GLOSSARY OF TERMS

Deductible

A specific dollar amount that your health insurance company requires you to pay out-of-pocket each year before your health insurance plan begins to make payments for claims. Not all health insurance plans require a deductible.

Out-of-Pocket Maximum

Out-of-pocket maximums apply to all medical plans. This is the maximum amount you will pay for health care costs in a calendar year. Once you have reached the out-of-pocket maximum, the plan will fully cover eligible medical expenses for the rest of the plan year. If you see an out-of-network provider, you will still be responsible for out-of-pocket costs that are above the “reasonable and customary” fees.

Copayment

A specific charge that you pay for a specific medical service or supply, also referred to as a "copay." For example, your health insurance plan may require a $30 copayment for an office visit or brand-name prescription drug, after which the insurance company pays the rest.

Coinsurance

The amount that you are required to pay for covered medical services after you've satisfied any co-payment or deductible required by your health insurance plan. Coinsurance is typically a percentage of the charge for a service. For example, if your insurance company covers 80% of the allowable charge for a specific service, you are responsible for the remaining 20% as coinsurance.

In-Network Provider

A healthcare professional, hospital, or pharmacy that has a contractual relationship with your health insurance company. This contract establishes allowable charges for specific services. In return, healthcare providers gain patients; primary care physicians may receive a capitation fee for each patient assigned to their care. An ***out-of-network*** provider is a healthcare professional, hospital, or pharmacy that ***is not*** part of your health plan's network of preferred (in-network) providers. You could pay more for services received from an out-of-network providers because there are no negotiated discounts given. You could pay more than the in-network allowable amount, therefore resulting in receiving a bill from your provider. It is important to check with your provider to determine if they participate with your medical plan’s network

Out-of-Pocket Maximum

Out-of-pocket maximums apply to all medical plans. This is the maximum amount you will pay for health care costs in a calendar year. Once you have reached the out-of-pocket maximum, the plan will cover most eligible medical expenses for the rest of the year.

Claim

A request by a plan member, or a plan member's health care provider, for the insurance company to pay for medical services.

GLOSSARY OF TERMS

Reasonable and Customary

Usual, customary and reasonable charges are set by the insurance company, based on the prevailing cost of a service in your geographic area. The insurance company then determines how much it will pay for a given service in your area.

Qualifying Life Event

A life event that allows you to make changes to your insurance coverage that otherwise are only allowed during the annual Open Enrollment period.

Examples of a qualifying life event include, but are not limited to, marriage, divorce, birth or adoption of a child, loss of prior coverage, relocation, and the arrival of a dependent from another country.

Preauthorization

Preauthorization (also known as 'prior authorization') means that approval is needed from your health plan before you have certain health tests or services. To help make sure your care is appropriate and avoid unexpected costs, it's important that approval is received before you get these services. Usually, your network provider will take care of preauthorization before the service is performed. But it is always a good idea to check if your doctor has gotten the needed approval.

Covered Services

Those services deemed by your plan to be medically necessary for the care and treatment of an injury or illness

Premium

The amount you pay for health insurance every month

Explanation of Benefits (EOB)

The statement sent to you by your health plan explaining the benefit calculation and payment of medical services that details the services rendered and the benefits paid or denied for each service. An EOB lists the charges submitted, the amount allowed, the amount paid and any balance owed as the patient's responsibility.

COBRA (Consolidated Omnibus Reconciliation Act)

Federal legislation allowing an employee or an employee's dependents to maintain group health insurance coverage through an employer's health insurance plan, at the individual's expense, for up to 18 months after the loss of employment.