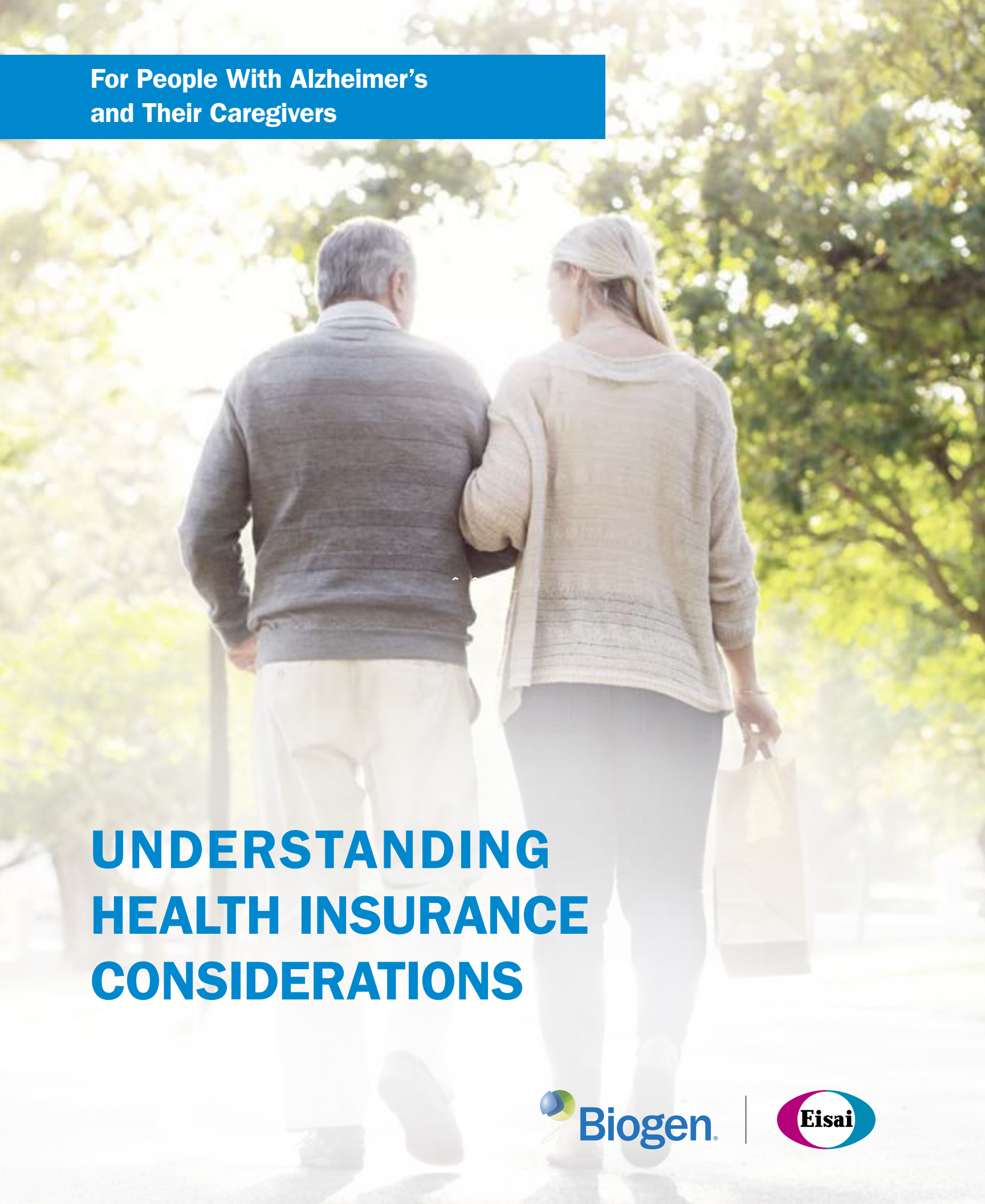
For People With Alzheimer's and Their Caregivers



UNDERSTANDING HEALTH INSURANCE CONSIDERATIONS

Biogen | Eisai

If you have Alzheimer's, you may worry about coverage for the costs related to your doctors' visits, diagnostic tests, potential treatments, and other expenses associated with managing your condition.

This guide is here to help you learn about some insurance options. It may help you research various plans for your care and considerations when discussing your options with your doctor, social worker, or health insurance specialist.

CHOOSING A MEDICARE PLAN THAT IS RIGHT FOR YOU

Many people with Alzheimer's qualify for Medicare. Medicare may be able to cover the costs of your doctor and hospital visits. It may also cover many of your medications. There are different Medicare plans; choosing a plan is a big decision.

Here are some things to think about:

- There are set times to enroll in Medicare. Find out when you can sign up
- You may need more than 1 plan (eg, 1 for your prescription and 1 for your doctor visits)
- You may be able to get help paying for your care from your state or other resources

CHOOSING A PRIVATE INSURANCE PLAN THAT IS RIGHT FOR YOU

Private insurance may be another option to help you pay for your treatment. Choosing a private health plan that's right for you is an important decision.

Here are some things to think about:

- If your employer offers health insurance, you typically sign up at the start of your employment, or you may want to join your company's insurance if you have had a major life change, such as no longer being covered on a spouse's health plan. There are many different types of private health insurance (including private insurance plans offered by the government through the Health Insurance Marketplace)
- You may need more than 1 insurance card for your healthcare benefits (eg, 1 for prescriptions and 1 for doctor visits)
- You may be able to get help paying for your care from your state or other resources

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MEDICARE

OVERVIEW OF MEDICARE

Medicare is an insurance plan offered by the government. You may be able to get Medicare if you

ARE AGE 65 YEARS OR OLDER **OR** ARE DISABLED AND YOUNGER THAN AGE 65 YEARS **OR** HAVE PERMANENT KIDNEY FAILURE OR END-STAGE RENAL DISEASE

Medicare has 4 parts

Part A
Inpatient Hospitalization

Part B
Outpatient Clinic and Hospital Services

Parts A and B are known as "Original Medicare"

Part C
Medicare Advantage

Part C provides some services that Parts A and B cannot provide alone

Part D
Prescription Drug Coverage

Part D covers prescription drug costs

Understanding Part A and Part B (Original Medicare)

Original Medicare includes Part A and Part B, which cover different healthcare services.

Services	
Part A	**Part B**
• Hospital visits • Nursing homes • Hospice care • Some home healthcare services	• Visits to infusion or hospital clinics for treatments you receive from your doctor • Doctor visits • Some home healthcare services • Medical equipment • Wellness services • Lab tests • Preventive screenings

Part B, which is optional,* also covers some drugs that you would not administer yourself, like those you get at a doctor's office or hospital outpatient setting.

Costs		
	Part A	**Part B**
Deductible	• [$1408] per benefit period†	• Annual deductible of [$198 for 2020]
Coinsurance	• [$0] for days 1 through 60 per benefit period • [$352] for days 61 through 90 per benefit period • [$704] for days 91 and beyond per benefit period • You pay for all costs after your lifetime reserve days‡ have been used	• Once the deductible is met, you pay a coinsurance of [20%] for all services
Premium	• Many people don't pay a Part A premium because they paid Medicare taxes when they had jobs • If you don't get premium-free Part A, you pay up to [$458] each month	• The standard monthly premium amount is projected to be [$148.50] in [2021] • You may pay a higher premium depending on your income

Many beneficiaries also purchase a Medigap plan to assist with the [20%] coinsurance (see page 8).

*Although Medicare Part B is optional, there are penalties for enrolling after the due date. See pages 12 and 13 for information on how your birthday and employment status at the time of enrollment can play a factor.

†Medicare coverage of up to 90 days in the hospital during a period of illness.

‡An additional 60 days of hospital coverage after the first 90 days.

Important Details to Remember for Part A and Part B

- You can sign up when you are close to age 65
- When you sign up for Medicare, you are enrolled in Part A and/or Part B. You can choose not to enroll in Part B when you enroll in Medicare, but you may have to pay a higher monthly premium
- If you are younger than age 65 and disabled, you may be automatically enrolled in both Part A and Part B
- You will receive your Medicare card in the mail

Medigap Policy Can Help Pay for Medicines and Healthcare Services

Ways Medigap Can Help

If you have Part A and Part B, you may consider a **Medigap** policy. Medigap policies are sold by private insurance companies. This is also called **Medicare Supplemental Insurance**. It can help pay for

- Copays and coinsurance for your treatments
- Copays and coinsurance for other medicines
- Coinsurance or deductibles for visits to hospitals, neurologists, and other healthcare specialists

Things to Know About Medigap

Medigap may help you pay for costs that are not covered by your Part A and Part B plans.

- You must have Part A and Part B to get Medigap
- You cannot get Medigap if you have Medicare Advantage (Part C)
- A Medigap policy charges a monthly premium
- There are many types of Medigap policies with varying monthly premiums
- Costs vary and can rise as you get older

You can buy Medigap for 6 months after the month you turn 65 if you have been enrolled in Part B. If you wait, you may not be able to get a Medigap policy or it may cost more.

For more information or to find Medigap policies in your area,

call 1-800-MEDICARE (1-800-633-4227)
or go to www.Medicare.gov

WHAT ARE MEDICARE SAVINGS PROGRAMS?

Medicare Savings Programs are state programs that help you pay for

- Medicare premiums
- Part A and Part B deductibles
- Part A and Part B coinsurance
- Part A and Part B copays

Depending on your income and resources, you may qualify for one of these programs:

- Qualified Medicare Beneficiary Program
- Specified Low-Income Medicare Beneficiary Program
- Qualifying Individual Program
- Qualified Disabled and Working Individuals Program

Do I Qualify for a Medicare Savings Program?

You must have or be eligible for Part A.

- Your income must be below a certain limit
- Your resources (such as savings, stocks, and bonds) must be below a certain limit

Each Medicare Savings Program has different income and resource limits. Even if you have a slightly higher income and more resources than the limits for a Medicare Savings Program, you may still qualify. For information, go to www.medicare.gov and search "Medicare Savings Programs." Call your state Medicaid office to see if you qualify for a Medicare Savings Program.

Some people who qualify for a Medicare Savings Program may qualify for Extra Help to pay for Part D prescriptions.

About Medicare Part C (Medicare Advantage)

Part C is another way to get Medicare coverage. A Part C plan is also called a Medicare Advantage plan.

- Part C was created to give Medicare patients more options
- Part C is optional. It covers everything that Part A (hospital insurance) and Part B (medical insurance) covers. It also covers additional services, such as dental, vision, hearing, and prescription drugs
- It is sold by private healthcare insurance companies who contract with Original Medicare to offer the same benefits as Part A and Part B
- A Medicare Advantage plan may cost you less over the year
- If you have Medicare Advantage, you cannot buy a Medigap policy (see page 8 for more information on Medigap)
- It has a maximum out-of-pocket amount of up to [$6,700] a year
- The Medicare Advantage Open Enrollment Period occurs each year between [January 1 and March 31]. If you already have a Medicare Advantage plan, you can opt to switch plans. You also have the option to cancel your Medicare Advantage plan

Medicare Special Needs Plans (SNPs) are also available to people with Alzheimer's. An SNP is a type of Medicare Advantage plan that provides special care and coverage for certain chronic conditions, including Alzheimer's. People who live in an institution (like a nursing home) also qualify to enroll in an SNP.

SNPs are not available everywhere. You may use the online Medicare Plan Finder at medicare.gov or call Medicare at 1-800-633-4227 to determine if a Medicare SNP is available in your area.

Understanding Medicare Part D (Prescription Drug Coverage)

Medicare Part D covers your prescriptions based on how your self-administered medication is taken.

- Pills you swallow (oral)
- Injections you give yourself
- Medicines you inhale

How Do I Know If I Need Part D?

- Part D helps cover the cost of your prescription drugs. But even if you do not take many prescriptions, you may want to consider a Part D plan. Your doctor may need to prescribe treatment during the year
- There are many Part D plans. Part D monthly premiums vary by plan and depend on your income
- You can compare Part D plans at www.Medicare.gov/find-a-plan

When Is the Best Time to Sign Up for a Part D Plan?

It is best to sign up for Part D when you first become eligible, as you may pay a penalty for joining later. You can sign up for a Part D drug plan if

- You have Part A and Part B
- You have a Medicare Advantage (Part C) plan that does not offer drug coverage

WHEN CAN I SIGN UP FOR MEDICARE?

The enrollment period begins when you turn 65 years old. It may also depend on if you have had Medicare in the past. You can enroll during certain times of the year.

Initial Enrollment Period | When you turn age 65

- You can sign up 3 months before the month you turn age 65 or up to 3 months after the month you turn age 65
- When you enroll, you will be asked if you want to sign up for Part A and Part B. If you do not sign up for Part B at this time, you may have to pay more, unless you qualify for a Special Enrollment Period
- If you have other health insurance when you qualify for Medicare, it is important to know if declining Part B will affect coverage from your other plan. Contact Medicare to discuss your specific circumstances

General Enrollment Period | If you did not sign up when you turned age 65

- Each year, from January 1 to March 31, you have the chance to sign up if you did not enroll at age 65
- Your coverage will start on July 1
- You may have to pay more for signing up after your initial enrollment period

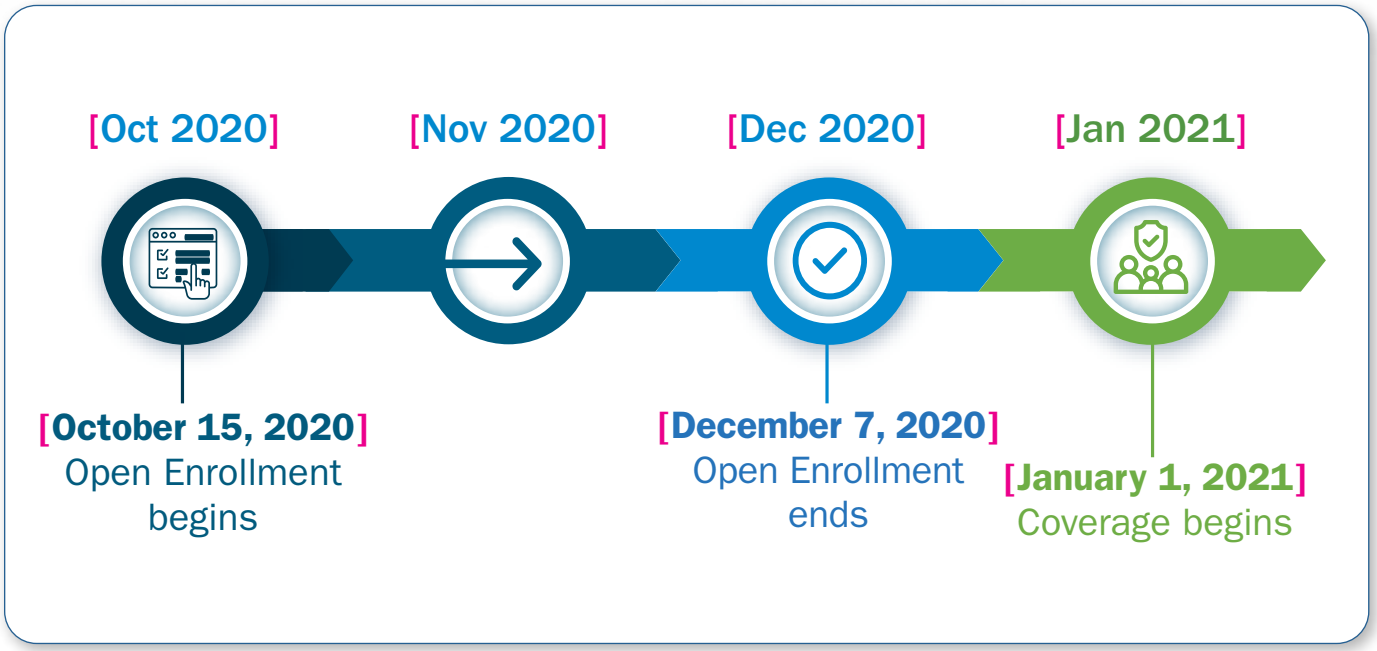
Special Enrollment Period | If you or your spouse are still working

- The Special Enrollment Period allows you to sign up for Part A and/or Part B if you did not do so when you were first able. There are no specific dates
- You can still sign up for Part A and/or Part B if you have a health plan through your job
- If you lose your health plan at your job, you can sign up for Part A and/or Part B. You would do this during the 8 months after coverage ends

When Does Open Enrollment for Medicare Begin?

Each year, between [October 15] and [December 7], you may enroll or even make changes to your health or drug plan for the next year. This is called Open Enrollment. Even if you have just enrolled in Medicare during one of the other enrollment periods, you will need to choose your plan for the next year during this period.

Open Enrollment lets you review your plan benefits. You can keep your current plan or you can compare plans to find one with the right coverage for you. Make sure the plan you choose covers the health services and medicines you will need next year. You can review plans as early as [October 1]. Once you pick a plan, your coverage will begin on [January 1].



How Do I Sign Up for Medicare?

You can sign up for Medicare in 2 ways:

Call the Social Security office at 1-800-772-1213

Sign up online at www.ssa.gov/benefits/medicare

If You Are Disabled, You Will Be Enrolled in Part A and Part B Without Having to Sign Up

1. You will be automatically enrolled by your 25th month of receiving disability benefits through Social Security.
2. You will get your Medicare card in the mail.
3. You pay an annual Part B deductible [($198 in 2020)]. You also start paying a Part B monthly premium. The standard amount is projected to increase from [$144.60 in 2020] to [$148.50 in 2021] (you may pay a higher premium depending on your income).
4. You may want to consider purchasing a Medigap policy. These policies are sold by private insurance companies. They can help with out-of-pocket costs (eg, deductibles, copays, and coinsurance) not covered by Part A and Part B.

Do I Qualify as Disabled?

If you have worked in the past, but cannot now because of your Alzheimer's, you may qualify as disabled. You can apply with Social Security. For more information, call Social Security at 1-800-772-1213 or go to www.ssa.gov/disability/.

Your red, white, and blue Medicare card will come in the mail. This card shows that you have Part A, Part B, or both. It also shows the date your coverage starts.

WHAT SHOULD I THINK ABOUT WHEN REVIEWING PLANS?

Whether you have Original Medicare (Part A and Part B) with Medigap and Part D or choose to enroll in a Medicare Advantage plan (Part C), it is important to understand your coverage. You may want to consider these questions as you review your plan options.

- **Are my current health services and prescription medications covered under Part B or Part D?**
- **Is my current treatment plan covered?**
- **What are the copays, coinsurance, and deductibles for my doctor visits? For my medicines?**
- **If I do not qualify for Medicare Savings Program assistance, is there a Medigap policy for me?**
  - Which Medigap plan might offer the most affordable and best coverage for my Medicare deductible/coinsurance needs?
- **Once my deductible is met, how much will I pay for coinsurance?**
- **For Medicare Advantage plans, is my doctor in the plan's network? Will I be able to keep seeing the same doctor?**

HOW CAN I LEARN MORE ABOUT MEDICARE?

There are many tools and resources that can help you review Medicare plans.

Medicare

- Call 1-800-MEDICARE (1-800-633-4227)
- Visit www.Medicare.gov/plan-compare

Your State Health Insurance Program (SHIP)

- Call 1-800-MEDICARE for the phone number of your local SHIP office
- Visit www.shiptacenter.org

For more information about Medicare, you can visit the following websites:

Centers for Medicare & Medicaid Services

www.Medicare.gov

National Institute on Aging—Paying for Care

www.nia.nih.gov/health/paying-care

Alzheimer's Association

www.alz.org (search "Medicare")

Social Security

www.socialsecurity.gov

PRIVATE INSURANCE

OVERVIEW OF PRIVATE INSURANCE

There are many types of private health insurance plans. Understanding how your health plan works and what it covers may help you get the most out of your benefits. It can also help you keep your total healthcare costs down.

These plans are usually funded by

What Is the Difference Between Private and Public Insurance?

	WHO FUNDS IT?	HOW DOES COVERAGE WORK?	WHO IS ELIGIBLE?
PRIVATE	Funded by employers, unions, trade organizations, and/or individuals and families	Coverage is based on the benefits package provided by your employer or the Health Insurance Marketplace	Everyone

PUBLIC	WHO FUNDS IT?	HOW DOES COVERAGE WORK?	WHO IS ELIGIBLE?
MEDICARE	Funded only by the federal government	Medicare provides coverage through 4 parts: Part A–inpatient hospital Part B–outpatient services Part C–Medicare Advantage Part D–prescription drug	All people aged 65 years or older are eligible, as well as younger people with certain disabilities and those with end-stage renal disease
MEDICAID	Funded by the federal government and/or your state	Under federal law, states are mandated to provide certain benefits and have the choice to cover optional benefits	Available only to individuals and families who qualify based on income and family size
TRICARE	Funded by the US Department of Defense	An assigned primary care manager provides healthcare services at no or minimal cost	All active-duty service members, military retirees, and their families
VETERANS AFFAIRS	Funded by the federal government	Free healthcare for conditions related to military service	Available to veterans who have served in the US military

What Types of Private Health Plans May Be Offered by My Employer?

Employer-Sponsored Health Plan

An employer-sponsored health plan is when a business pays for its employees' health insurance. It is usually part of an overall benefits package. Employees may be required to pay a portion of the costs. Most private (commercial) health insurance in the United States is sponsored by employers.

If you sign up for this plan, you can enroll when you are hired or during your set Open Enrollment Period. If you miss that period, you will have to wait until the next Open Enrollment Period or until you have a qualifying life event (for example, losing other coverage or getting married). If you experience a qualifying life event, you can sign up or change your health insurance during the Special Enrollment Period. For information about different types of employer-sponsored plans, see page 24.

Consumer-Driven Health Plan and High-Deductible Health Plan

Consumer-driven health plans (CDHPs) let you control how your healthcare dollars are spent. High-deductible health plans (HDHPs) are a type of CDHP that let you pay less toward your premium. But you pay 100% of the costs toward your healthcare expenses until your deductible is met. When your deductible is met, you share a percentage of the costs with your health plan. This is called your coinsurance.

A CDHP can be offered through 3 types of accounts:

- A health reimbursement account (HRA) funded by your employer
- A flexible spending account (FSA) funded by you and potentially your employer
- A health savings account (HSA) funded by you

Are There Other Ways to Pay for My Healthcare Expenses?

An HRA, FSA, and HSA are all ways to pay for medical, prescription, dental, and vision expenses tax free.

Health Reimbursement Account

HRAs pay for covered healthcare expenses. You must meet a set deductible each year before your health plan benefits begin. Any funds in your HRA that you don't use up by the end of the year automatically roll over into the next year. They are added to the annual contribution from your employer.

Flexible Spending Account

An FSA is an account that you put money into to pay toward certain out-of-pocket healthcare costs. The money you contribute to an FSA is not taxed. This means that you save the same amount you put in your FSA that would have been taken out of your paycheck toward taxes.

Employers may contribute to your FSA, but they don't have to. The amount you put into your account can only be changed 2 times:

- During Open Enrollment
- When there is a change in your family or employment status

An FSA is limited to [$2,750] per employee. Unlike an HSA or HRA, you must spend all of the money in your FSA within the plan year since it cannot be rolled over to the next year. Choose the amount you expect to use carefully.

FSA Maximum Contribution in [2021]

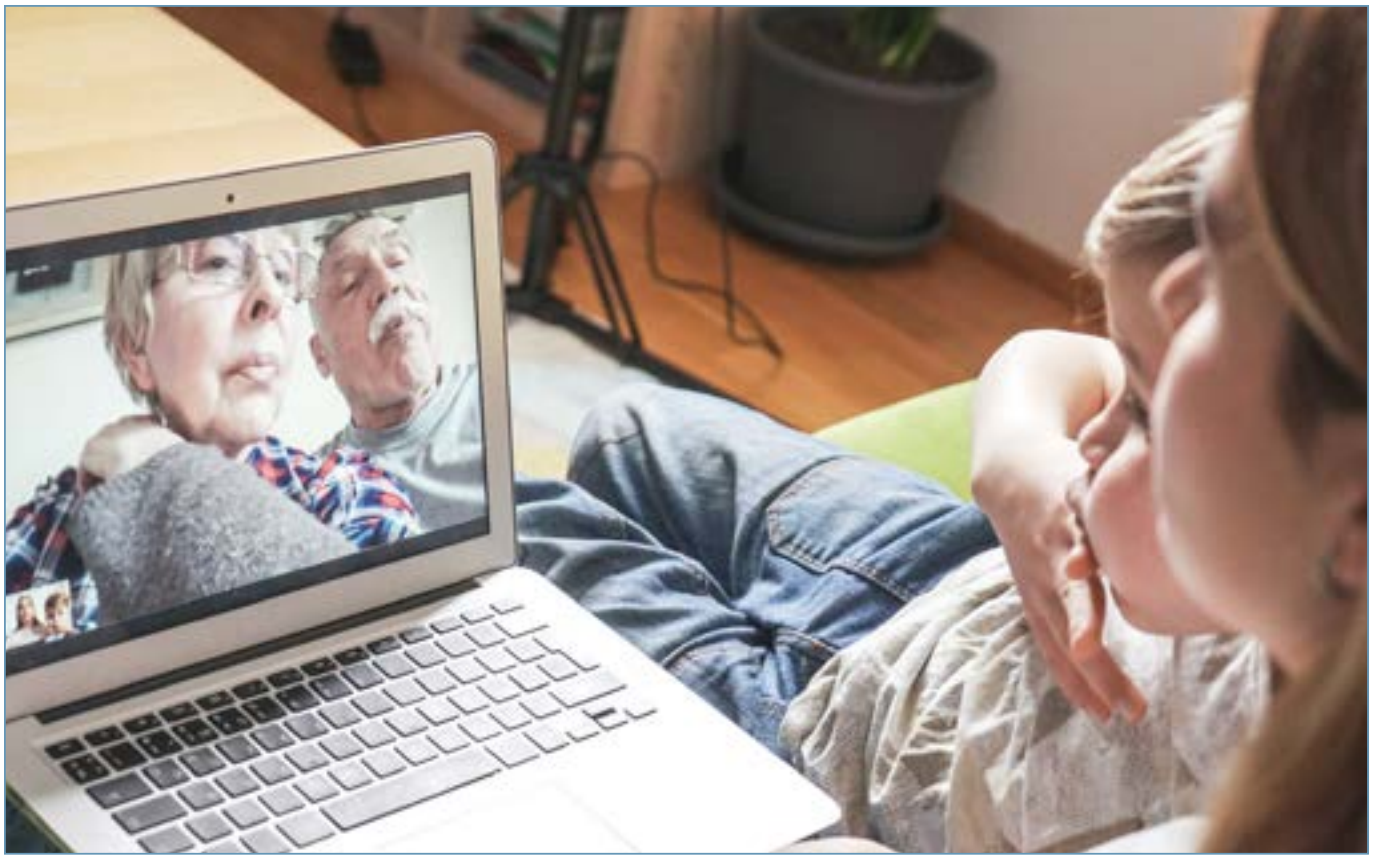
[$2,750] maximum per employee

[$2,500 + $2,500 = $5,000] maximum per married couple

Health Savings Account

An HSA is a type of savings account that allows you and your employer to set aside money for current and future healthcare. You can open an HSA through your bank. You don't pay taxes on this money. In [2020], an HSA is limited to [$3,550] for an individual with self-only coverage under an HDHP. For an individual with family coverage under an HDHP, an HSA is limited to [$7,100]. An HSA can be used only if you have an HDHP. Here are some of the benefits of these plans:

- You can lower your overall healthcare costs by using untaxed money in an HSA to pay for expenses before you reach your deductible and other out-of-pocket costs, like copays for your treatment
- Unlike an FSA, HSA funds roll over year to year if you don't spend them
- An HSA may earn interest



Overview of HRAs, FSAs, and HSAs

HRA	FSA	HSA
Only your employer can fund it	Flexibility in the amount you want to contribute up to [$2,750]	A pretax savings account you fund to pay for qualified medical expenses
Any unused money can roll over into the following year	Plan on using all of the money you contribute within the year, as contributions do not roll over	Any unused money can roll over into the following year
Your employer contributes a set amount	Contribution amounts can be adjusted only at Open Enrollment or with a change in employment or family status	Flexibility to change how much you contribute to the account at any point during the year

Types of Managed Care Plans

A managed care plan is also offered by an employer. There are 3 types of managed care plans:

Health maintenance organization (HMO) plans	• Made up of a network of providers that offers healthcare services at a certain rate • Offer coverage only if you stay within the network • Let you choose your primary care physician (PCP) who provides and coordinates all your basic healthcare needs • Require a referral to see a specialist • May require you to pay all of out-of-pocket costs to see a provider out of your network (unless a true medical emergency) • Typically allow only a certain number of visits, tests, or treatments
Preferred provider option (PPO) plans	• Allow more flexibility in your choice of provider • May require you to pay more than you would if you go outside the network. Most plans will still cover a portion of the bill • May provide access to out-of-state providers that are considered in-network
Point-of-service (POS) plans	• A blend of HMO and PPO plan • Require a referral from your PCP if you want to see a specialist • Let you pay less if you use providers or hospitals from the network • Offer access to providers who are out of network at a higher cost

Fee-for-Service or Indemnity Plan

In a fee-for-service or indemnity plan, both you and your health plan pay a portion of the costs for each visit or service. The plan pays its share in one of 2 ways:

- It pays the provider directly
- It pays you back after you file an insurance claim for each expense that is covered

These plans often offer more choices of providers or hospitals, but they tend to cost more.

Individual Insurance

If you work for yourself or do not have coverage from another source, you can buy individual insurance directly from an insurance company. This can be expensive, but you may be able to get group coverage through a union or trade group. You may get even more affordable coverage through the Health Insurance Marketplace.

THINGS TO CONSIDER ABOUT THE HEALTH INSURANCE MARKETPLACE

If you do not have health insurance through your job, you may be able to get private insurance through the Health Insurance Marketplace, or the Marketplace.

The Marketplace helps you shop for and enroll in an affordable health insurance plan. In most states, it is run by the US federal government through HealthCare.gov.

When you apply for coverage, you will be asked to provide income and household information. You will then find out if you are eligible for

- Premium tax credits and other savings
- Coverage through Medicaid in your state

All plans that offer coverage through the Marketplace must cover certain healthcare services.

Some services that that may impact people with Alzheimer's include

WHERE WILL I GET MY MEDICINE?

When talking with your provider about your treatment, it is also important to talk about your insurance coverage and where you will get your medicine.

Based on the type of medicine and your insurance coverage, you could receive your medicine from any of these sources:

Local pharmacy

Doctor's office

Mail-order pharmacy

Specialty pharmacy

UNDERSTANDING THE COST OF PRIVATE HEALTH INSURANCE

Finding a plan that is affordable starts with knowing the real costs of coverage. But getting this information can be hard. Monthly premiums, deductibles, and medication costs all have to be considered. Sometimes the plan that seems the least expensive may end up costing you more. It may not give you enough coverage for your medical needs. This table shows some examples of coverage and costs.

Note: These numbers are just examples. They are not meant to show actual plan coverage and costs. Contact your insurance plan for actual coverage and costs.

Examples of Health Plan Coverage and Costs

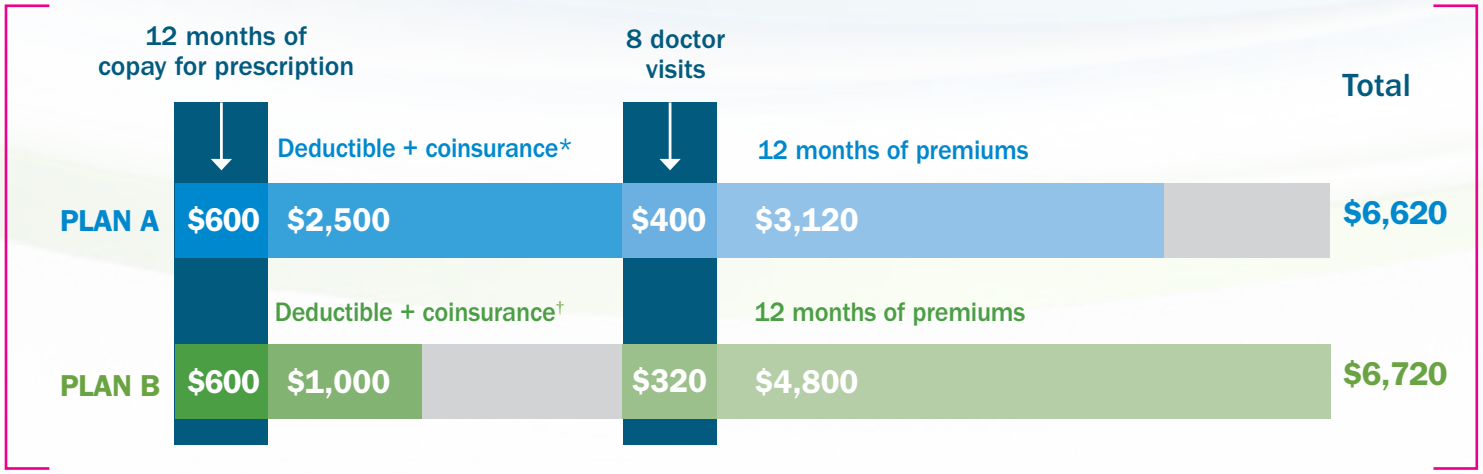
Plan	Monthly premium (individual)	Patient copay for 1 doctor visit	Deductible/ coinsurance/ out-of-pocket maximum*	Copay for prescription
Plan A (high deductible/ low premium)	$260	$50	$2,000 50% $6,000	$50
Plan B (low deductible/ high premium)	$400	$40	$500 80% $4,000	$50

*This is an example for illustrative purposes. This example reviews expenses for services covered within your network. Be sure to find out the out-of-pocket maximum when choosing a plan.
This is the amount you will pay before your insurance plan covers the rest of the balance leftover.

To understand the difference in total costs between these 2 types of plans, look at what you would pay if you had:

- **12 MONTHS OF PREMIUMS**
- **8 DOCTOR VISITS IN 12 MONTHS**
- **COSTS FOR TESTS AND OTHER MEDICAL TREATMENT DURING THE YEAR THAT COUNT TOWARD YOUR DEDUCTIBLE**
- **12 MONTHS OF COPAY FOR PRESCRIPTION**

Sample Healthcare Costs for Plan A and Plan B



*You pay a $2,000 deductible, then the plan covers 50% of the remaining $1,000. You pay $500 in coinsurance.

†You pay a $500 deductible, then the plan covers 80% of the remaining $2,500. You pay $500 in coinsurance.

Note: These numbers are just examples. This example reviews expenses for services covered within your network. They are not meant to show actual plan coverage and costs. Going outside of network usually results in higher costs. Contact your insurance plan for actual coverage and costs.

In this example, a lower-deductible health plan with a higher premium would cost [$100] more than a high-deductible health plan with a lower premium. That is why it is important to think about all of your healthcare costs before choosing the plan that is right for you.

WHAT SHOULD I THINK ABOUT WHEN REVIEWING PLANS?

Be sure to look for a plan that covers the services you need for all of your healthcare at an affordable price. To help you choose a plan, ask your benefits manager, administrator, or health plan these questions:

- **Do I qualify for the health plan I want to join?**
- **Is my treatment covered?**
- **What happens if my doctor changes my prescription before the year is over?**
  - Will that affect my coverage?
- **Will I have to change doctors?**
  - Will my doctor still be in-network?
- **What if I need to see a new doctor or specialist?**
  - Will the services I need be in-network or out-of-network?
- **Will the health plan cover all my doctor visits?**
- **How much is the premium each year?**
- **Is there a deductible? How much?**
- **What is the copay for doctor visits?**
  - What is the copay for testing, such as magnetic resonance imaging? For administration of a drug (eg, shot or infusion) given in a doctor's office?

GLOSSARY

Coinsurance: A percentage of the total cost of care. Typically, you pay about 20% of total costs.

Consumer-driven health plan (CDHP): A health plan that lets you use HSAs or HRAs to pay directly for routine healthcare costs. To have a CDHP, you must be enrolled in an HDHP. These plans protect you from catastrophic medical expenses.

Copay (copayment): A fixed amount, such as $15 or $20, which you pay when you get medical care or medicine. Your plan pays the rest of the costs.

Deductible: A certain dollar amount you must pay each year before your plan provides coverage.

Fee-for-service (FFS): A structure in which you and your health plan pay a portion of your costs at each visit or service. These plans often offer more flexibility in choice of providers or hospitals. But they tend to cost more. FFS is also known as indemnity insurance.

Flexible spending account (FSA): An account that you set up through your job to help pay for healthcare costs. You don't pay taxes on this money. But if you don't spend all of your FSA money by the end of year, you lose the money that is left.

Health Insurance Marketplace: A government-sponsored resource where you can choose a health plan. It also provides information on programs that offer financial help for insurance coverage.

Health maintenance organization (HMO): A type of plan in which you get care from a network of providers. Your PCP coordinates all of your care.

Health savings account (HSA): An account you set up with your employer to save money for medical expenses. Like an FSA, you don't have to pay taxes on this money. Unlike an FSA, money can be carried over to the next year if you don't use it.

High-deductible health plan (HDHP): A healthcare plan with a lower premium, but the deductible is higher than that of a traditional healthcare plan.

In-network: Doctors, hospitals, or other providers who participate in the health plan you chose. You usually pay less when using an in-network provider. Some plans only pay for services when the member uses in-network providers. Other plans will pay some of the cost even if the member uses an out-of-network provider.

Managed care plan: Plans that include a network of doctors, hospitals, and other providers to coordinate care.

Open Enrollment: A set period of time during which people can choose to make changes in their insurance coverage for the coming year.

Out-of-network: Doctors, hospitals, or other providers who are not part of the health insurance plan you chose. You will pay more for these services.

Out-of-pocket (OOP) and OOP maximum: The money you pay for your healthcare costs that is not paid back by your health plan. The OOP maximum is the most you will have to pay during your policy period (usually 1 year). After you pay that amount, your health plan covers all costs.

Point-of-service (POS) plan: A plan that coordinates care with a primary care doctor. It allows for more flexibility in choice of doctors and hospitals than an HMO.

Preferred provider organization (PPO): A plan that contracts doctors and hospitals to create a network of providers. You can get care outside of the network. But you'll pay less if you use in-network providers.

Premium: The amount paid for health insurance. This is usually paid every month.

Primary care physician (PCP): A doctor who provides or coordinates a range of healthcare services for a patient.

Private insurance plan: Plans usually funded by employers. They can also be funded by unions, trade organizations, or individuals and families. HMOs, POS plans, PPOs, individual insurance, and consumer savings plans are all private plans.

Public insurance plan: Government-funded programs that provide coverage for people who are older, have certain disabilities, and/or have limited finances. Medicare and Medicaid are public plans.

Specialty pharmacy: A type of pharmacy that coordinates medication delivery and offers support services for drugs that treat complex conditions.

