GLOSSARY

Below are English definitions for some of the most common insurance terms. Learning these key terms will help you understand the information in this guide and help you choose the benefits that are best for you and your family.

TERM	DEFINITION
Allowable Charge	Sometimes known as the "allowed amount," "maximum allowable," and "usual, customary, and reasonable (UCR)" charge, this is the dollar amount considered by a health insurance company to be a reasonable charge for medical services or supplies based on the rates in your area.
Claim	A request by a plan member, or a plan member's health care provider, for the insurance company to pay for medical services.
Coinsurance	The amount you pay to share the cost of covered services after your deductible has been paid. The coinsurance rate is usually a percentage. For example, if the insurance company pays 80% of the claim, you pay 20%.
Copayment	One of the ways you share in your medical costs. You pay a flat fee for certain medical expenses (e.g., $10 for every visit to the doctor), while your insurance company pays the rest.
Deductible	The amount of money you must pay each year to cover eligible medical expenses before your insurance policy starts paying.
Explanation of Benefits	The health insurance company's written explanation of how a medical claim was paid. It contains detailed information about what the company paid and what portion of the costs you are responsible for.
Out-of-Pocket Maximum	The most money you will pay during a year for coverage. It includes deductibles, copayments, and coinsurance, but is in addition to your regular premiums. Beyond this amount, the insurance company will pay all expenses for the remainder of the year.
Health Maintenance Organization (HMO)	A health care financing and delivery system that provides comprehensive health care services for enrollees in a particular geographic area. HMOs require the use of specific, in-network plan providers.
Preferred Provider Organization (PPO)	A health insurance plan that offers greater freedom of choice than HMO (health maintenance organization) plans. Members of PPOs are free to receive care from both in-network or out-of-network (non-preferred) providers, but will receive the highest level of benefits when they use providers inside the network.
Health Reimbursement Account (HRA)	A health reimbursement account consists of employer-funded plans that reimburse employees for incurred medical expenses that are not covered by the company's standard insurance plan. Because the employer funds the plan, any distributions are considered tax deductible (to the employer).
In-Network Provider	A health care professional, hospital, or pharmacy that is part of a health plan's network of preferred providers. You will generally pay less for services received from in-network providers because they have negotiated a discount for their services in exchange for the insurance company sending more patients their way.
Non-Network Provider	A health care professional, hospital, or pharmacy that is not part of a health plan's network of preferred providers. You will generally pay more for services received from out-of-network providers
Network	The group of doctors, hospitals, and other health care providers that insurance companies contract with to provide services at discounted rates. You will generally pay less for services received from providers in your network.
Premium	The amount you or your employer pays each month in exchange for insurance coverage.
Provider	Any person (i.e., doctor, nurse, dentist) or institution (i.e., hospital or clinic) that provides medical care.
Primary Care Physician	Is a physician who provides both the first contact for a person with an undiagnosed health concern as well as continuing care of varied medical conditions, not limited by cause, organ system, or diagnosis.