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| **FAQs** **Network Plus Plan (Choice Plus PPO)** |  |

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| Network Plus Plan (Choice Plus PPO) |
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| https://secure.benergy.com/images/spacer.gif | **What is a preferred provider organization (PPO) plan, and how does it work?**

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|   | A preferred provider organization (PPO) plan works for you in two ways: through a panel or network of physicians and other service providers (such as hospitals and labs), or through providers you select that are not in the network. Each time you or a covered family member needs care, you choose whether to see an in-network or an out-of-network provider.Network providers are listed in your plan's provider directory. When you use an in-network provider, also called "going in-network," you generally receive a higher level of benefits. Also, fees from in-network providers tend to be lower, because the providers and the network have negotiated to have the providers accept certain fees for certain services. |

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| https://secure.benergy.com/images/spacer.gif | **What are the advantages of obtaining my care from in-network providers?**

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|   | There are several advantages when you go in-network. Generally: * You don't need to submit claim forms and wait to be reimbursed by your plan.
* Your in-network provider obtains any needed preauthorization for you.
* You generally receive a higher level of benefits because participating providers (doctors, hospitals and other health care facilities) have agreed to provide their services at lower fees.
* Some plans provide preventive care services in-network that are not covered out-of-network.
* Some plans limit covered services out-of-network, but offer these services without a limit on the number of visits when the care is provided in-network.
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| https://secure.benergy.com/images/spacer.gif | **How does the PPO plan work when I go out-of-network?**

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|   | Generally, you may use any covered health care provider you choose. However, your cost will generally be higher and you have certain added responsibilities. For example: * Each year, you must pay part of your eligible out-of-network expenses before the PPO plan begins to pay benefits. This amount is called the deductible.
	+ After you satisfy the deductible, the plan will reimburse you for a percentage of your eligible expenses and you will pay the balance. The percentage you pay is called your coinsurance percentage.
	+ You must get preauthorization for certain covered expenses such as a hospital stay. If you don't get the required preauthorization, the amount of benefits available will be reduced or the expenses will not be covered at all. This means your cost will be higher.
	+ You must complete claim forms and file claims with your health care company to receive payment of benefits.
	+ The plan will not cover any benefit reductions due to failure to preauthorize certain treatments.
	+ The plan will not cover any charges above the allowable amount.
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| https://secure.benergy.com/images/spacer.gif | **What happens if I need specialty care that is not available from in-network providers where I live?**

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|   | You may be referred to an out-of-network provider if you need specialized care that your health care company determines to be medically necessary and that is not available through an in-network provider in your area. As long as you use the provider you're referred to as authorized by your health care company and follow your plan’s rules, you'll be covered for that care at in-network benefit levels. |

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| https://secure.benergy.com/images/spacer.gif | **What happens in an emergency?**

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|   | In a true emergency, get the care you need as quickly as you can. If you are able, contact member services for your health care company at the number on your ID card, even in an emergency. However, even if you are unable to contact member services, get the care you need. Even if you need to go out-of-network, your plan will cover emergency care at in-network benefit levels as long as you follow the plan rules. |

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| https://secure.benergy.com/images/spacer.gif | **What happens if I need care while I'm traveling?**

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|   | If it's not an emergency and you need care while traveling, call member services for your health care company at the number on your ID card. Member services can refer you to an in-network provider.In a true emergency, get the care you need as quickly as you can. If you are able, contact member services even in an emergency, and your health care company can help you decide where to go for care. However, even if you are unable to contact member services, get the care you need. Even if you need to go out-of-network, your plan will cover emergency care at in-network benefit levels as long as you follow the plan rules.Check to see how your plan defines a true emergency. Examples typically include severe bleeding, chest pain, and unconsciousness. Also check to see how soon after the onset of the emergency you must notify your health care company in order to be covered in-network. |

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| https://secure.benergy.com/images/spacer.gif | **What is a deductible?**

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|   | A deductible is the part of eligible expenses you must pay before the plan begins to pay a percentage of your eligible expenses. |

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| https://secure.benergy.com/images/spacer.gif | **Are there expenses that don't count toward my deductible?**

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|   | Yes. Some of your expenses will not count toward your deductible. For example, any penalty you may pay because you failed to preauthorize treatment through your health care company will not count. For out-of-network care, amounts your care provider charges above the plan’s allowable amount for a given service also will not count toward your deductible. |

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| https://secure.benergy.com/images/spacer.gif | **What is a copayment?**

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|   | A copayment generally applies to in-network care. When you stay in-network, you may pay a fixed amount at the time you receive certain services. That amount is called your copayment. |

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| https://secure.benergy.com/images/spacer.gif | **What are covered services?**

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|   | Covered services are services covered by the plan. No medical plan covers everything. If you obtain services that are not covered services, you pay the full cost for those services. |

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| https://secure.benergy.com/images/spacer.gif | **What is an out-of-pocket maximum?**

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|   | An out-of-pocket maximum is the most you would have to pay out of your own pocket for eligible expenses. Check your Benefits Overview for details. Once you reach the out-of-pocket maximum for a given year, the plan would pay all eligible expenses for covered services until any lifetime maximum benefit is reached.Not all expenses count toward an out-of-pocket maximum. Expenses for services that are not covered under the plan, amounts over any allowable amount limit, and penalties for not preauthorizing care when needed would not count toward your out-of-pocket maximum. |

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| **What is a lifetime maximum?**

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|   | A lifetime maximum is the most that will be paid by the plan for covered services for a given plan member. Once you reach the lifetime maximum, you pay all expenses over that amount. |

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