HEALTH COVERAGE TERMS TO KNOW

APPEAL

An appeal is the action you can take if you disagree with a coverage or payment decision by your health plan. You can appeal if your health plan denies one of the following:

- Your request for a health care service, supply, or prescription drug that you think you should be able to get.
- Your request for payment for health care or a prescription drug you already got.
- Your request to change the amount you must pay for a prescription drug.
- Your plan stops paying for coverage you were getting.

COINSURANCE

An amount you may be required to pay as your share of the cost for services after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

COPAYMENT

An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or prescription drug. A copayment is usually a set amount, rather than a percentage.
For example, you might pay $10 or $20 for a doctor's visit or prescription.

DEDUCTIBLE

The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay.

EMERGENCY SERVICES

Evaluation of an illness, injury, symptom, or condition so serious that a reasonable person would seek care and treatment right away to keep the condition from getting worse.

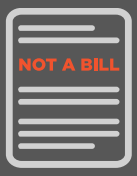
EXCLUDED SERVICES

Health care services for which your insurance company will not pay and that are not covered on your health insurance plan.

HEALTH COVERAGE TERMS TO KNOW

EXPLANATION OF BENEFITS

A summary of health care charges that your insurance company sends you after you see a provider or get a service. It is not a bill. It is a record of the health care you or individuals covered on your policy received and how much your provider is charging your insurance company.



FORMULARY

A list of prescription drugs covered by a drug plan or another insurance plan offering prescription drug benefits. Also called a drug list.

HOSPITAL OUTPATIENT CARE

Care in a hospital that usually doesn't require an overnight stay.

IN-NETWORK COINSURANCE

The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network coinsurance usually costs you less than out-of-network coinsurance.

IN-NETWORK COPAYMENT

A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network copayments usually are less than out-of-network copayments.

NETWORK (ALSO REFERRED TO AS IN-NETWORK)

The facilities, providers, and suppliers your health insurer or plan has contracted with to provide health care services.

OUT-OF-NETWORK

A facility, provider, or supplier who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to use them.

OUT-OF-NETWORK COINSURANCE

The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who don't contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

OUT-OF-NETWORK COPAYMENT

HEALTH COVERAGE TERMS TO KNOW

A fixed amount (for example, $30) you pay for covered health care services from providers who don't contract with your health insurance or plan. Out-of-network copayments usually are more than in-network copayments.

OUT-OF-POCKET MAXIMUM

The most you pay during a policy period (usually one year) before your health insurance or plan starts to pay 100% for covered essential health benefits. The out-of-pocket maximum includes the yearly deductible and may also include any cost sharing you have after the deductible. For most health plans for 2015, the highest out-of-pocket maximum for an individual is $6,600 and $13,200 for a family. These numbers will rise in 2016.

PREAUTHORIZATION

A decision by your health insurer or plan that a health care service, treatment plan, prescription drug, or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval, or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

PREMIUM

The periodic payment to an insurance company or a health care plan for health or prescription drug coverage.

PREVENTIVE SERVICES

Routine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems or to detect illness at an early stage, when treatment is likely to work best (this can include services like flu and pneumonia shots, vaccines, and screenings like mammograms, depression/behavioral health screenings, or blood pressure tests, depending on what is recommended for you).

PRIMARY CARE PROVIDER

The doctor you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many health plans, you must see your primary care doctor before you see any other health care provider.

SPECIALIST

A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.