federal employees

A guide to understanding your health plan options

www.fepblue.org
Choosing a health plan that’s right for you

The U.S. Office of Personnel Management (OPM), Office of Insurance Programs, administers the Federal Employees Health Benefits Program (FEHBP), the largest health insurance program in the world.

Every year during open enrollment, known as Open Season, all employees eligible to participate in the FEHBP have an opportunity to change or enroll in a healthcare plan. The decisions you make during this period will determine your out-of-pocket costs and how you access healthcare.

This brochure gives you basic information that will help you understand the different types of plans participating in the FEHBP or available to Medicare-enrolled annuitants and survivors in California. For specific information about plan-type options, plan benefits, or membership requirements, please refer to each plan’s FEHBP contract brochure or contact the Social Security Administration in your area. The Social Security Administration can also answer your questions about Medicare HMOs.*

It’s easy to feel a little confused about where to start when choosing a health plan. Knowing the right questions to ask can help you make an informed decision and find the right plan for you and your family. Here you’ll find brief plan descriptions and frequently asked questions, with answers and tools that can help you select a health plan that meets your needs.

* Medicare HMOs are not offered through the FEHBP but are available in some areas for federal Medicare enrollees who qualify. Contact the Social Security Administration in your area for information.
Understanding your federal health plan options

As a federal employee, you’re eligible to enroll in various health plans. Here are the types of plan options available to you.

Preferred provider organization (PPO) with non-network benefits
A PPO is a managed fee-for-service plan that offers members financial incentives to use a select network of healthcare professionals called “preferred providers.” Preferred providers have contracted with the plan to discount their fees to plan members. A traditional PPO includes a non-network benefit where members can choose any provider in or out of the plan’s network for covered medical services. But by using preferred providers, members can receive covered services at reduced cost.

Basic features of PPOs:
• Access to care without authorization or coordination by a primary care physician.
• Members can self-refer to the plan’s PPO providers anywhere.
• Plans do not have service areas; all covered services are paid at the preferred or non-preferred (non-network) benefit level wherever they are accessed.
• Members generally do not have deductibles* only copayments* and coinsurances* for certain covered services.
• Generally, hospital admissions must be pre-authorized prior to hospitalization for elective admissions.

Exclusive provider organization (EPO) with limited non-network benefits
An EPO is a plan with limited non-network benefits. In an EPO, you must use PPO providers except in cases of true medical emergencies and other exceptions listed in the plan’s brochure.

Basic features of EPOs:
• Access to care through the plan’s PPO providers without authorization or coordination by a primary care physician.
• Members can self-refer to the plan’s PPO providers anywhere.
• Members generally do not have deductibles, only copayments and coinsurances for certain covered services.
• Generally, hospital admissions must be pre-authorized prior to hospitalization for elective admissions.

Health maintenance organization (HMO)
An HMO is a prepaid health plan that provides a comprehensive array of medical services, emphasizing prevention and early detection through contracted doctors, hospitals, and other providers.

Basic features of HMOs:
• Members must live or work within the geographic area known as the “service area” to enroll.
• Members must select a primary care physician* (PCP) from the plan’s HMO network.
• A PCP must obtain any necessary authorizations from the plan before referring you to a specialist or making arrangements for hospitalization. Please note: Some plans offer self-referral under certain conditions, but members must use HMO network providers.
• All healthcare must be provided or coordinated by the PCP with the exception of true medical emergencies.
• There are no annual deductibles.
• Copayments vary depending on the plan and type of service.
• Only emergency care is covered outside the service area and/or without the plan’s authorization. (See the plan’s definition of emergency care.)

* See glossary for more detailed information.
Managed fee for service (MFS)
All fee-for-service plans participating in the FEHBP have managed care provisions. The FEHBP managed fee-for-service plans are without a PPO feature. It’s still considered a managed fee-for-service plan because covered services and fees paid are determined using medical necessity, “usual and customary” billing, and other cost-containment measures. In this type of plan, the costs of covered services are paid after services are received. An evaluation is made after the fact for medical necessity, appropriateness, and efficiency of the use of medical services, procedures, and facilities. The plan determines what payments, if any, will be made for services rendered.

Basic features of managed fee-for-service plans:
• One level of benefits.
• Generally a pre-authorization is required for hospital admissions.
• Members generally have to meet a deductible.
• Members are responsible for all coinsurance, a percentage of covered charges.
• Members are responsible for all charges above the allowable charge if services are received from a non-network provider.

Consumer-driven health plan (CDHP)
CDHPs offer a variety of approaches that give you more incentives to control the cost of either your health benefits or healthcare spending. One type of CDHP is a high-deductible health plan (HDHP).

For more information on choosing the right plan for you and your family, please contact your benefits administrator or go to www.opm.gov/healthcare-insurance/healthcare.
**High-deductible health plan (HDHP)**
A high-deductible health plan (HDHP) with a health savings account (HSA) or a health reimbursement arrangement (HRA) provides traditional medical coverage and a tax-free way to help you build savings for future medical expenses. The HDHP/HSA or HRA gives you greater flexibility and discretion over how you use your healthcare benefits. If you are Medicare enrolled, you are not eligible for an HSA. For more information, please go to www.opm.gov/insure/health/hsa/hsa.asp.

Depending on the HDHP you choose, you may have the choice of using network and non-network providers. With the exception of preventive care, you must meet the annual deductible before the plan pays benefits.

**Basic features of HDHPs:**
- Preventive-care services are generally paid as first-dollar coverage,* usually with low or no deductible copayment.
- For non-preventive care, you must meet the plan deductible before the health plan pays benefits.

**Financial accounts that work with HDHPs**
With HDHPs, the FEHBP establishes and partially funds HSAs for all eligible enrollees, or provides a comparable HRA for enrollees who are not eligible for an HSA. The HSA funding or HRA credit amounts vary by plan. For more information about HSAs or HRAs, please see details and links below.

**Health savings account (HSA)**
Funds deposited into an HSA are not taxed, the balance in the HSA grows tax free, and that amount is available on a tax-free basis to pay medical costs. To open an HSA, you must be covered under an HDHP and cannot be eligible for Medicare or covered by another plan that is not an HDHP, or a general purpose health care flexible spending account (HCFSA), or be dependent on another person’s tax return.

HSAs are subject to rules and limitations established by the U.S. Department of the Treasury. Visit www.treasury.gov/resource-center/faqs/Taxes/Pages/Health-Savings-Accounts.aspx for more information.

**Basic features of HSAs:**
- The account is owned by you, and it goes with you into retirement.
- Unused funds and interest are carried over from year to year.
- Tax-free withdrawals for qualified medical expenses.
- Tax-deferred interest is earned on the account.
- You make tax-deductible deposits to the HSA.

**Health reimbursement arrangement (HRA)**
HRAs are sometimes referred to as Personal Care Accounts. They’re available to enrollees who are ineligible for an HSA. HRAs are similar to HSAs except enrollees cannot make deposits into an HRA, a health plan may impose a ceiling on the value of an HRA, interest is not earned on an HRA, and the amount in an HRA is not transferable if the enrollee leaves the health plan. Each month, the plan automatically credits a portion of the health plan premium into your HRA based on your eligibility as of the first day of the month. You can pay your deductible with funds from your HRA.

**Basic features of HRAs:**
- Credits in an HRA do not earn interest.
- Credits in the HRA are forfeited if you leave federal employment or switch health insurance plans.
- Unused credits are carried over from year to year.
- Tax-free withdrawals for qualified medical expenses.

For more information on HDHPs with HSAs or HRAs, please visit www.opm.gov/healthcare-insurance/healthcare.

* See glossary for more detailed information.
Use this chart to review and compare the various plan options and benefits available to you.

<table>
<thead>
<tr>
<th>Type</th>
<th>Benefits</th>
<th>Network</th>
<th>Claims</th>
<th>Deductible</th>
<th>Copay/Coinsurance</th>
<th>Referrals</th>
<th>Advantage</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPO</td>
<td>Comprehensive, preventive, wellness, and maternity care</td>
<td>Contracts with providers to form network. Benefits are higher when network providers are used for care, but you can go out of the network for care.</td>
<td>Network care: Filed for you Non-network care: You may need to file</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Freedom to choose your providers</td>
</tr>
<tr>
<td>HMO</td>
<td>Emphasizes preventive care and wellness programs</td>
<td>Must use network providers to receive coverage, except in emergencies. Typically must select a primary care physician.</td>
<td>Filed for you</td>
<td>No</td>
<td>Yes</td>
<td>Usually</td>
<td>No deductible</td>
</tr>
<tr>
<td>HDHP</td>
<td>Features higher annual deductibles and annual out-of-pocket limits</td>
<td>Network and non-network benefits available</td>
<td>Network care: Filed for you Non-network care: You may need to file</td>
<td>Yes, non-preventive care requires a deductible</td>
<td>Yes</td>
<td>No</td>
<td>Preventive care is often covered in full</td>
</tr>
</tbody>
</table>

**Financial accounts that work with HDHPs**

<table>
<thead>
<tr>
<th>Type</th>
<th>Benefits</th>
<th>NA</th>
<th>NA</th>
<th>NA</th>
<th>NA</th>
<th>NA</th>
<th>Portability: the account is member-owned and yours to keep</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSA</td>
<td>Tax-free withdrawals for qualified medical expenses</td>
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<td></td>
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<td></td>
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<tr>
<td>HRA</td>
<td>Carryover of unused credits from year to year</td>
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<td></td>
<td></td>
<td></td>
<td>Tax-free withdrawals for qualified medical expenses</td>
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Federal Employees Retirement System (FERS)

Level of benefits
There are four categories of benefits in the Federal Employees Retirement System (FERS) Basic Benefit Plan:

- **Immediate** – Starts within 30 days from the date you stop working.
- **Early** – Available in certain involuntary and voluntary separation cases, including a major reorganization or reduction in force.
- **Deferred** – If you leave federal service before you meet the age and service requirements for an immediate retirement benefit, you may be eligible for deferred retirement benefits.
- **Disability** – You must have become disabled, while employed in a position subject to FERS because of a disease or injury, for useful and efficient service in your current position. The disability must be expected to last at least one year. Your employer must certify that it is unable to accommodate your disabling medical condition in your present position and that it has considered you for any vacant position in the same agency at the same grade/pay level, within the same commuting area, for which you are qualified for reassignment.

Eligibility is determined by your age and the number of years of creditable service. In some cases, you must have reached the minimum retirement age (MRA) to receive retirement benefits.

For more information on eligibility requirements, please go to www.opm.gov/retirement-services.

Non-FEHBP plans for retirees

The following plan types, MHMO and TRICARE, are not a part of FEHBP, and are available only to individuals eligible for Medicare benefits.

Medicare health maintenance organizations (MHMOs)
An MHMO is an HMO that contracts with Medicare to provide coverage for healthcare services to Medicare beneficiaries. MHMOs are sometimes called Medicare Advantage, Coordinated Care, Medicare Risk, or Medicare Prepaid Plans. MHMOs are available only to persons entitled to Medicare benefits and are an alternative to fee-for-service coverage under Medicare. MHMOs are not a part of FEHBP. Also note: If you are enrolled in Medicare, you are not eligible for HSA-eligible plans.

Members may join if they are enrolled in Medicare Part A (hospital) and Part B (professional) coverage or Part B only, live in the plan’s service area, do not have permanent kidney failure, and have not elected the Medicare hospice benefit. FEHBP members may join an MHMO and temporarily suspend their FEHBP coverage. Members can rejoin FEHBP only after the next Open Season or when they involuntarily lose coverage or move out of the service area. Do not leave your MHMO prematurely.

MHMO plans have generally the same basic features and characteristics of HMOs, which are highlighted in the HMO section of this brochure. Please note: See the MHMO’s certificate of coverage that governs the Medicare risk or cost contract for definitions of emergency and urgent care.

Any Social Security Administration office can provide a list of MHMOs contracted to serve an area. Before joining any MHMO, please read the membership and benefit information carefully.
**TRICARE for Life**

TRICARE for Life is a regionally managed healthcare program that will cover all uniformed service retirees, spouses, and other qualifying dependents and survivors (including certain former spouses) who are Medicare-eligible and enrolled in Medicare Part B, regardless of age.

TRICARE offers eligible beneficiaries three choices for their health plan:

- **TRICARE Prime** – where military treatment facilities (MTFs) are the principal source of healthcare.
- **TRICARE Extra** – a preferred-provider option that saves money.
- **TRICARE Standard** – a fee-for-service option (formerly known as CHAMPUS). Beneficiary counseling and assistance coordinators at the nearest TRICARE service center or military treatment facility can help you decide which option is best for you.

**Please note:** OPM has issued a final ruling to allow TRICARE-eligible FEHBP annuitants, survivors, and former spouses to suspend their FEHBP enrollments, and then return to the FEHBP during Open Season, or return to FEHBP coverage immediately if they involuntarily lose TRICARE coverage. The intent of the rule is to allow TRICARE-eligible beneficiaries to avoid the expense of continuing to pay FEHBP premiums while they are using TRICARE coverage, without endangering their ability to return to the FEHBP in the future.

For more information about eligibility for TRICARE, Medicare/Medicaid, or certain state sponsored Medical Assistance Plans, please go to www.opm.gov/healthcare-insurance/healthcare.
Now that you understand your options, knowing the right questions to ask can help you make an informed decision and find the right plan for you and your family. The first step is to review the plan’s brochure for information on specific benefit coverage and rates, or go to the FEHBP’s website at www.opm.gov.

Q: How can I figure out which health plan is right for me?
A: First, consider how much coverage you need. Are you single or do you have a family? Do you or a family member have a chronic condition? It’s important to look at the full range of services and copays or coinsurance you will spend out of pocket for doctors’ visits, surgery, hospital stays, or other types of care. And it’s important to know whether your plan covers preventive services, prescription drugs, new glasses, or other services you may need.

Q: Does the health plan’s network include the doctors and hospitals I want?
A: If you already have a family doctor, you may want to check to see if your doctor is included in the health plan’s network.

Q: What about cost? Should it be a factor in the decision?
A: The cost of coverage is an important issue. You need to understand how much you will pay for your coverage in monthly premiums and what you will pay when you visit the doctor or go to a hospital or urgent care facility. Also, is there an annual deductible? Will you pay a dollar-amount copay, or a percentage of the costs for services you receive?

For plans with deductibles, keep in mind that higher deductibles usually mean lower rates.

Q: What if you have a lot of options and are confused about how to narrow down your choices?
A: Start with the basics. You need to know what types of doctors’ visits, surgery, or hospital services are covered in the benefit plan. Find out if the plan covers prescription drugs. And, of course, you need to know how much you’re going to pay out of pocket, if there is a copayment or deductible you need to meet, or if there’s an overall limit or cap on benefits. The bottom line is that it’s important to know how the plan works. Don’t wait until you need healthcare to ask those important questions.

When comparing plan options, consider these additional questions:
• Does the health plan offer preventive services and programs to help keep you well?
• Does the health plan provide tools to make it easy for you to find quality care, such as locating and comparing providers?
• Does the health plan help you manage your prescriptions with benefits and resources that provide ease and cost savings?
• Does the health plan keep your family members covered while they’re traveling or outside California?
• Does the health plan offer additional services and programs to help keep you healthy and help save you money?
• Does the health plan make it easy to do business with them, with a customer service team who can help you with questions and any claims?
Once you’ve narrowed down your top health plan picks, use the chart below to compare costs side by side. Your calculations should include total copayments, out-of-paycheck premium, and any deductibles or coinsurance that may be required by your health plan.

This chart is only a summary for informational purposes. For a complete list of the benefits, exclusions, and limitations, and rates of each plan, please refer to the plan’s contract brochure.

### Health plan cost comparison

<table>
<thead>
<tr>
<th>Compare benefits</th>
<th>Choice plan A</th>
<th>Choice plan B</th>
<th>Choice plan C</th>
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</thead>
<tbody>
<tr>
<td>Annual physical/preventive care</td>
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<tr>
<td>Office visits</td>
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<tr>
<td>Diagnostics (such as lab work)</td>
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<tr>
<td>Maternity coverage</td>
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<tr>
<td>Well-baby exams</td>
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<tr>
<td>Emergency room visits</td>
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<tr>
<td>Hospital care (outpatient services)</td>
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<tr>
<td>Prescription drug costs</td>
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<tr>
<td>Copayment for alternative-care visits (such as chiropractic)</td>
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<tr>
<td>Mental health services</td>
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<tr>
<td>Annual deductible</td>
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<tr>
<td>Annual out-of-pocket maximum or copayment maximum</td>
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<tr>
<td>Lifetime maximum</td>
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<tr>
<td>Monthly rate</td>
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<tr>
<td>Total costs</td>
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Here are short explanations of some commonly used terms to help you better understand the terms included in your enrollment materials. **Blue text** indicates a term defined in this Glossary. For the official explanations of these terms, please refer to the plan’s FEHBP contract brochure.

**Allowed amount**: Maximum amount on which payment is based for covered healthcare 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.

**Brand-name drugs**: FDA-approved drugs under patent to the original manufacturer and available only under the original manufacturer’s branded name.

**Calendar year**: June 1 through December 31 of the same year.

**Claim**: A notification to your health plan that a service has been provided and payment is requested.

**Coinsurance**: Your share of the costs of a covered healthcare service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay coinsurance 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 coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

**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.

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

**Deductible**: The amount you owe for healthcare services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1,000, your plan won’t pay anything until you’ve met your $1,000 deductible for covered healthcare services subject to the deductible. The deductible may not apply to all services.

**Durable medical equipment (DME)**: Equipment and supplies ordered by a healthcare 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 received in an emergency room.
**Emergency services:** Evaluation of an *emergency medical condition* and treatment to keep the condition from getting worse.

**Excluded services:** Healthcare services that your *health insurance* or *plan* doesn’t pay for or cover.

**First-dollar coverage:** First dollar coverage in health insurance means that your insurance covers health care expenses without copayments or deductibles having to be paid first. It pays expenses beginning with the first dollar charged for health care or hospitalization depending on the type of policy purchased.

**Formulary:** A comprehensive list of covered drugs, designed to assist physicians in prescribing drugs that are *medically necessary* and cost effective. In most plans, members pay less for formulary than for non-formulary drugs. A formulary typically includes *generic drugs*.

**Generic drugs:** Drugs that (1) are approved by the FDA as a therapeutic equivalent to the *brand-name drug*, (2) contain the same active ingredient as the brand-name drug, and (3) cost less than the brand-name drug equivalent.

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

**Inpatient:** An individual who has been admitted to a hospital as a registered bed patient and is receiving services under the direction of a physician.

**Habilitation services:** Healthcare 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 healthcare costs in exchange for a *premium*.

**Home health care:** Healthcare 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.

**Medical emergency:** The sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that may be determined as medical emergencies. What they all have in common is the need for quick action.

**Medically necessary:** Healthcare 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 healthcare services.

**Network coinsurance:** The percent (for example, 20%) you pay of the *allowed amount* for covered healthcare services to *providers* who contract with your *health insurance* or *plan*. Network coinsurance usually costs you less than *non-network coinsurance*.

**Network copayment:** A fixed amount (for example, $15) you pay for covered healthcare services to *providers* who contract with your *health insurance* or *plan*. Network copayments usually are less than *non-network copayments*. 
**Non-formulary drugs:** Drugs determined by the health plan as being duplicative, experimental, not medically necessary, or as having preferred formulary drug alternatives available. For some plans, benefits may be provided for non-formulary drugs and are subject to a non-formulary copayment.

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

**Non-network copayment:** A fixed amount (for example, $30) you pay for covered healthcare services from providers who do not contract with your health insurance or plan. Non-network copayments usually are more than network copayments.

**Non-network provider:** See non-preferred provider.

**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.

**Outpatient:** An individual receiving services but not as an inpatient (i.e., not admitted to a hospital).

**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 copayments, deductibles, coinsurance payments, non-network payments, or other expenses toward this limit.

**Out-of-pocket maximum:** A dollar limit on the total amount that a member has to pay for many covered services in a calendar year, including the copayments, coinsurance, and deductible.

**Physician services:** Healthcare 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 healthcare services.

**Preauthorization:** A decision by your health insurer or plan that a healthcare 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.
**Preventive care**: Medical services provided by a physician for the early detection of disease when no symptoms are present and for routine physical examinations.

**Primary care physician**: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of healthcare 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 healthcare services.

**Provider**: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), healthcare professional or healthcare 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**: Healthcare services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because the 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 received 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 healthcare.

**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.