Definitions for Summary of Options

Deductible:
The annual portion you must pay before the insurance starts paying.
The deductible applies to the calendar year, not the school's insurance "year".

Copay/Coinsurance Percentage:
A copayment is applied to the insurance bill (charges) after the deductible.
It is a percentage of the total bill.

Annual Copay Dollar Maximum:
This is the maximum you could spend in a calendar year. It includes all deductibles, copays, coinsurance and prescription drug copays.

Network:
PPO - Blue Cross Blue Shield
HMO - Blue Care Network

In-Network:
Providers (hospitals, physicians) that participate in the network.

Out-of-Network:
PPO - Providers (hospitals, physicians) that DO NOT participate in the PPO network.
You will spend more money by using non-participating providers.
HMO - No out-of-network providers.

Flat Dollar Copays:
Office Visit - You will pay this for every physician office visit.
Emergency Room - You will pay this for every emergency room visit.
Urgent Care Copay - You will pay this for every Urgent Care visit.
Prescription Drug Copay - You will pay this for each prescription drug.

Annual Premium:
The total 12-month cost for the insurance, from August 1 to July 31.

1 Person
Student only

2 Person
Student and spouse
(or domestic partner)

Family
Student and family (including children of domestic partner)

Managed Care Networks
All managed care plans contract with doctors, hospitals, clinics, and other healthcare providers such as pharmacies, labs, x-ray centers, and medical equipment vendors. This group of contracted healthcare providers is known as the health plan's network.

In some types of managed care plans, you may be required to receive all your healthcare services from a network provider. In other managed care plans, you may be able to receive care from providers who are not part of the network, but you will pay a larger share of the cost to receive those services.

Health Maintenance Organizations (HMOs)
If you are enrolled in a health maintenance organization (HMO) you will need to receive most or all of your healthcare from a network provider. HMOs require that you select a primary care physician (PCP) who is responsible for managing and coordinating all of your healthcare.

Your PCP will serve as your personal doctor to provide all of your basic healthcare services. PCPs include internal medicine physicians, family physicians, and in some HMOs, gynecologists who provide basic healthcare for women. For your children, you can select a pediatrician or a family physician to be their PCP.

If you need care from a physician specialist in the network or a diagnostic service such as a lab test or x-ray, your primary care physician (PCP) will have to provide you with a referral. If you do not have a referral or you choose to go to a doctor outside of your HMO's network, you will most likely have to pay all or most of the cost for that care.

Preferred Provider Organizations (PPOs)
A preferred provider organization (PPO) is a health plan that has contracts with a network of "preferred" providers from which you can choose. You do not need to select a PCP and you do not need referrals to see other providers in the network.

If you receive your care from a doctor in the preferred network you will only be responsible for your annual deductible (a feature of some PPOs) and a copayment for your visit. If you get health services from a doctor or hospital that is not in the preferred network (known as going "out-of-network") you will pay a higher amount. And, you will need to pay the doctor directly and file a claim with the PPO to get reimbursed.