Maryland
INSURANCE ADMINISTRATION

HOW TO USE YOUR HEALTH PLAN

HEALTH PLAN TERMS GLOSSARY

Balance Billing: When a provider, who isn't in your plan's network, charges more than your plan pays and bills you for the difference in addition to cost-sharing.

Benefits: The health care services a health plan covers. The plan's documents define the benefits that it does and doesn't cover.

Claim: A request for your health plan to pay for health care services. You or your health care provider submits to the claim.

Coinsurance: The percentage of the cost of a covered health care service you pay (20%, for example) after you've met your deductible.

Let's say your plan's allowed amount for an office visit is $100, and your coinsurance is 20%.

- If you've met your deductible: You pay 20% of $100 or $20. The insurer pays the rest.
- If you haven't met your deductible: You pay the full allowed amount, $100.

Coordination of Benefits: A way to figure out which plan pays first when two or more health plans are responsible to pay the same claim.

WORD OF THE DAY

Informative videos explaining insurance terms in easy to understand language - from A to Z.

WATCH NOW

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Co-payments: A fixed amount ($20, for example) you pay for a covered health care service after you've met your deductible.

Let's say your health plan's allowed amount for a doctor's office visit is $100. Your co-payment for a doctor's visit is $20. • If you've met your deductible: You pay $20, usually at the time of the visit. • If you haven't met your deductible: You pay $100, the full allowed amount for the visit.

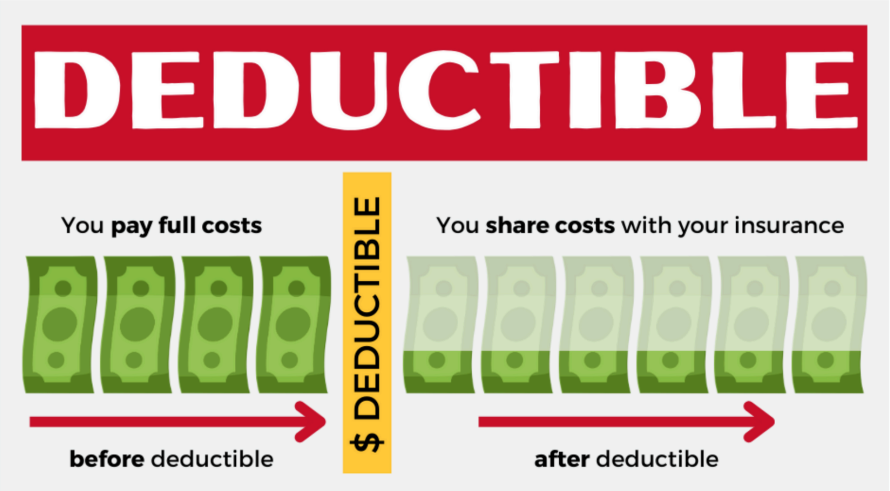
Co-payments (sometimes called "co-pays") can vary within the same plan for different services, like drugs, lab tests, and visits to specialists.

Cost-Sharing: The share of costs for covered services that you pay yourself. This term generally includes deductibles, coinsurance, and co-payments. It doesn't include premiums, balance billing amounts for providers not in the network, or the cost of health care services the plan doesn't cover.

Deductible: The amount you pay for covered health care services before your health plan starts to pay. If you have a $2,000 deductible, for example, you pay the first $2,000 of covered services in a plan year. After you've paid $2,000 of your own money for covered services, you usually pay only a co-payment or coinsurance for covered services for the rest of the plan year. Your plan pays the rest.

Exclusions: Health care services your health plan doesn't cover. If you receive these services, you pay all of the costs.

Network: The facilities, providers, and suppliers your health plan has a contract with to provide health care services.



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HEALTH PLAN TERMS GLOSSARY

Open Enrollment Period: A time (once a year) when anyone can enroll in or change their health plan.

Out-of-Pocket Costs: Expenses for health care your health plan doesn't pay. Out-of-pocket costs include deductibles, coinsurance, and co-payments for covered services plus all costs for services your health plan doesn't cover.

Out-of-Pocket Maximum/Limit: The most you have to pay for covered services in a plan year. After you spend this amount on deductibles, co-payments, and coinsurance, your health plan pays all of the costs of covered services.

The out-of-pocket limit doesn't include your monthly premium. It also doesn't include anything you pay for services your plan doesn't cover.

Primary Care: Health services that include a range of prevention and wellness as well as treatments for common illnesses.

Primary Care Providers (PCP): Health care professionals (including doctors, nurses, nurse practitioners, and physician assistants) who manage your care. A PCP often maintains long-term relationships with you. He/She advises and treats you for a range of health-related issues. A PCP also may coordinate your care with specialists.

Prior Authorization: Approval from a health plan to get a service or fill a prescription. If your plan requires prior authorization and you don't get it, the plan may not pay any of the costs.

Qualifying Event: A life change (for example, a marriage or a job change) that lets you enroll in or change your health plan before the next open enrollment period.

Referral: An order from your Primary Care Provider to see a specialist or get certain medical services. Many Health Maintenance Organizations (HMOs) require you to have a referral before they pay for health care from anyone other than your Primary Care Provider.

Self-Funded Health Plan: A type of plan where the employer itself collects premiums from enrollees and pays medical claims. Used by many large employers, the employers can contract with a third-party administrator to manage enrollment, process claims, and manage provider networks. Or, the employer can manage the plan itself.

HOW TO USE YOUR HEALTH PLAN

HEALTH PLAN TERMS GLOSSARY

Special Enrollment Period: A time when you can enroll in or change your health plan because of a qualifying event.

Third-Party Administrator: A company that reviews and pays claims for an employer's self-funded health plan. May share a brand name with a health insurer.

Urgent Care: Care for an illness, injury, or condition so serious that a reasonable person would seek care right away, but not so serious as to require emergency department care.

FOR MORE GLOSSARY OF INSURANCE TERMS, VISIT:

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https://content.naic.org/consumer_glossary

NEED ASSISTANCE?

The Health Coverage Assistance Team (H-CAT) can help you:

- Get answers to your health insurance questions.
- Address health insurance problems or concerns.
- File a complaint about your health insurance issue or concern.
- Connect you to resources.

H-CAT
HEALTH COVERAGE ASSISTANCE TEAM
Navigating Health Insurance

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