your health

how it works: out-of-network providers

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The **Medical PPO**, **High Deductible Health Plan (HDHP)**, **HDHP Basic** and **Dental PPO plans** are all preferred provider organization (PPO) health plans. This means you aren't restricted to just the providers in the plan's network. You have the choice to use any provider you want, **network** or **out-of-network**. However, there are key differences when it comes to your costs and your responsibilities when you visit an out-of-network provider. Here are **five things to know** when you visit an out-of-network provider for covered services.

1 is your provider in the network?

Even if your provider was in the network last year or last visit, it's always a good idea to verify before each visit to be sure you know what to expect. Health plans negotiate with providers periodically, so the network of providers could change. How to find a network provider.

2 the deductible might be different

Your Chevron medical plans generally require you to satisfy an **annual deductible** for covered services, whether you visit a network or out-of-network provider. But when you visit an **out-of-network provider** you must satisfy a **higher** deductible. Why does this matter to you? The deductible is an amount you must pay out of your pocket *before* your health plan will begin to share the cost of covered services. Contact your plan if you have questions about deductibles.

3 preventive care is covered, but you'll share the cost

These health plans provide coverage for certain preventive care services, as specified by the Affordable Care Act. If you see an **out-of-network** provider, preventive care is subject to the deductible and you'll pay a percentage of the cost (coinsurance) for the service. But when you see a **network** provider, your plan provides 100 percent coverage with no deductible for certain preventive care services. Learn more about preventive care.

4 you may have to pay the bill first and file a claim later

Network providers have a contracted relationship with the health plan, so when you use a network provider, your provider will usually file a claim for you. The health plan will pay its share of costs – if any – directly to **your provider**. If you still owe anything, the provider will typically bill you, unless you paid your portion of the charge when you received the service.

The health plan generally does not directly pay **out-of-network** providers. In these situations, you're responsible for paying your provider. So, if you go to an out-of-network provider, you typically will first pay for the services and supplies you receive, out of your pocket, at the time of service. You must then file a claim for benefits with your health plan. The health plan will pay its share of costs – if any – directly to **you**. Contact your plan if you have questions about filing a claim.

5 your share of the costs are different

Generally after you satisfy your annual deductible, the health plans share the cost of covered services through **coinsurance**. This means you'll pay a percentage of the cost for the covered service and the plan will pay the remainder. The percentage you pay depends on the type of service and whether you visited a network or out-of-network provider. With an **out-of-network** provider your share of the cost – the coinsurance percentage – is **greater** than if you visited a network provider.

In addition, out-of-network providers can charge *any* price they want. In certain situations, your health plan may only share the cost of a covered service *up to* a **maximum allowed amount**. If the cost of your service exceeds a maximum allowed amount, you'll pay your coinsurance *and* any additional costs over the maximum allowed amount. This is called **balance billing**. Here's an example of how balance billing works. Contact your plan if you have additional questions.

balanced billing example
For illustration purposes only. Your charges may be different

	You receive services from an out-of-network provider. Your provider charges:	**$250**	**Amount over maximum allowed amount** **$50**
	Your plan's maximum allowed amount for that service in your area is:	**$200**	
	Your network coinsurance for this service is **20%**, after you meet the deductible. For this example, let's assume you have met your deductible. Coinsurance is applied to the maximum allowed amount:	**20% x $200** **$40**	
	You pay the **coinsurance amount** *plus* the amount over maximum allowed amount.	**$40 + $50** **$90**	**You pay $90** **Plan pays $160**

Don't forget to make sure your services are covered

All health plans – Chevron's health plans included – determine what services the plan will cover (covered services) and the services they won't. If it's not a covered service under your plan, you'll have to pay the *full cost* out of your pocket even if you visit a network provider. Contact your plan if you have questions about the services covered under your plan.