher risk
- Smoking cessation counseling and interventions

** Check your health plan documents for coverage information and details*

Preventive and Diagnostic Services

It is important to recognize the difference between preventive care and diagnostic care. The goal of preventive care is disease prevention and early detection.

Your health plan may cover preventive care services at no out-of-pocket cost. However, if during a preventive care visit you receive services that are not related to your preventive care visit, you may incur out-of-pocket costs based on your benefit plan.

Providers are not allowed to combine and bill diagnostic services as preventive care even if the services are received during the same office visit.

Diagnostic care includes evaluating and treating a known or suspected condition. When you receive diagnostic care, you may incur out-of-pocket costs based on your health plan.

Preventive Care	Diagnostic Care
Screening mammogram for women age 40 and over when there are no symptoms or previous breast disease diagnosis.	Mammogram after suspicious results are found on a screening mammogram or when signs of possible breast disease are present.
Diabetes screening using a lab test to check if a person has a high blood sugar level and possible diabetes.	Diabetes monitoring on a routine basis using lab tests to check blood sugar control.
Well-child visit to check growth and development.	Sick-child visit to diagnose and treat symptoms.

Hospitalization

This includes specific services received during an extended stay (inpatient) in a hospital setting such as operating or rehabilitative services, and nursery care for newborn babies.

Optional Benefit Plans

In addition to your health plan, your employer may offer optional benefit plans. These plans may cover certain healthcare services, such as:

- **Acupuncture:** Medically necessary therapies to treat pain and nausea and correct body imbalances.
- **Chiropractic Care:** Manual adjustments, spinal manipulations and related treatments.
- **Dental:** Routine cleanings, X-rays, and fillings.
- **Infertility**: Consultations, examinations, diagnostic services, and medications.
- **Orthotics:** Special footwear and related equipment and supplies.
- **Vision:** Routine exams and prescription hardware like frames and lenses.

Outpatient Services

Most routine care you receive is outpatient care—X-rays, ultrasounds, CT scans, blood draws, and visits to urgent care, walk-in care, and primary and specialty care doctors.

Referral vs. Authorization

In many HMO health plans, a PCP will partner with you to best manage your care. They will help you with any needed referrals for specialty care and other medical services. A referral is a request to transfer your care from one provider to another, usually for specialty services.

Some services, treatments, prescription drugs, and supplies may require prior authorization from your medical group or health plan. An authorization is approval from your health plan to pay for specific services before they are provided. It's important to follow your health plan's rules about authorizations and referrals. If you don't, you may have to pay the entire cost of the service.

Care Away from Home

Before you leave on a trip or your child goes to college, understand what services are covered away from home. If you are out of your health plan's service area and need emergency or urgent care, go to the nearest hospital or medical facility that can provide the care you need. If you are admitted to an out-of-network hospital, call the number on your ID card within 24 hours, or as soon as reasonably possible.

Billing Basics

A premium is a monthly payment from your employer to your health plan to secure your coverage. Your employer may collect a portion of your premium from you through payroll deductions.

After you are seen by a provider, your provider will submit a claim to your health plan to request payment for the medical services. After processing the claim, the health plan sends you an *Explanation of Benefits* (*EOB*), the proof of claim payment according to your medical benefits. The medical provider sends you a billing invoice resulting from the services, specifying the amount owed for payment.

EOBs contain other key terms you should know. Total charges specify the amount billed by the medical provider to the health plan. Covered or allowed charges indicate the negotiated rate between the provider and the health plan for the services. A provider in the health plan's network cannot bill you for any charges exceeding the allowed amount.

What You Pay

Your out-of-pocket costs may include separate types of cost shares depending on the health plan you select. A copayment is a fixed amount you must pay to receive certain covered services. Coinsurance is a percentage of the allowed charges you must pay for certain covered services. A deductible is the annual amount you must pay to providers before your health plan pays for certain covered services.

Glossary of Terms

Annual Out-of-Pocket Maximum: The total maximum amount you pay in a benefit period for copayments, coinsurance and deductibles for covered services. Any premium payment you pay does not accumulate toward your annual out-of-pocket maximum.

Coinsurance: The percentage of the cost of the allowed charges you must pay for certain covered services.

Copayment: A specific dollar amount you pay when you receive certain covered services.

Cost Sharing: The amount you must pay for covered services (i.e., deductibles, copayments or coinsurance).

Deductible: The amount you must pay for certain covered services before your health plan will pay. If you are on a family plan, once the family deductible is satisfied by any combination of individual member payments, family members pay copayments or coinsurance for certain services until the family out-of-pocket maximum is reached.

Health Reimbursement Arrangement: An employer-funded group health benefit that provides tax-free reimbursement to pay for qualifying medical expenses.

Health Savings Account: A tax-advantaged savings account designed to be used in conjunction with certain high-deductible health insurance plans to pay for qualifying medical expenses.

High-Deductible Health Plan (HDHP): An HDHP is a medical plan that must conform to established federal guidelines, such as minimum deductible amounts and maximum out-of-pocket costs and which optional benefits are allowed.

Network: The facilities, providers and suppliers your health plan has contracted with to provide healthcare services.

Open Enrollment Period: The yearly period when you can enroll in a health plan. Outside the open enrollment period, you can generally only enroll in a health plan if you qualify for a special enrollment period. You qualify for a special enrollment period if you experience certain life events, such as getting married, having a baby or losing other health coverage. Each employer-based plan may have a different open enrollment period.

Premium: A premium is the dollar amount due to your health plan each month for healthcare coverage. In most cases, your employer pays part of the premium and you pay the rest, usually in the form of payroll deduction.

Prior Authorization: The process where a health plan or medical group reviews a request for specific healthcare services or products, resulting in a decision (based on applicable medical standards or criteria, regulatory requirements, plan benefits, etc.) to approve, modify or deny the requested service or item.

Referral: The process where a physician directs a patient to see a specialist or get certain medical services, for the purpose of diagnosing or treating a specific condition.

Service Area: A health plan's area of service that may include some or all ZIP codes within a specific county. It is also the area where members can get routine (non-emergency) services. Enrollment with a health plan may be limited to where people live, reside or work.

Sutter Health

sutterhealth.org