
**What You Need to Know About
Healthcare in the U.S.:
A Guide for International Scholars**



I. INTRODUCTION

This guide was written specifically for individuals who are unfamiliar with the American healthcare system and the complex and daunting processes of selecting health insurance and accessing medical care in the United States. Our most important piece of advice is this: **Do not be afraid to ask questions.** Navigating through healthcare issues in the U.S. is extremely difficult, even for Americans. You **must** ask questions at each step of the process to ensure that you are making the best choices for yourself and your family. This guide is not intended to answer all of your questions, but it should give you enough background about healthcare in the U.S. so that you feel comfortable requesting the additional information you need.

The guide is organized into four distinct sections. Section II discusses the characteristics of the U.S. healthcare system and points out some of the ways it might differ from the system in your home country or other systems with which you may be more familiar. Section III covers the particulars of medical insurance, including why it is so important for you to have insurance while you are in the U.S. Section III also discusses how to choose medical insurance that will meet the needs of you and your family. Section IV reviews where and how to obtain medical services. Section V covers evacuation and repatriation.

Throughout this guide, terms that have a special meaning in a healthcare setting are highlighted in italics. All italicized terms are defined in the *Glossary of Terms* at the end of this document.

We hope that you find this guide a useful introduction to the U.S. healthcare system. We invite you to contact us with comments and suggestions, your own experiences with medical care in the U.S., and any questions that are not addressed here.

II. AN OVERVIEW OF HEALTHCARE IN THE UNITED STATES

SYSTEM, WHAT SYSTEM?

Many commentators have observed that the U.S. healthcare system is not really a system at all. Rather, it is a patchwork of health care providers who practice in various configurations and of multiple payers -- primarily private, but public as well.

Providers consist of *primary care providers*, *specialists*, and the nursing and administrative staff that support them. Primary care providers are often physicians who have been trained as General Practitioners (GPs) or in internal or family medicine. *Nurse Practitioners* also provide primary care. Primary care is the term used to describe more basic services such as routine medical examinations and the treatment of illnesses like the cold or flu. Primary care providers often serve as a patient's initial point of entry into the healthcare system, even if the patient has a more serious condition that must be referred to a specialist.

Specialists are physicians who are trained and certified in a particular medical specialty such as Cardiology (heart and circulatory system), Dermatology (skin disorders), or Oncology (the treatment of cancer). Often, a patient is required to obtain a referral from his or her primary care provider before s/he will be able to see a specialist.

Healthcare providers may practice independently of a larger organization as solo practitioners or in partnership with one or more other providers. They may also be part of a clinic that employs

Healthcare providers may practice independently of a larger organization as solo practitioners or in partnership with one or more other providers. They may also be part of a clinic that employs many providers, or be an employee of a medical group that is directly affiliated with a hospital or network of hospitals. For example, many physicians in the Denver metro area are affiliated with the University of Colorado Hospital. Some of these physicians are located at the Anschutz Medical Center, others practice at satellite *outpatient clinics* throughout the city and suburbs.

Medical facilities and hospitals may be owned by a corporation and operated for profit; they may be owned by non-profit organizations, including religious groups; or they may be owned by the local government where they are located. In the Denver metro area, Kaiser Permanente is a nonprofit organization that operates a large network of clinics. HealthOne is a joint venture between Hospital Corporation of America and The Colorado Health Foundation, a nonprofit. As the largest healthcare system in Denver, HealthOne operates seven hospitals and 35 outpatient clinics.

Denver Health is owned and operated by the city of Denver. It is an integrated system that includes the Denver Health Medical Center and Rocky Mountain Regional Trauma Center; eight family health centers located in neighborhoods throughout the city; the emergency response system; the Rocky Mountain Poison and Drug Center; the Denver Public Health department; as well as other facilities.

Among the entities that pay for the medical services provided to individuals are a large number of private insurance companies; state and federal government agencies and programs, which pay the healthcare expenses of the elderly, poor children and low-income adults; and individual health care consumers.

HEALTHCARE IN THE U.S. IS VERY EXPENSIVE

You've probably heard that healthcare in the U.S. is very expensive, but you may not realize exactly what this could mean for you and your family. Here are some examples that illustrate the serious financial consequences that an unexpected injury or illness could have for you:

If you got sick and had to be hospitalized, the daily hospital charge for your room, board, and doctor's fees could easily be \$2,500 a day, not including any medication, surgery, medical tests, laboratory costs, and other related expenses.

If you were out skiing and had a bad fall that caused very serious injuries, you might be sent to an *Intensive Care Unit (ICU)*. This is a specialty facility which treats individuals who are seriously ill or injured. A stay in the ICU can cost as much as \$30,000 a day!

As you might expect, having a baby in the United States is expensive too. A routine delivery can cost around \$6,000. For a *cesarean delivery* with no complications, you may be charged well over \$12,000. If there are complications, costs can quickly escalate by thousands of dollars.

III. MEDICAL INSURANCE

Unlike many countries where the government provides and/or pays for the healthcare needs of its citizens, and sometimes non-citizens living in within its borders, individuals in the U.S. are responsible for their own healthcare costs unless they are elderly or have a very low income. Individuals can pay for healthcare by purchasing health insurance that covers certain medical treatments and hospital stays, by paying for healthcare services *out-of-pocket*, or by combining health insurance coverage with out-of-pocket payments.

Private healthcare insurance works by taking a group of people (for example, all of those who are employees or who are the immediate family members of employees of a particular company) and pooling the money that the company and/or the employees pay for insurance policies (*premiums*). Then, when an individual who is a member of that group visits a doctor or goes to the hospital, the bill -- or at least a portion of the bill -- is paid for out of the pool of money collected from each member's premiums.

It is common for individuals and families in the U.S. to obtain health insurance through their employers. In 2011, 58.3 percent of Americans under age 65 received health insurance through their employers or family members' employers.

Because health insurance has traditionally been obtained through an employer, people who are self-employed or who do not have a job do not have easy access to health insurance. Unlike other wealthy, industrialized countries, not everyone in the U.S. has healthcare coverage. According to the U.S. Census Bureau 15.7 percent, or nearly 48.6 million, of Americans did not have healthcare insurance in 2011.

YOU MUST HAVE MEDICAL INSURANCE!

You must have medical insurance while you are in the U.S. AND your insurance must adequately provide for your healthcare needs as well as those of any family member(s) who accompany you.

To protect yourself and your family, you must have adequate healthcare coverage in place from the moment you arrive in the U.S. until after you leave the country. You never know when you or one of your dependents may become ill or suffer an injury. You cannot afford to wait to purchase insurance until after you or a family member gets sick because insurance companies often exclude "pre-existing conditions." This means that an insurance company will refuse to cover treatment for an illness or injury that you had before you bought insurance.

Paying for necessary treatment without adequate medical insurance could cause serious financial hardship, depending on the severity of the injury or disease. This is not an idle warning. The burden of healthcare costs not covered by insurance causes very grave financial difficulties for many people in the U.S. According to many sources, half of all bankruptcies in the U.S. are due to medical bills that people cannot afford to pay.

Further, not having good medical insurance may prevent or limit your access to healthcare when you need it. One study found that Americans with below-average incomes, a group more likely not to have adequate medical insurance, were much more likely than their counterparts in other countries to report not visiting a physician when sick, not getting a recommended test, treatment or follow-up care, not filling a prescription, or not seeing a dentist when needed because they felt they couldn't afford it.

Finally, U.S. immigration regulations require many non-immigrants to carry medical insurance, either as a condition of maintaining status or as a part of their financial certification. If you are in F, J, or M status, you are required by law to have a certain level of medical insurance and also to have insurance that covers medical evacuation and repatriation of remains.

OBTAINING MEDICAL INSURANCE

In some cases, the organization that you will be working for will provide health insurance for you, and may also provide health insurance for the dependent family members who accompany you. If your employer does not offer medical insurance as part of your employment benefits package, you will be responsible for purchasing your own health insurance. You can ask your employer or sponsor for advice; visit the National Association of Health Underwriters at www.nahu.org to find and compare health insurance plans; or go to the Colorado Division of Insurance at <http://www.dora.state.co.us/insurance/> for consumer information on medical and other types of insurance.

If your employer does offer medical insurance to you and your dependents, you will be able to enroll within a certain period of time after your employment begins. Each year, you will be able to change your policy during your employer's *open enrollment period*, usually at the end of the calendar or fiscal year.

In addition, you will have the opportunity to modify your insurance plan if certain events happen to you or your family. Depending on the event, these special enrollment periods can last either 30 or 60 days from the date of the event. For example, if you get married, you will be allowed to add your spouse to your insurance plan. If you or your spouse have a baby, you will be allowed to add the new child to your existing plan.

Only the most expensive medical insurance policies cover 100 percent of all healthcare services. Be aware that medical insurance in the U.S. does not usually cover services that are considered "alternative treatments" such as massage, acupuncture, or herbal remedies. Nor does it cover *over-the-counter drugs*. If you use alternative treatments or take medications that do not require a doctor's prescription, you should expect to pay for them yourself.

In the U.S., many medications (drugs) are only available through a prescription from a physician. Be aware that some of the drugs that you could buy at home without authorization from a doctor will require a prescription here. Most likely, your doctor will require that you schedule an appointment to be seen in-person before s/he will write a prescription.

CHOOSING A PLAN

Even when your employer buys insurance for you, you may have to select from among a number of different plans on offer. Several broad categories of plans are outlined below.

Fee-for-Service plans pay a fee for covered services received from a medical provider. This type of coverage allows you to choose which doctors you want to see, including specialists. If you need to see a specialist, you will be able to choose who you want to see yourself and will not need to get a referral from a primary care provider. However, you will only be reimbursed for covered services that are listed in the plan's benefits summary. Even then, you may not be reimbursed for all of the cost. You will be responsible for any portion of the bill that is not paid for by the insurance company. Fee-for-service plans generally charge a higher *premium* for the ability to select your own doctors.

Preferred Provider Organizations (PPOs) require you to choose the doctors you see from a list of physicians who have agreed to provide services under the plan. You may choose your own specialists, as long as they are on the PPO's list of providers. The premium will be lower than a fee-for-service plan will be lower because of this restriction.

Point of Service (POS) plans require your primary care provider to choose a specialist for you. The other features of POS plans are the same as PPOs.

Health Maintenance Organization (HMO) insurance plans restrict who you can see and where you can obtain services, but they offer the least expensive type of medical insurance.

Below is a list of ten factors you may want to consider when choosing a specific plan. Even though some of these factors may be difficult to assess if you are not in the Denver area, it may be helpful to be aware of them before you arrive.

1. Access to Doctors: Some health care plans require you to use their network of doctors. If there is a specific physician that you would like to be able to see, check first to see if your doctor is included in the health care plan you are considering. If you need to choose a new doctor from the health care plan consider researching the doctors credentials by calling the medical office she works for or checking with the [AMA](#). Location and availability are other factors to consider when choosing a doctor. You will also want to find out the hours of the facility where the doctor is located and see if the doctor is available all of those hours as some doctors work in multiple facilities.

2. Access to Specialists: If you have specific medical conditions or anticipate needing a specialist, you will want to find out the procedures required to use a specialist under the plan. Check to see if you need a referral from your primary care provider before seeing a specialist. Also ask how long a referral remains active. If you have a specific specialist in mind, you will want to find out if that specialist belongs to the plan's network of doctors.

3. Pre-Existing Conditions: Coverage of pre-existing conditions can vary widely between plans. Some plans completely exclude pre-existing conditions. For example, if you have diabetes, a plan may refuse to pay for any medical treatment related to your pre-existing diabetes. Some plans will fully cover pre-existing conditions. Other plans fall somewhere in-between, and may cover only a certain percentage of the cost associated with a pre-existing condition or may cover it only after you have been on the plan for a specific amount of time. The Health Insurance Portability and Accountability Act (HIPAA) guarantees coverage for pre-existing conditions if you are joining a new group plan from your employer and were insured the previous twelve months.

4. Emergency and Hospital Care: You will want to find out what emergency rooms and hospitals are covered on your plan. In addition, find out how the plan defines "emergency." Sometimes your definition of an emergency may not be the same as the health care plan you are considering and you could seek emergency treatment only to find out that it was not covered under the plan. Also, check to see if you need to contact your primary care provider before seeking emergency care.

5. Regular Physicals and Health Screenings: If you get regular physicals and health screenings you will want to make sure they are covered. Most managed care plans cover one check-up a year (also known as an annual physical), but some independent insurance plans do not cover these types of preventative services at all. Also, if you have young children verify that *well-baby check-ups* and immunizations are covered.

6. Prescription Drug Coverage: If you currently use *prescription drugs* on a regular basis or think you may need to in the future, you will want to look for a plan that offers good prescription drug coverage. Be aware that coverage can vary enormously from plan to plan. Some plans do not cover prescription drugs at all, while others cover all types of prescription drugs. Still others require varying co-pays for different types of drugs. Also, if you are unwilling or unable to use the generic forms of prescription drugs, find out how that will affect the price of prescription drugs under the plan.

Let's say that your insurance plan does not cover (pay for) prescription drugs. If you go to the doctor because you have a persistent sore throat and cough, and he prescribes antibiotics to treat your illness, you will have to pay for the medication yourself, because the cost of prescription drugs is not covered by your policy.

Compare that to an insurance plan that covers prescription drugs, but requires a \$15 *co-pay*. If your doctor prescribes a medication that costs \$60, you will have to pay \$15 yourself, but your insurance company will pay the remaining \$45, either by reimbursing the pharmacy directly or by reimbursing you when you file a claim.

7. Obstetrician-Gynecologist (OB-GYN): If you or your spouse regularly sees an *Obstetrician-Gynecologist*, find out if the doctor you want to see is covered in the plan you are considering. Also, if you or your spouse is pregnant or may become pregnant while you are in the U.S., find out how much you will have to pay out-of-pocket for pregnancy care and child birth under the plan.

8. Additional Benefits: Consider what additional services are covered when comparing health plans. Some examples of additional services that may be important to you include: dental and/or vision benefits, *health savings accounts*, mental health care, counseling, experimental treatments, alternative treatments, or chiropractic care.

9. Costs: Once you have decided what you want in your health care plan, you must compare costs. Both premiums and out-of-pocket costs should be considered as you are evaluating the cost of insurance.

Premium – This is the monthly cost that you will have to pay for insurance coverage. If you obtain insurance through your employer, the employer may pay all or a portion of the premium. It is more and more common, however, for individual employees to have to pay at least part of the monthly premium.

Co-insurance – This is the percentage of overall total for a medical service that the policy-holder must pay out of his or her own pocket. For example, if the insurance policy pays 80 percent of all medical services, your co-insurance percentage would be 20 percent. Because healthcare is so expensive, even 20 percent of the total can be significant.

Co-payment – A co-payment (also called a co-pay) is the fee you must pay yourself when visiting your doctor, hospital, or emergency room. A co-payment can vary according to what type of medical appointment or procedure you are having done. For example, the co-pay for a routine medical check-up may be \$20 while the co-pay to see a specialist may be \$30. You have to pay the co-pay amount when you check-in for your medical appointment, and the insurance company will not reimburse you for this amount. The higher the co-payments, the lower your premiums will be.

Deductible – Many insurance policies may require you to pay a certain amount out-of-pocket before medical services will be covered under the insurance policy. For example, you may be required to pay the first \$500 of medical expenses that you and your family incur each year. After you've paid \$500 worth of medical expenses, your policy will cover any subsequent healthcare expenses for the rest of the year. The higher the deductible, the lower your insurance premium will be. In addition to finding out the amount of the deductible, you will also want to know if your deductible needs to be paid before any services can be used. Also, find out what percent the health care will pay after your deductible, as well what percent they will pay if you need to use a doctor, hospital, or specialist that is out of network. Note that any amount you pay for co-payments does not count toward your deductible.

10. Exclusions: You will want to review each plan's *exclusions* list to find out what is not covered and to see if any condition you currently have or expect to have in the future, is included on that list.

11. Limitations: Some plans have lifetime limits on how much the health care plan will pay and some have lifetime limits along with yearly limits. Given how expensive medical care can be, most experts recommend a plan that provides coverage for at least \$1 million in health care costs.

Please go to Appendix I for a comparison plan.

12. Balancing Price and Level of Coverage: To choose the medical insurance plan that is right for you, you must prioritize what is important to you based on your individual healthcare needs and those of your family members as well as the price you are willing to pay for a higher level of coverage.

If you do choose a plan with a high deductible and lower premium, you may also want to establish a *health savings account* (HSA). The money you save on premiums can be deposited into the HSA before you pay income taxes on it. The funds then grow in the HSA until you use them to pay for any unexpected medical expenses. The only drawback is that if you do not use all the funds, you will lose them. Therefore, you should carefully think through your expected out-of-pocket medical expenses for the year before opening an HSA.

If you don't understand something about your options, don't hesitate to ask questions! Medical insurance is complicated and difficult to understand, even for Americans. Do not sign anything until you feel comfortable that you understand 1) how much you will need to pay, both for premiums and any out-of-pocket expenses, and 2) what benefits (dollar amounts of coverage, access to providers and services, etc.) you will get in return. You need to make sure that you understand how your insurance plan works. Don't wait until you or a family member has a medical emergency to ask question.

ACCESS TO GOVERNMENT HEALTH BENEFITS

It is a violation of U.S. immigration law for individuals who are in non-immigrant categories to accept public assistance from federal, state, or local government agencies. Accepting such assistance could jeopardize your ability to obtain a visa or to reenter the United States. You might also be forced to pay back any funds that you receive for medical expenses.

IV. ACCESSING MEDICAL SERVICES IN THE U.S.

YOUR INSURANCE CARD IS EVERYTHING!

The insurance company from whom your policy was purchased will send you an insurance identification card. You must show this card to service providers to prove that you have insurance. Keep in mind that the card will be valid only as long as the required premiums are paid.

Keep your insurance card with you at all times. If you have a medical emergency, emergency room personnel will ask you for your insurance card. If you seek treatment at an urgent care facility, the front desk will ask you for your insurance card. When you call to schedule a doctor's appointment, the person you speak with will ask you for information from your insurance card. When you go to that doctor's appointment, the receptionist will ask you for your insurance card when you arrive. If you go to a pharmacy to pick up a prescription, the pharmacist will ask you for your insurance card.

PAYMENT VERSUS REIMBURSEMENT

Some healthcare providers will work directly with your insurance company to obtain payment. Others will require that you pay the full amount at the time service is provided, and then seek reimbursement yourself from your insurance company by filing a *claim*.

You should ask about the cost of services and the service provider's payment arrangements with your insurance company when you make an appointment or receive medical treatment. This way, you will know what to expect and can make any necessary financial arrangements (i.e., moving money from savings to a checking account to pay for your medical treatment).

If you are required to file a claim for reimbursement, be sure to complete the claim forms accurately (call the insurance company if you have any questions about the information that is required). If the insurance company contacts you for additional information, respond immediately to the request. Failing to fill out claim forms correctly and/or failing to respond quickly to a request for additional information could result in a delayed payment to you or to your doctor or other provider.

WHERE TO GO FOR MEDICAL TREATMENT

Primary Care Provider - For medical check-ups or other routine doctor visits that you have time to schedule in advance, you will want to see a Primary Care Provider. The practitioners who provide these services include General Practitioners (GPs), Physicians who specialize in Internal Medicine, and Nurse Practitioners. For women, OB-GYN's may often be designated as Primary Care Providers. If your insurance plan is not a Fee-for-Service plan, you should refer to the list of providers that the insurance company gave you to select a physician.

Specialist – In the U.S., any provider who is not a primary care provider is considered a specialist. Specialists include OB-GYNs, Orthopedic Surgeons, Cardiologists, Oncologists, etc. Unless you have Fee-for-Service health insurance, you will need to obtain a *referral* from your Primary Care Provider before you can make an appointment to see a specialist.

Prescription Drugs – Retail pharmacies in Denver are located in drug stores including Walgreen's and Rite Aid, in discount stores like Target and Wal-Mart, and in most supermarkets. You should shop around for the best prescription prices, especially if you have an insurance plan that does not cover prescription drugs or requires you to pay a certain percentage of the cost. Prices can vary significantly among pharmacies.

You can either bring the written prescription that your doctor gives you to the pharmacy; or you can have your doctor telephone the pharmacy directly with the information needed to fill your prescription. Remember to ask your Pharmacist any questions you may have about side effects, drug interactions, or related concerns.

Some insurance plans have a mail-order pharmacy option. To use this option, you send your doctor's prescription for routine maintenance drugs (e.g., blood pressure medications, drugs to control blood sugar, and other drugs that are used on a regular basis) to the mail-order pharmacy. The mail-order pharmacy will usually send you a 3-month supply of your medication in the mail. You will still pay the required co-pay, but the cost is generally lower than it would be at a retail pharmacy.

Urgent Care Facilities are designed to provide immediate medical care during evenings or weekends when your doctor's office or clinic is not open. Often, you can obtain services on a walk-in basis, although you may be able to set a specific appointment time at some locations. Urgent care facilities treat a variety of non-life and limb threatening injuries and illnesses for children and adults, including:

- sports injuries, sports physicals, and sports medicine
- school, daycare, and camp physicals
- colds, flu, etc.
- sprains and strains
- strep and sore throat
- headaches, abdominal pain / stomach aches
- infections and wounds
- non-life threatening cuts requiring stitches

There are two important advantages to being treated at an urgent care facility instead of an emergency room for the types of conditions listed above: 1) You will be seen faster; and 2) you will have to pay much less for treatment.

In the Denver Metro Area, several providers offer urgent care facilities.

AfterOurs Urgent Care – www.afteroursinc.com. Multiple locations. (303) 952-0670.

Concentra Urgent Care – www.ConcentraUrgentCare.com. Multiple locations.

Guardian Urgent Care 1 Broadway, Building A, Suite 100, Denver, CO 80203. Tel: (720) 381-2317.

HealthONE – Multiple locations. Tel: (877) 432-5846.

Emergency Room (ER) – If you have a medical condition that is a life or limb threatening emergency, call 911 for an ambulance or go immediately to your nearest hospital emergency room. Emergency room treatment is required for conditions like extensive bleeding, broken bones, or a severe allergic reaction.

There are a number of hospitals in the Denver Metro Area. These include:

Aurora South - www.auroramed.com. (303) 695-2600.
Centura Health: St. Anthony Central Hospital – www.centura.org. (303) 629-3511.
Denver Health – www.denverhealth.org. (303) 436-6000.
North Suburban Medical Center – www.northsuburban.com. (303) 254-6941.
Presbyterian-Saint Lukes Medical Center – www.pslmc.com. (303) 584-6045.
Rose Medical Center – www.rosemed.com. (303) 320-2244.
St. Joseph Hospital – www.exempla.org. (303) 837-6800.
Swedish Medical Center - www.swedishhospital.com. (303) 788-5000.
The Children’s Hospital - www.thechildrenshospital.org. (720) 777-1234.
University of Colorado Hospital – www.uch.edu/about/index.aspx. (720) 848-0000.

In addition to emergency services, hospitals provide other types of care such as certain medical tests, in-patient procedures that require an overnight stay, and out-patient procedures that require you to be in the hospital for only a part of the day.

MENTAL HEALTH SERVICES

Health is not just about your physical condition, but also about your mental wellbeing. Moving, starting a new job, and adjusting to a new culture are very stressful. During your initial few months in the United States, you should be especially mindful of how you are feeling and take special steps to take care of both your physical and mental health.

An Employee Assistance Program (EAP) may be offered as part of your health insurance benefits. EAPs are intended to help employees deal with personal problems that might adversely impact their work performance, health, and well-being. EAP services generally include assessment, short-term counseling and referral services for employees and their family members.

V. INSURANCE FOR MEDICAL EVACUATION AND REPATRIATION OF REMAINS

Scholars who are in J status are required to have insurance coverage for *medical evacuation* and *repatriation of remains*. We strongly encourage scholars in other visa categories to purchase this type of insurance coverage as well.

Medical evacuation coverage allows you to return to your home country to obtain medical treatment and hospital care in the case of a serious accident or illness. Insurance that covers repatriation of remains will pay for all or part of the cost of returning the body of the covered individual to his or her home country for funeral or burial.

While it may be uncomfortable to think about anything so dire as a serious accident or illness or even death happening while you are working in the United States, being prepared can save you and your family tens of thousands of dollars and can make what is already a difficult time a bit less painful for you and your loved ones.

APPENDIX I

Often, the plans from which you can choose are laid out in a schedule that makes it easier to compare the varying features of each plan. It might look something like this:

Plan Name	Provider Coverage	Prescription Drug Covered	Co-Pay Required	Monthly Premium
Plan A	Services from all providers is covered.	All prescription drugs covered with \$15 co-pay.	No co-pay for preventative check-ups, \$20 for all other services.	\$220 (individual) \$275 (family)
Plan B	100% of in-network providers, 80% for doctors outside the network.	100% of generic prescription drugs covered; 80% of non-generics covered.	Co-pay of \$20 for all services.	\$200 (individual) \$250 (family)
Plan C	80% of services provided by in-network. Covers no services by providers outside the network, except in an emergency.	No prescription drugs are covered.	Plan members are responsible for 20% of the cost of all services received.	\$150 (individual) \$200 (family)

GLOSSARY OF TERMS

Cesarean Section Delivery – A Cesarean section (C-section) is a surgical procedure to deliver a baby. The baby is taken out through the mother's abdomen. In the United States, about one in four women have their babies this way.

Claim – The notification that you or your doctor send to your insurance company to receive reimbursement after you have seen a medical provider and incurred a covered medical expense.

Co-insurance – The amount you must pay for medical care after your expenses reach the amount of your deductible. Often, a plan will pay 80% and your co-insurance amount will be 20% after you reach your deductible.

Copayment (also called a co-pay) – The amount that you are required to personally pay when you see a medical provider. After you have paid your co-pay amount, the insurance company will generally pay any remaining portion of the bill. Typically, the co-pay amount ranges from \$15 to \$40 per visit.

Deductible – The amount of money you must pay yourself for medical services during the course of a year before your insurance policy will begin to pay for medical services. The higher the deductible, the lower the premium.

Enrollment Period – The limited period of time after beginning a job with a new employer when a new employee can enroll in employer-sponsored health insurance.

Exclusions – Services that are not covered by a particular plan. This means that the insurance company will not pay for these services, and you will be completely responsible for their cost.

Formulary – The list of drugs that are covered under a specific insurance plan.

Health Maintenance Organization (closed panel) – In a closed panel Health Maintenance Organization (HMO), all of the physicians and other medical practitioners that provide care work directly for the HMO. As a result, the HMO and its staff must provide all services in order to be covered under the healthcare plan. If you seek services outside the HMO, you will have to pay for them yourself.

Health Maintenance Organization (open access) – A Health Maintenance Organization (HMO) with open access requires that you first see a “primary care provider” that you have selected from a list of physicians the HMO will give to you or, more likely, give you access to via a website. Your insurance will pay for visits to your primary care provider and for most of the services (visits to specialists, tests, medications) that he or she recommends. If you independently seek services from another provider without first consulting your primary care provider, any expenses you incur will generally NOT be covered.

Health Savings Account – An account established at the beginning of the year using pre-tax dollars which the employee then uses to pay for qualified medical expenses during the year.

Indemnity Plan – A type of insurance plan where you pay an insurance premium and then choose your own physician and other health care providers, refer yourself to specialists, and otherwise make independent decisions about what type of care you need. Under this plan, the insurance company pays a fixed percentage (for example, 80%) and usually requires you to pay a deductible and co-payments.

Intensive Care Unit (ICU) – A specially-equipped area of a hospital where care is provided to severely injured or seriously ill patients. Once the patient's condition stabilizes, s/he is generally transferred to another unit of the hospital.

Medical Evacuation – A type of insurance that covers the cost of evacuating a sick or injured individual to his or her home country.

Nurse Practitioner – A healthcare professional who is not a medical doctor, but who has the training necessary to perform many of the routine duties performed by physicians.

Obstetrician-Gynecologist (OB-GYN) – A medical doctor who specializes in women's health, including the care of the female reproductive system and care related to pregnancy. This physician serves as a consultant to other physicians, and as a primary physician for women.

Open Enrollment Period – The once-a-year window of opportunity when companies allow you to change your health benefits even without a “qualifying event” such as a marriage, divorce, or the birth of a child.

Out-of-Pocket – refers to medical expenses paid out of one's own personal funds.

Outpatient Clinics – A medical facility that provides medical care or treatment that does not require an overnight stay.

Over-the-Counter Drugs (OTC Drugs) – Medications, such as aspirin, that are available without a doctor's prescription.

GLOSSARY OF TERMS

(CONTINUED)

Outpatient Clinics – A medical facility that provides medical care or treatment that does not require an overnight stay.

Over-the-Counter Drugs (OTC Drugs) – Medications, such as aspirin, that are available without a doctor’s prescription.

Plan – Distinguishes different levels of medical insurance coverage from the same company. For example, a plan called “Aetna Full Coverage” may be a bit more expensive, but provide unlimited access to healthcare specialists, limit the co-payments you are required to make out-of-pocket, and pay for prescription drugs. In contrast, a plan called “Aetna Health” may be less expensive, require that you obtain a referral from your primary care physician before seeing a specialist, require a larger co-payment at the time you receive service, and exclude prescription drugs.

Pre-existing Condition – An illness or injury that you already have before you purchase healthcare insurance.

Preferred Provider Organization (PPO) – This type of insurance plan provides incentives for insured individuals to seek care from practitioners who are designated as “preferred providers” by the insurance company. Under a PPO plan, the insurance company will generally cover a higher percentage of the medical costs you incur, and may sometimes allow you to pay a lower deductible, if you choose a physician or other medical practitioner who participates as a “preferred provider.”

Premium – The amount that the employer and/or the individual pay to belong to an insurance plan. The price is usually calculated on a monthly or pay-period basis.

Prescription Drugs or Prescription Medication – Medications that can only be obtained with a doctor’s prescription. Generally, you will first need to see your physician so that s/he can evaluate your symptoms. The doctor will then give you a “script” that you can take to a pharmacy to obtain the medication you need.

Primary Care Provider (also referred to as a *Primary Care Physician* or *Primary Care Practitioner*) – Usually a family practice doctor, internist, OB-GYN, or pediatrician. He or she is your first point of contact with the health care system, particularly if you are in a managed care plan.

Referral – Permission obtained from your Primary Care Provider that allows you to see a specialist. You may need to obtain such permission to ensure that the specialist’s services are covered under your healthcare plan.

Repatriation of Remains – A type of insurance that covers the cost of returning the body of a deceased person to his or her home country for a funeral and/or burial).

Well-Baby Check-Ups – Periodic pediatric examination for infants and toddlers to verify that the child is developing normally.