HEALTH INSURANCE TERMINOLOGY

These **definitions** should not be relied upon in any legal or quasi-legal context.

Co-insurance: The portion of the approved claim that you, the policy holder, are obligated to pay. A typical arrangement is for the insurance company and you to share the payment of all claims, based on a percentage basis up to an agreed amount of money, after which the insurance company then pays 100% of covered expenses during the remainder of the calendar year up to any limits of the policy.

Co-Payment: A set fee paid by you for medical expenses upon each occurrence, such as a doctor's office visit, OUTPATIENT SURGERY CENTER VISIT, or other medical services.

Deductible: The amount that you must pay within a specified accumulation period, usually due to a new year, before the insurance company will reimburse you for eligible expenses.

Explanation of Benefits (EOB): A document sent to you when the plan or insurance company handles a claim. The document explains how reimbursement was made e.g., to the insured or to the provider, or why the claim was not paid, and if any additional information is needed. The appeals procedure should be outlined to advise you of your rights if there is dissatisfaction with the decision.

Family Deductible: A health insurance deductible that is based on the medical expenses of the collective members of a family rather than one individual.

Network Providers: Limited grouping or panels of providers in a managed care arrangement. You may be required to use only network providers or you may have financing liability for using non-network providers for medical services.

Out of Network Providers: Medical services obtained by managed care members from unaffiliated or non-contracted health care providers. Often, such care will not be reimbursed unless previous authorization is obtained.

Out of Pocket Maximum Expenses: The maximum amount paid by you before 100% of medical expenses will be covered by the insurance company. Also called "stop-loss."