WMH wants to help you understand your insurance

What is a HMO?

A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. HMOs require you to choose a PCP. All referrals to specialists need to be through your PCP. It generally won't cover out-of-network care except in an emergency.

What is a PPO?

A type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. PPOs do not require you to choose a PCP. No referrals are needed to see a specialist. You pay less if you use providers that belong to the plan's network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

What it means if you have a Co-Pay

A co-pay is a fixed amount you pay for a covered health care service after you've paid your deductible (if you have a deductible)

- ***For example*:** Your insurance card states $20 co-pay for PCP, you pay $20 at the office visit.

What it means if you have a Deductible

The amount you pay for covered health care services before your insurance plan starts to pay. After you pay your deductible, you usually pay only a copayment or coinsurance for covered services.

- ***For example:*** If you have a $1000 deductible, you will pay out of pocket for your health care expenses until you reach $1000, after that you will only pay a co-pay, co-insurance or nothing depending on your plan.

What it means if you have a Co-Insurance

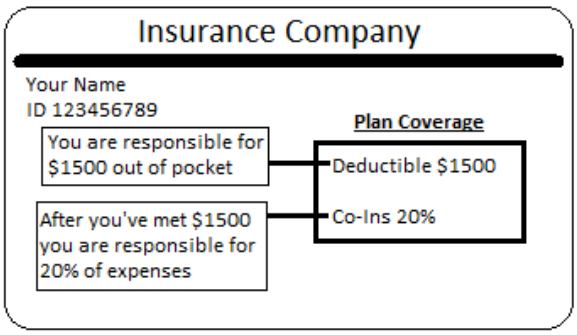
The percentage of costs of a covered health care service you pay after you've paid your deductible.

- ***For example:*** If you've already paid your deductible and you have a 20% Co-Insurance, your insurance is billed $100, you will be responsible for $20 of the bill.

What Out-of-pocket maximum/limit means

The most you have to pay for covered services in a plan year. After you spend this amount on deductibles, copayments, and coinsurance, your health plan pays 100% of the costs of covered benefits.

Sample Insurance Card



How this applies to labs and imaging

Your plan coverage as defined above, applies to lab costs as well as any imaging (MRI, Ultrasound, Echo). If labs or imaging are ordered and they are not 100% covered, you will be subject to the conditions determined by your insurance (co-ins, co-pay, co-ins). It is **YOUR RESPONSIBILITY** to know what portion you are responsible for.

- ***For example***: A MRI costs $500 and you have a 20% co-ins, you will be responsible for $100 of the cost of the MRI.

Does self - pay make more sense?

There are instances where paying the self pay rates whether it be labs or imaging is more beneficial. We can provide you with the self pay rates for labs and for imaging centers.

- ***For example:*** The same MRI from above will cost $500 and if you have a deductible or co-insurance you could be responsible for all or a large portion of the cost. However, the MRI could cost $250 out of pocket for self pay when it is not submitted through your insurance.

Source: www.healthcare.gov