

Out-of-Pocket Maximum

This is the maximum amount that you pay before your insurance company will pay 100% of the allowable amount for covered health care services. Depending upon the terms of your policy or plan, this amount can include deductibles as well as copays and coinsurance. Check with your insurance company to determine what is included in this amount under your policy or plan.

Premium

The amount you and/or your employer pay to your insurance company for your policy or plan. This amount may be paid monthly, quarterly or yearly. Failure to pay the premium will result in cancellation of your policy or plan. For more information on how insurance companies determine premiums, see *Frequently Asked Questions: Health Insurance Rates and the Review Process* at www.insurance.maryland.gov.

Preventive Services

You do not need to meet your deductible before you receive preventive services from an in-network provider. You also do not have to pay a copayment or coinsurance for preventive services you receive from an in-network provider. Preventive services include screenings and immunizations, as well as other services. For a complete listing of preventive services that are covered without cost to you, check with your insurance company. Usually, preventive services do not include diagnosis or follow-up visits and services for problems. If you visit your health care provider and discuss a health problem, you may be charged your deductible or coinsurance or copay for the part of the visit dealing with the problem, even if the initial purpose of the visit was preventive.

The Maryland Insurance Administration (MIA) is the state agency that regulates the business of insurance in the State of Maryland. If you have a question about insurance or experience a problem, please do not hesitate to contact the MIA at 800-492-6116 or visit our website at www.insurance.maryland.gov.

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A CONSUMER GUIDE TO UNDERSTANDING YOUR HEALTH INSURANCE COSTS



In order to fully understand the cost of your health insurance, it is important that you know the different costs for which you may be responsible and the terms used to describe them. Some of these key terms are defined below for general information purposes. You should check your policy or plan contract for specific information about how these terms are defined for purposes of your policy.

Allowable Amount

The maximum amount the insurance company* will use when deciding what to pay for a covered health care service. This is sometimes referred to as "payment allowance" or "negotiated rate." You may have to pay the difference if your provider charges more than the allowable amount.

**The term "insurance company" includes HMOs and non-profit health service plans.*

Balance Billing

If you receive covered services from an out-of-network provider, and the cost of these services is more than the allowable amount, the provider may be permitted to bill you for the difference. In some circumstances, you may be protected from balance billing. For example, if you are treated by a Maryland doctor in an emergency room, the law may protect you. If you have a choice of providers, and you choose an out-of-network provider, you may have to pay the full amount of the provider's bill.

Coinsurance

This is your share of the costs of a covered health care service. The coinsurance is applied after any deductible is satisfied. Your share is a percentage, such as 20%, of the allowable amount for the service. Here is how it works:

- a. Your x-ray costs \$200.
- b. The insurance company has an allowable amount of \$150.
- c. Your coinsurance is 20%. Assuming your deductible has already been satisfied, you pay 20% of \$150, which is \$30 and the insurance company pays the remaining \$120.

Copay

This is a set dollar amount that you must pay for a particular service. The amount may be different based on the type of service and whether the service is provided by an in-network or out-of-network provider. For example, your plan may require a \$20 copay for an office visit to an in-network provider and a \$40 copay for an office visit for an out-of-network provider. This fee may be in addition to any deductible for which you are responsible under the plan.

Deductible

This is the amount of money you must pay towards covered services before your insurance company will begin making payments. The deductible may not apply to all services that are covered by your policy or plan. Contact your insurance company for a list of services that are not subject to a deductible under your policy or

plan. For a service subject to the deductible, you or your health care provider will submit a claim(s) to your insurance company even though you are responsible for paying the provider. The insurance company will then apply the allowable amounts for covered services to your deductible. When the total of the allowable amounts equals your deductible, the insurance company will begin to pay claims. Until you meet your deductible, you will need to pay the allowable amount to your health care provider. After you meet your deductible, you will pay only any applicable coinsurance or copay. Generally, you will have to meet your deductible every year.

In-Network Providers

These are providers that have a contract with your insurance company. If you receive covered services from an in-network provider, generally you will only need to pay your deductible and any applicable copay or coinsurance. You may not be billed for the balance by the provider.

Out-of-Network Providers

These are providers that do not have a contract with your insurance company. If you receive covered services from an out-of-network provider, the insurance company may not be required to pay any portion of the charges, or your copay or coinsurance may be larger than if the services had been provided by an in-network provider.