

Quartz

Health Insurance **101**



Quartz

What is
Insurance?

Insurance is a **Contract**

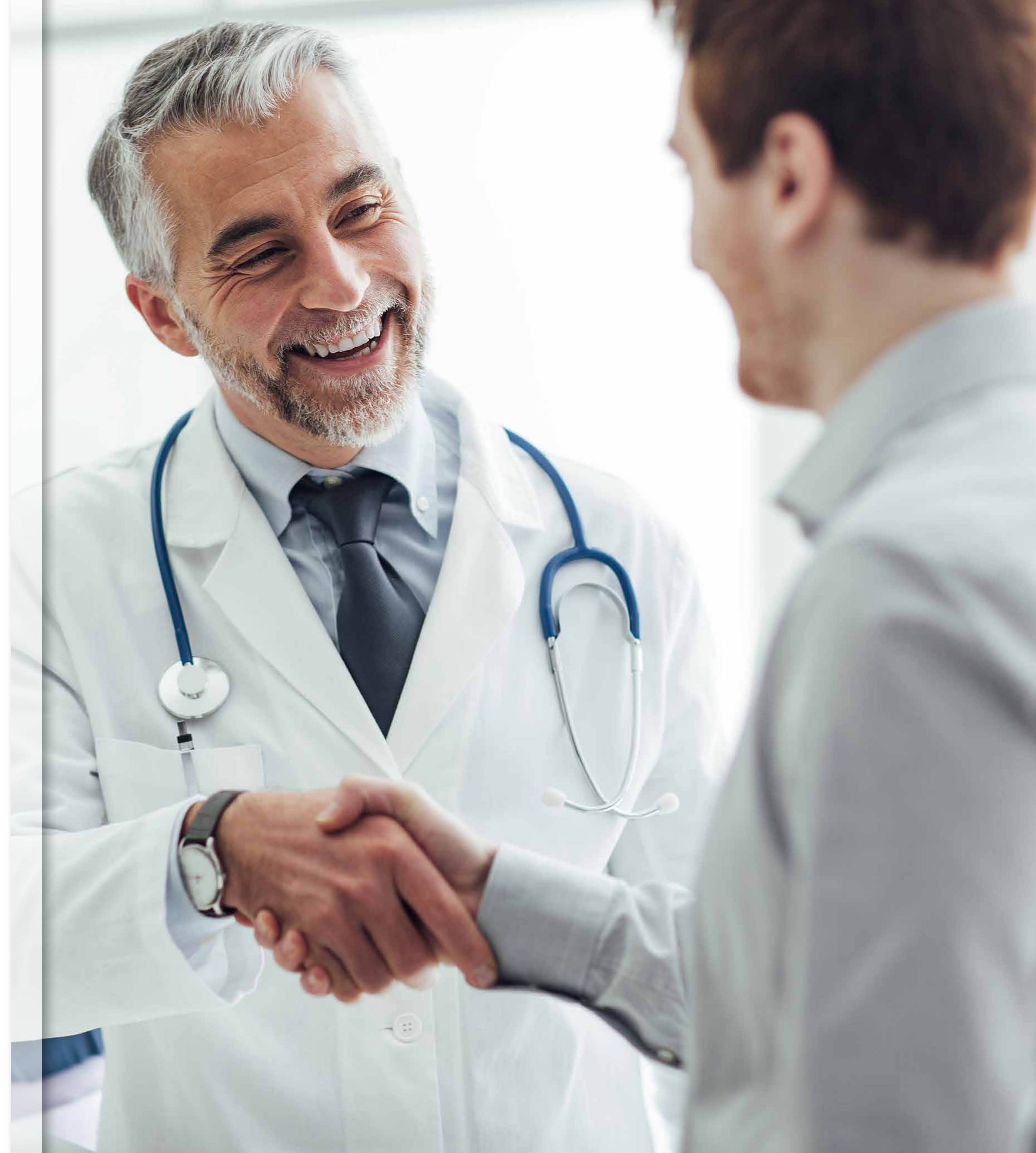
What does the contract do?

Tells when a health insurer will
provide payment for certain
covered services to you
(a health insurance member).



Contracts with Doctors

Health insurance companies may also **set up contracts with doctors and hospitals** in the area to provide services to members. This is called a **provider network.**



Networks of Doctors

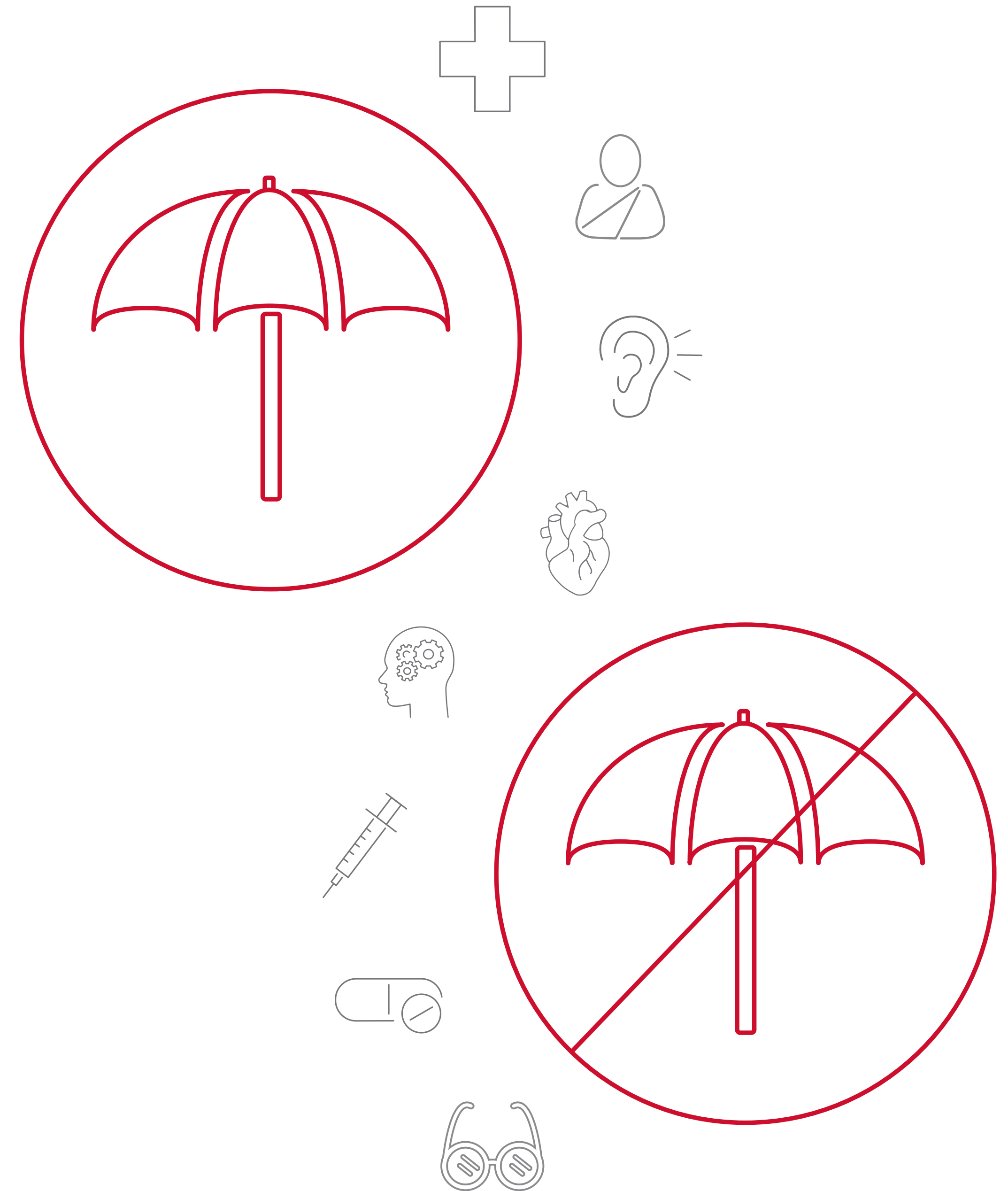
Why is a network important?
Insurance may cover charges **only by doctors in the network.**
Always check to see if your doctor is in your health insurance network.



How do I know
What's Covered?

Certificate of Coverage

The **Certificate of Coverage** tells **what services are covered or excluded** by the health insurer. Please read it carefully.



SBC

In the insurance company's online portal, a **Summary of Benefits and Coverage** or **SBC** is available that **outlines your plan.**

Important Questions

Answers

Why This Matters

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
Physicians Plus Insurance Corporation: 2018 PPO Copay Standard Gold 2000
Medical Code: JZC3520GAC Rx: AYS2735M30

Coverage Period: Beginning on or after 01/01/2018
Coverage for: Member/Family | Plan Type: HMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.pplusic.com or call 1-800-545-5015. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other [underlined terms](#) see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call 1-800-545-5015 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$2,000 Member / \$4,000 Family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services, office visits, and pharmacy services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Medical and Pharmacy: \$3,000 Member / \$6,000 Family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See http://directory.pplusic.com/ or call 1-800-545-5015 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes. Out-of-network specialists require prior written referral approval from the plan.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

1 of 6
P-6753-1708

Who Pays for What?

Claims

After your doctor provides treatment, **the doctor's office staff prepares a claim.**

The claim is sent to the insurance company for processing.



EOB

Explanation of Benefits or EOB

is a letter from the insurance company to you that lists the amounts that the insurance pays for and the costs the member may need to pay for (called “member responsibility”). A doctor may bill you for those amounts.



ER Visit
\$200



Cast
\$200

Total: \$400

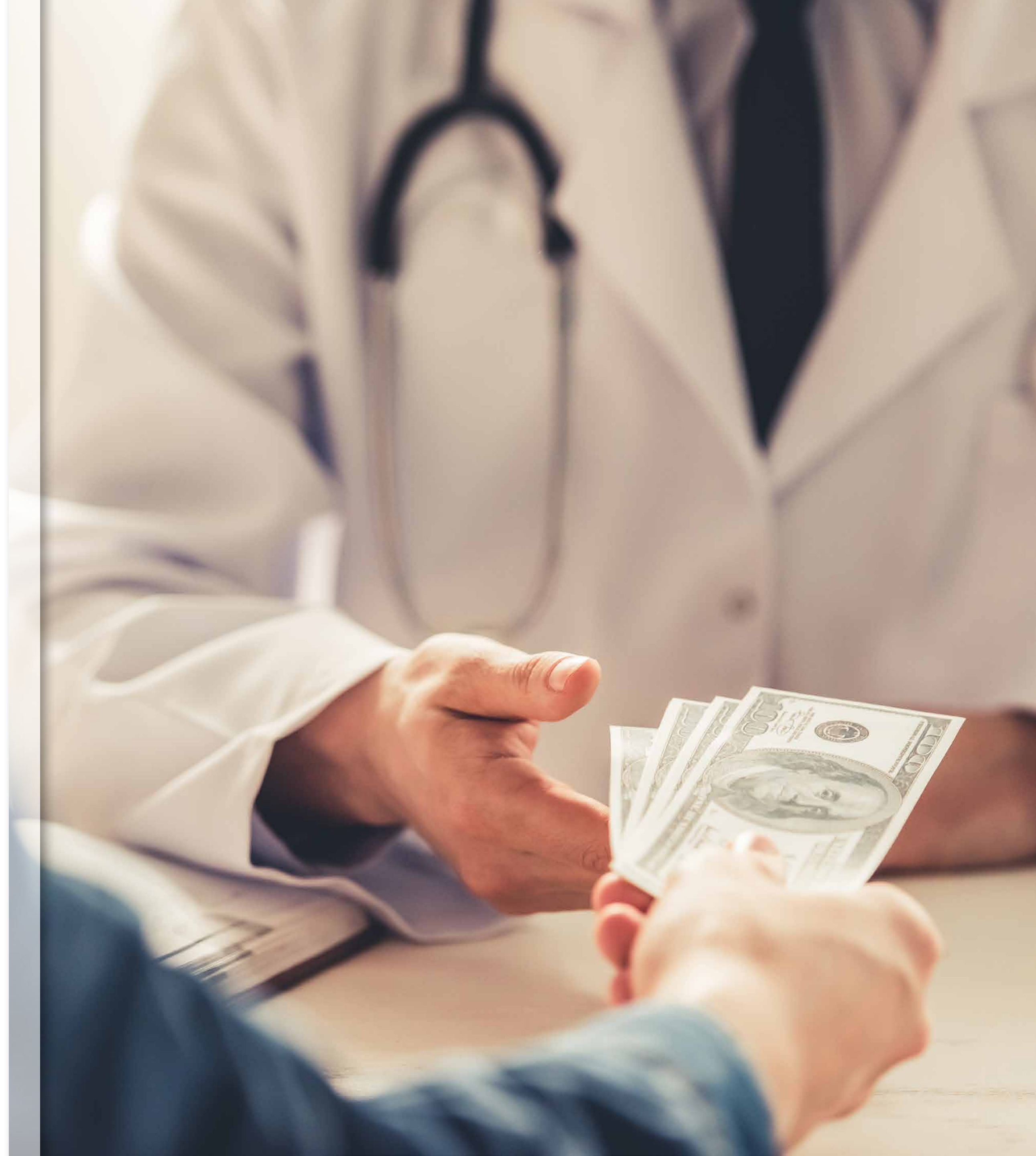
Quartz = \$250

You owe = \$150

Copay

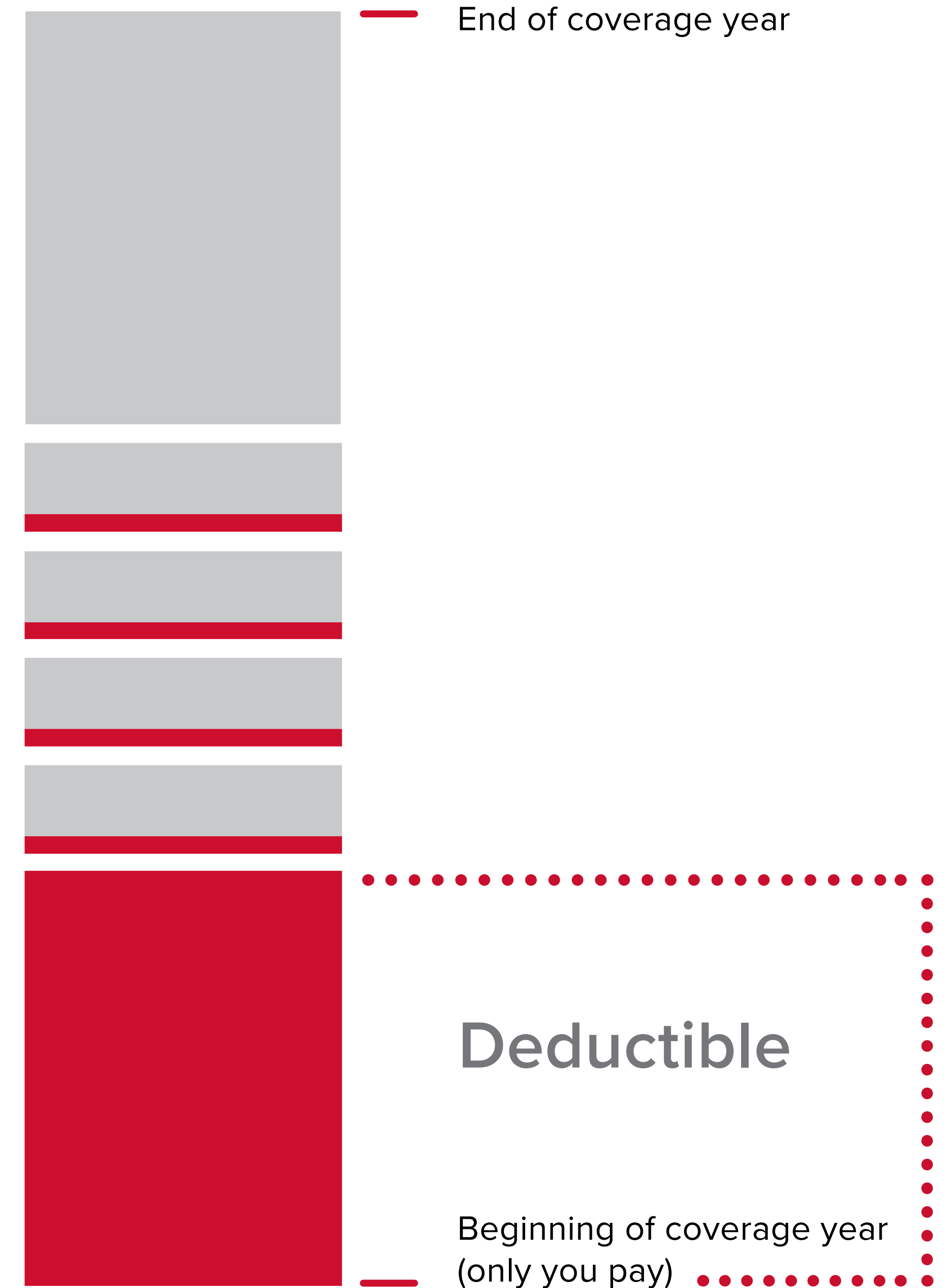
When you go to the doctor, your policy might require you to **pay a copay**. **That's a flat fee for visiting the doctor.**

It might be \$20 or \$30 or more, depending on the type of doctor.



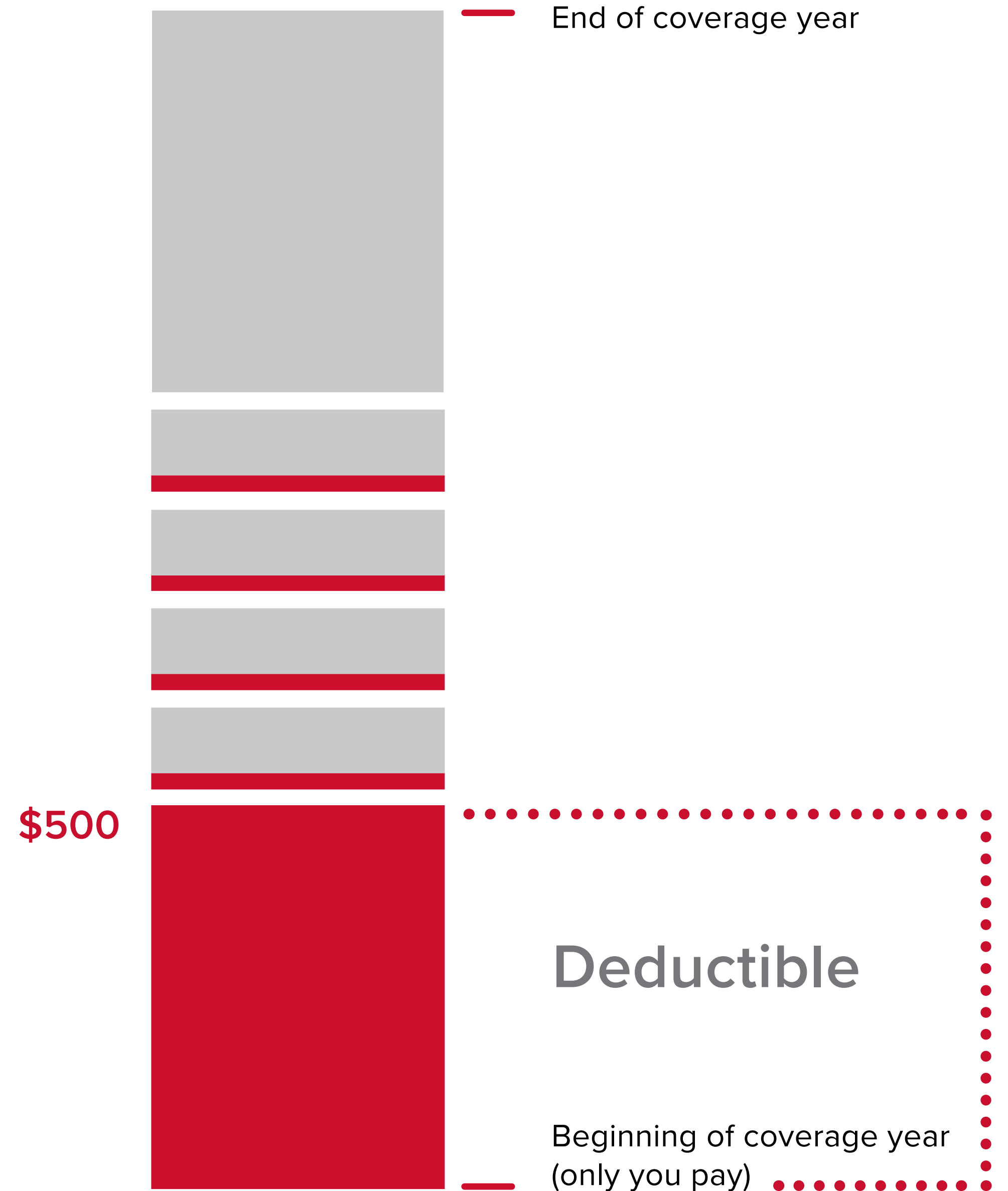
Deductible

If your policy has a deductible, your insurance company won't pay the initial claims. Instead, it will tell the doctor to send the bill directly to you. You must pay most of the bills until you reach your deductible.



Pay Up to the Deductible

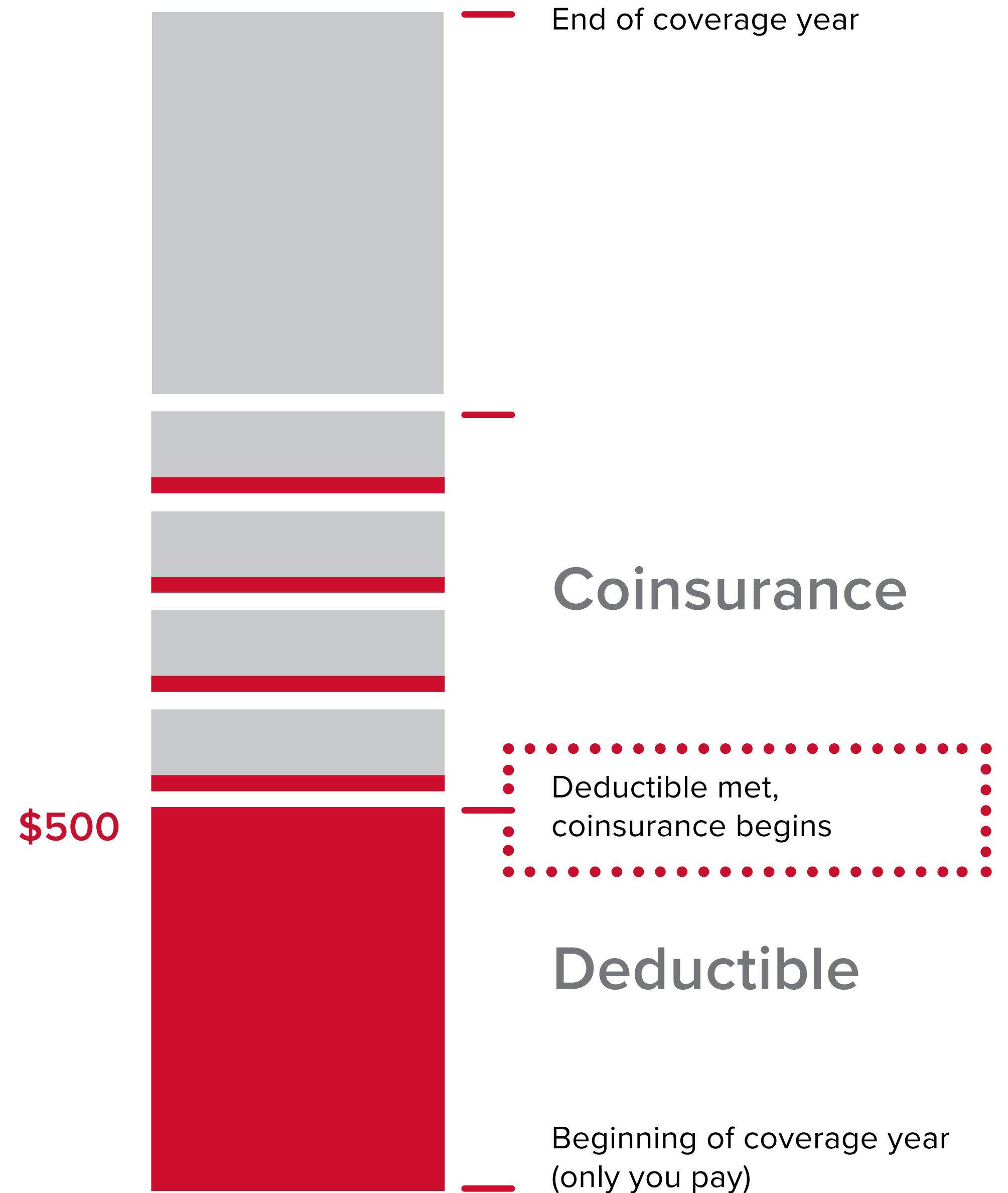
If your deductible is **\$500** per year, you must **pay the first \$500** of charges from doctors and facilities.



Insurance Starts to Pay

After that...whenever you visit a doctor, the insurance company will pay a **portion of the charges.**

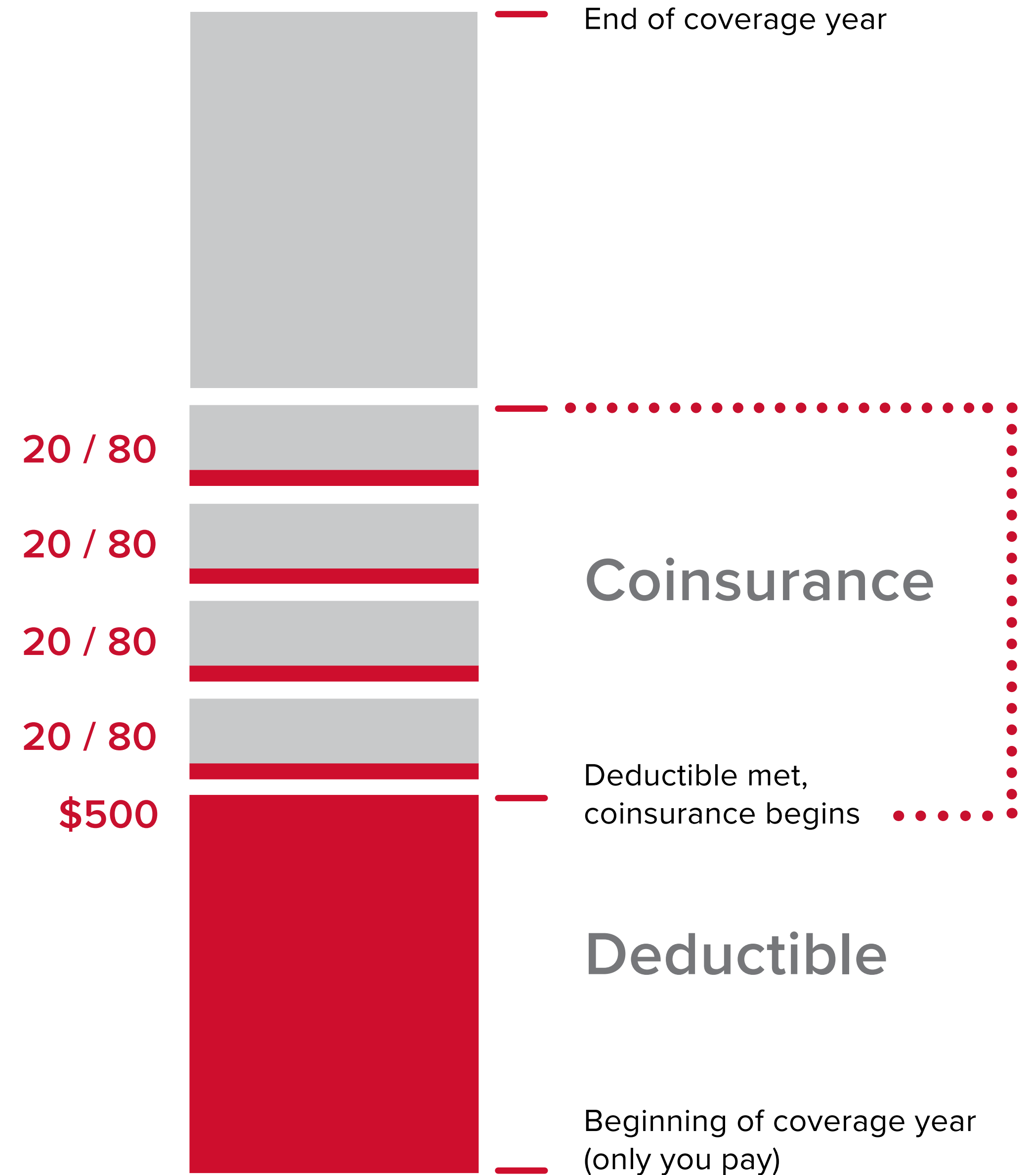
The insurance company will pay the doctor and also let the doctor know how much to bill you directly.



Coinsurance

After you have satisfied your deductible, your share of the bill is called coinsurance.

For example, your coinsurance might be **20%**. You would pay 20% of each bill and the insurance company will pay 80%.

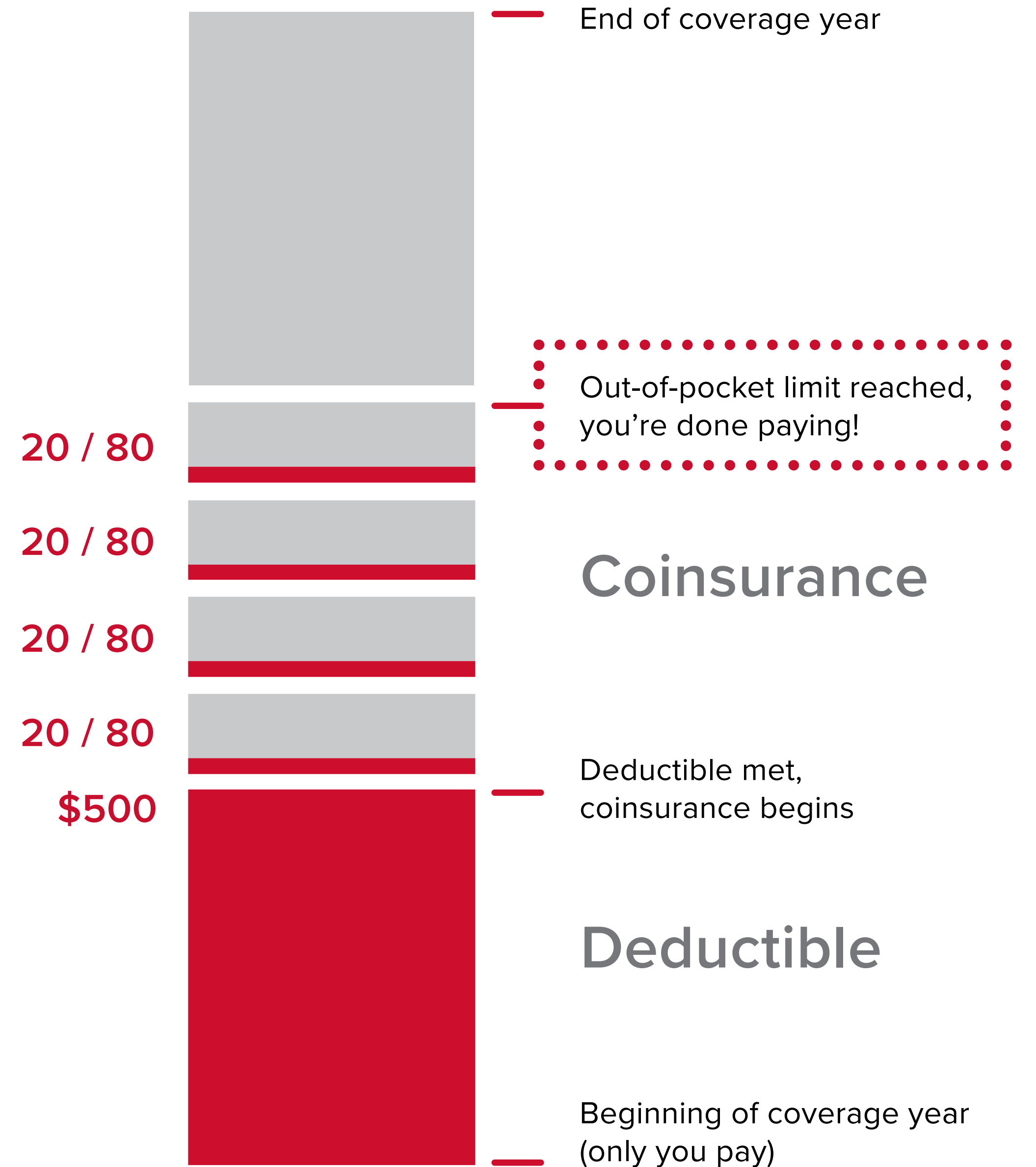


OOP

But there's a limit! For most plans, you can stop paying coinsurance if you reach your OOP.

What's an OOP? It's an **Out-of-Pocket limit**.

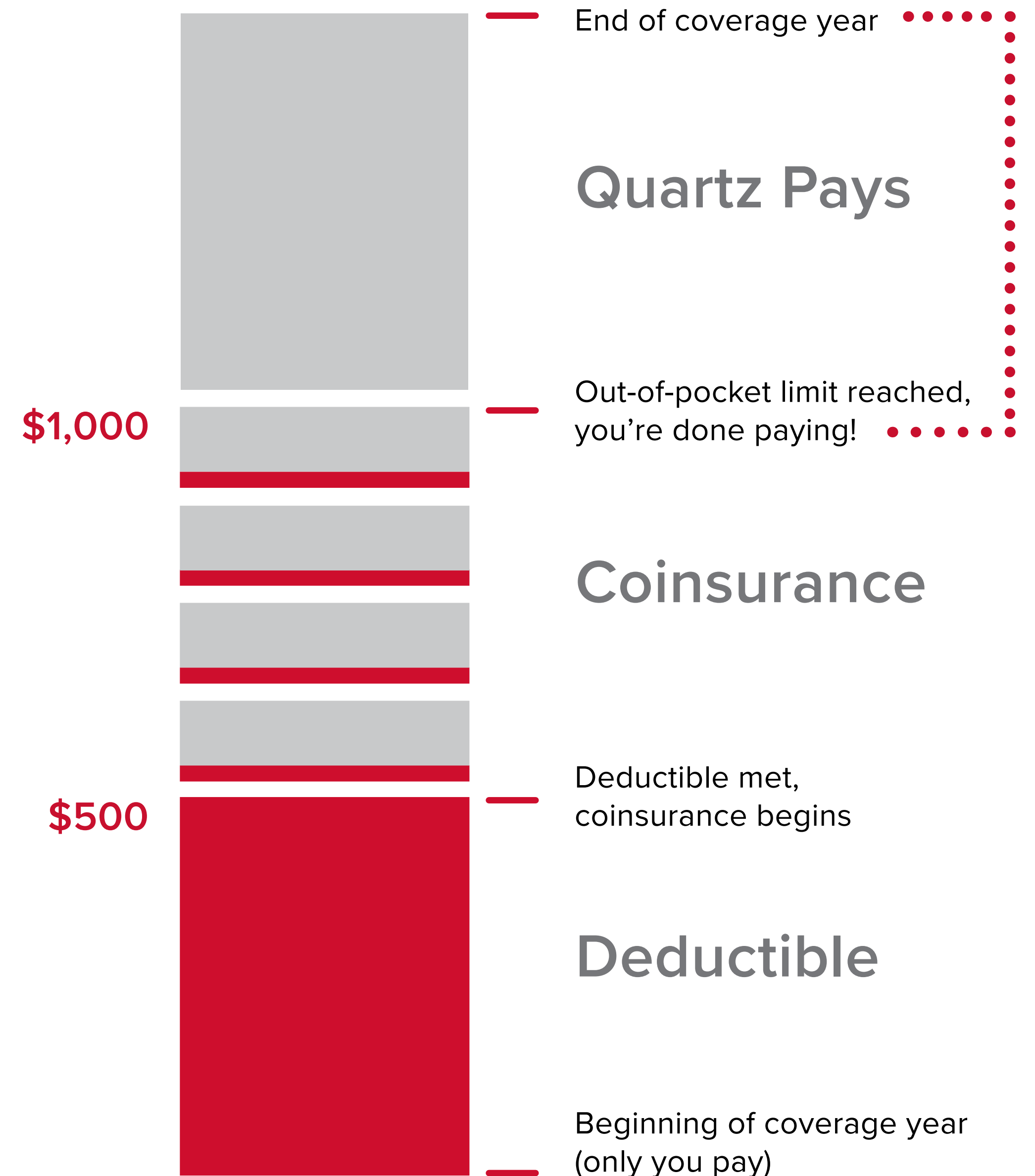
When you reach your policy's OOP, you no longer need to pay coinsurance for that year. Check your certificate or SBC for the OOP.



Pay Up to the OOP

Your OOP might be **\$1,000**.

When you've paid a total of **\$1,000** toward healthcare costs (including deductible and coinsurance) you've **reached your OOP** and the insurance company pays 100% of covered services.

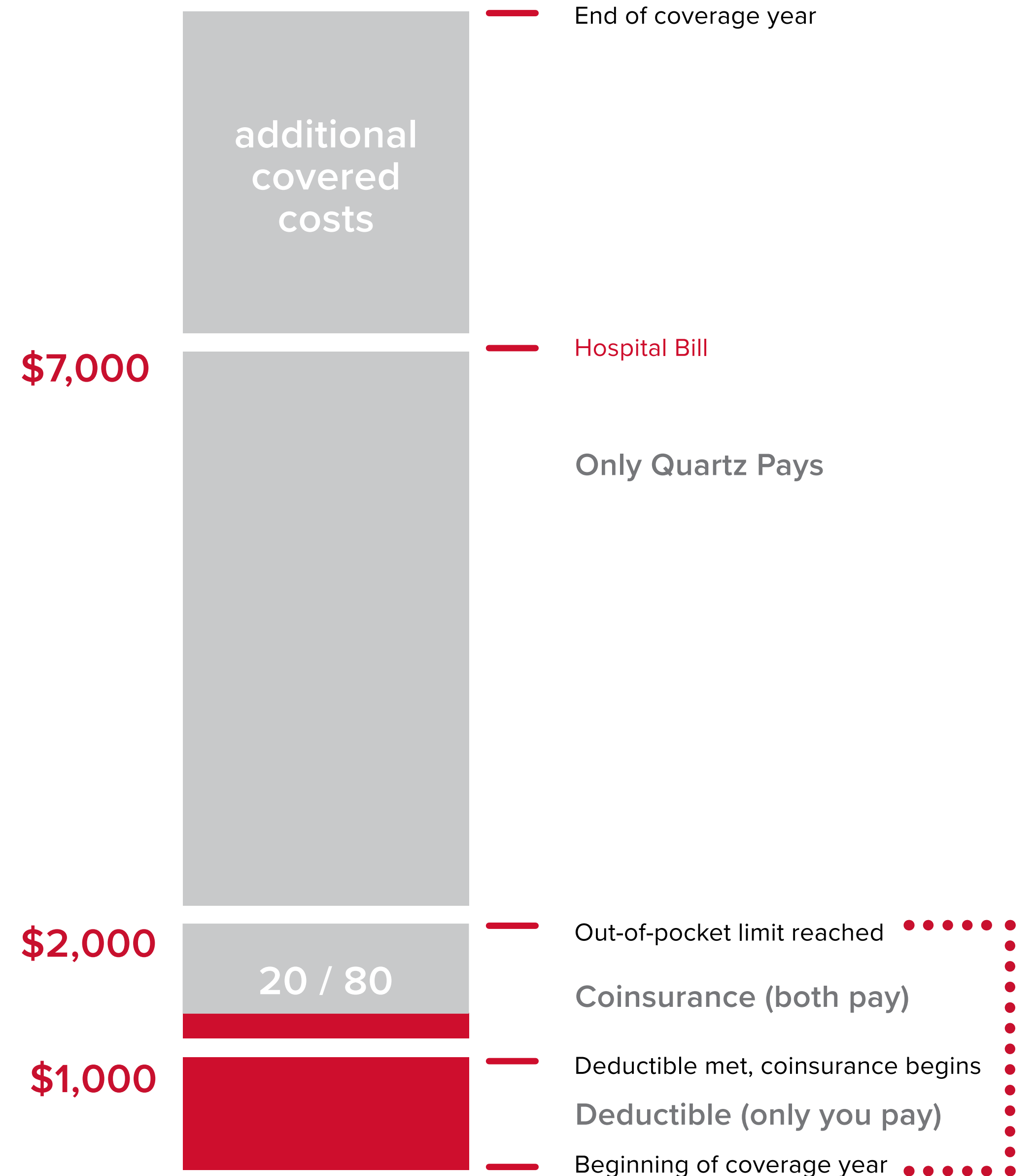


OOP Example

Your **OOP** might be **\$2,000**. For example, let's imagine you were in the hospital and the **hospital bill was \$7,000**. Your plan has a **\$1,000 deductible, 20% coinsurance** and a **\$2,000 OOP**.

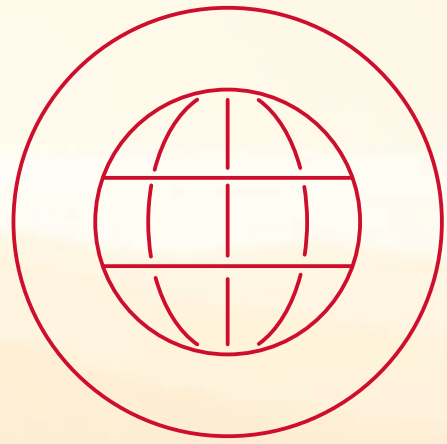
Under your plan you only need to **pay up to \$2,000**.

You would have to pay your **\$1,000 deductible + up to \$1,000 coinsurance** to reach your OOP. After you reach your OOP, the health insurance company will **pay the rest of covered costs** for the year.



Questions?

REMINDERS



Is the doctor in the network? To find out **check your health insurer's website** or call customer service.



Is my treatment covered by my health plan? Refer to **certificate of coverage** or call customer service.



Quartz

Thank you!