Health care 101

Understanding your choices just got easier

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Medical plans, plain and simple

If you find health insurance terms to be confusing, you're not alone. That's why we made this handy guide. No more jargon or complicated descriptions. Just straightforward explanations about plans, payments and easy ways to save.

Types of health plans

Knowing the differences between these common plans is your first step. This will help you feel confident about choosing the plan that's right for you. Keep in mind, your actual plan may vary from the descriptions below.

Covered doesn't mean free. A covered health care service is one that your plan recognizes. Your plan only pays for this service after you've met the deductible, coinsurance or copay.

A referral is like a permission slip from your primary care physician (PCP) to see a specialist or another provider. Many doctors can send referrals electronically.

Network providers participate in our network. And they offer special lower rates for our members.

	Preferred provider organization (PPO)	High-deductible health plan (HDHP)	Health maintenance organization (HMO)
Your contributions	▲ Usually higher than HDHPs and HMOs	▼ Usually lower than PPOs and HMOs	▼ Usually lower than PPOs
Deductible	▼ Lower than HDHPs	▲ Higher than PPOs and HMOs	▼ Lower than HDHPs
Primary care physician (PCP)*	You usually don't need to pick a PCP	Depends if plan is a PPO or HMO	You must pick a PCP and coordinate your care through them
Referrals	You may see any licensed doctor without a referral	Depends if plan is a PPO or HMO	You'll need a referral from your PCP to see other doctors and specialists
Out-of-network coverage	$ You're covered outside the network, but you'll usually pay more	$ You're covered outside the network, but you'll usually pay more	X You're not covered outside the network, except for emergency care**

*In Texas, PCP is known as physician (primary care). In the state of Washington, PCP refers to primary care provider. In Missouri, you do not have to choose a PCP on a PPO plan.

**For HMO products in Missouri, you are also covered for two mental health visits.

Paying for care

An overview of terms

PROCESSING

Claims

Claims are requests for your plan to pay for services you receive. We use these to check what your plan will cover and the amount we'll pay. You can find updated status and amounts billed for your claim on your member website or the Aetna Health℠ app.

Provider bills

Bills show the amount you actually owe for services. You'll get this from your provider. You can make payments for what you owe directly to your provider or through the "Pay Your Provider" link on each of your claims.

Explanation of Benefits (EOB) statements

An Explanation of Benefits, or EOB, statement shows a breakdown of how we process your claims. It is not a bill and may not show the current balance you owe. Anytime something changes with your claim, you'll get a new statement.

Coordination of benefits

Some members have health coverage under more than one health plan. When this happens, we work with the other carriers to decide which plan pays first and which plan pays second, based on the rules in your plan documents. We call this process "coordination of benefits," or COB.

YOU PAY

Deductible

Each year, you pay 100% of your covered expenses until you meet your deductible amount.

For most plans, eligible preventive care is covered at 100% with no deductible when you use network providers.

YOU + THE PLAN PAY

Cost sharing

Once you meet your deductible, you share the cost with the plan. Your share may be in the form of coinsurance and/or copayments (also called copays).

Coinsurance

A fixed percentage. For example, if your care is $100 and your coinsurance is 20%, you pay $20.

Copay

A fixed dollar amount. For example, you may pay $25 per doctor office visit.

THE PLAN PAYS

Out-of-pocket maximum

The maximum you pay each year for covered expenses. Once you hit your maximum, the plan pays 100% of covered expenses for the rest of the year.

In-network care

Who pays for what

Visit your doctor and show your ID card.

There's no need to pay at your visit unless you have a copay.

(Out of network, you may need to pay the full amount at your visit.)

Your doctor files your claim.
(Out of network, you file your own claims.)

The plan pays

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The plan pays your doctor any amount it owes based on the negotiated rate.

(Out of network, the plan pays you back what it owes, up to the "reasonable and customary" limit.)

Your doctor bills you for any amount you owe.

5 ways to save

1 Stay in the network

In-network doctors, labs, hospitals and other health care providers charge lower, negotiated rates. Plus, your coinsurance is lower. You can use the provider search tool at **Aetna.com** to find network providers.

2 Get preventive care

Keep up with preventive services to catch any problems early. You pay nothing as long as you stay in the network.

3 Pay less for prescriptions

Generic drugs can be just as effective as name-brand, and they usually cost less. You can also save by using your plan's home delivery service for regular prescriptions.

4 Compare costs before you go

Use your cost-of-care tools to compare costs before you go to the doctor.

5 Use the ER for emergencies only

Visit an urgent care center or walk in clinic for non life threatening medical issues.

HRA vs. HSA vs. FSA

You may be offered one or more of these tax-free accounts to help pay for qualified health care expenses. Your specific plan may vary, but here are the main differences:

HRA

Health reimbursement arrangement*

- An HRA is part of your medical plan. It automatically pays first for qualified health expenses until the funds run out.
- It usually pairs with an HDHP.
- Only eligible employers can contribute.
- Your balance can carry over as long as you stay in the plan. Your employer may limit how much can carry over.

HSA

Health savings account**

- An HSA is a separate account you own and use for qualified health care expenses as you like.
- It requires an HDHP.
- You, your employer or anyone else can contribute.
- You can use funds now or save them for later. Plus, you keep your account even if you leave the plan or the company.

FSA

Health care flexible spending account

- FSA funds can be used for qualified health care expenses up to the amount you select during enrollment.
- It pairs with most types of health plans, but a health plan isn't required.
- You and your employer can contribute.
- You lose funds if you don't use them before the end of the plan year (plus any grace period or carryover, if offered).

*HRAs are currently not available to HMO members in Illinois and Small Group members in Florida.
**HSAs are currently not available to HMO members in California and Illinois.

Know more, get more.

Now you know how health plans work.
So you can choose confidently and
use yours wisely — all year long.

There may be fees associated with a Health Savings Account ("HSA"). These are the same types of fees you may pay for checking account transactions. Please see the HSA fee schedule in your HSA enrollment materials for more information.

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