Know Your Benefits

Glossary of Terms

Allowed Amount – This is the maximum payment the plan will pay for a covered Health care service. May also be called “eligible expense,” “payment allowance,” or “negotiated rate.”

Covered Expenses—Health care expenses that are covered under your health plan.

Claim – A request for a benefit (including Reimbursement of a health care expense) made by you or your health care provider to your health insurer or plan for ítems or services you think are covered.

Coinsurance—The amount or percentage that you pay for certain covered health care services under your health plan. This is typically the amount paid after a deductible is met, and can vary based on the plan design.

Copayment—A flat fee that you pay toward the cost of covered medical services.

Cost Sharing – Your share of costs for services that a plan covers that you must pay out of your own pocket. Examples include copayments, deductibles, and coinsurance.

Deductible—A specific dollar amount you pay out of pocket before benefits are available through a health plan. Under some plans, the deductible is waived for certain services.

Member—You and those covered become members when you enroll in a health plan. This includes eligible employees, their dependents, COBRA beneficiaries and surviving spouses.

Dependent—Individuals who meet eligibility requirements under a health plan and are enrolled in the plan as a qualified dependent.

Flexible Spending Account (FSA)—An account that allows you to save tax-free dollars for qualified medical and/or dependent care expenses that are not reimbursed. You determine how much you want to contribute to the FSA at the beginning of the plan year. Most funds must be used by the end of the year, as there is only a limited carryover amount.

Health Reimbursement Arrangement (HRA)—An employer-owned medical savings account in which the company deposits pre-tax dollars for each of its covered employees. Employees can then use this account as reimbursement for qualified health care expenses.

In-network—Health care received from your primary care physician or from a specialist within an outlined list of health care practitioners.

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Out-of-network—Health care you receive without a physician referral, or services received by a non-network service provider. Out-of-network health care and plan payments are subject to deductibles and copayments.

Out-of-pocket Expense—Amount that you must pay toward the cost of health care services. This includes deductibles, copayments and coinsurance.

Out-of-pocket Maximum (OOPM)—The highest out-of-pocket amount paid for covered services during a benefit period.

Out-of-pocket Limit – The most you could pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet This limit the plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs. The limit does not include your premium, balance-billed charges or health care you plan doesn't cover.

Excluded Services – Health care services that your plan doesn't pay for or cover.

Premium—The amount you pay for a health plan in exchange for coverage. Health plans with higher deductibles typically have lower premiums.

Prescription Drug Coverage – Coverage under a plan that helps pay for prescription drugs.

Formulary – A list of drugs your plan covers.