DEFINITION OF TERMS

- **Premium** - The amount you pay for your health insurance every paycheck.

- **Deductible** - The amount you pay for healthcare services before your insurance company (BCBS) begins to pay. (Some services are subject to copayment first before a deductible).

- **Coinsurance** - The percentage of costs for health services that you are responsible for until your out-of-pocket limit is met.

- **Out-of-pocket limit** - The most you have to pay for covered services in a plan year. After you reach this limit, your insurance company (BCBS) pays 100% of the costs of covered benefits. The out-of-pocket limit does not include your biweekly premiums.

- **Network provider** - A list of doctors, other heath care providers, and hospitals that a plan contracts with to provide medical care to its members.

- **Copayment** - An amount that you pay each time you go to your doctor or fill a prescription.

PPO VS HMO

- PPO premiums are more expensive but give you more freedom.
- PPO plans are more flexible when picking a doctor or hospital.
- PPO plans are great if you seek medical care often and/or have routine scheduled medical treatment for chronic health conditions.
- PPO plans include network providers. There are few restrictions when seeing non-network providers.
- You do not need referrals to see a specialist with PPO plans.

- **HMO plans do not have out-of-network benefits.**
- HMO premiums are lower.
- HMO plans are ideal if you just need basic coverage such as an annual doctor visit.
- With HMO plans, you also have access to in-network-services with a copayment for providers as well as prescription drugs.
- HMO plans have a smaller provider network.
- HMO plans require a PCP (Primary Care Physician)
- You will not have access to providers without a referral from your PCP.