Overalls Open Enrollment Glossary

Allowed Amount: This is the maximum amount the plan will pay for a covered health care service. May also be called "eligible expense,","payment allowance", or "negotiated rate."

Appeal: A request that you submit to your health insurer or plan to review a decision that denies a benefit or payment (either in whole or in part).

Balance Billing: When a provider bills you for the difference between their charge and the amount covered by insurance. For example, if the provider charges $200 and the insurance covers $110, you may owe the remaining $90. This usually happens with out-of-network providers. Preferred providers typically do not bill you for covered services.

Claim: A request for a benefit (including reimbursement of a health care expense) made by you or your health care provider to your health insurer or plan for items or services you think are covered.

Coinsurance: The portion of a loss covered by insurance after your deductible is met. For example, with 80% coinsurance, a $500 deductible, and a $1,200 claim, you pay $500 upfront. The remaining $700 is split, with insurance covering 80% and you covering 20%. Out-of-network coinsurance typically costs more than in-network.

Copayment: A fixed amount (for example, $15) you pay for a covered health care service, usually at the time you receive the service. The amount can vary by the type of covered health care service. In-network copayments usually are less than out-of-network copayments.

Overalls Open Enrollment Glossary

Cost Sharing: Your share of costs for covered services that you pay out of pocket, including copayments, deductibles, and coinsurance. Family cost sharing refers to the total amount you and your dependents pay out of pocket for deductibles and other covered costs. Premiums, penalties, and non-covered care are not typically considered cost sharing.

Death Benefit: This is less creepy than it sounds. Specific to life insurance, the death benefit is the payout (one lump sum) to the designated beneficiary or trust.

Deductible: The amount you must pay for covered health care services before your plan starts paying. This can be an annual deductible or a per-claim deductible. With a per-claim deductible, you pay the deductible amount (e.g., the first $500) for each claim, and the insurance covers the rest.

Flexible Savings Account: A tax-advantaged savings account for out-of-pocket health expenses like copays, medical bills, and vision care. Managed by your employer, it's funded with pre-tax contributions, with an annual contribution cap. Unused funds don't roll over to the next year.

Formulary: A list of drugs your plan covers. A formulary may include how much your share of the cost is for each drug. Your plan may put drugs in different cost sharing levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different cost sharing amounts will apply to each tier.

Health Insurance: A contract that requires a health insurer to pay some or all of your health care costs in exchange for a premium. A health insurance contract may also be called a "policy" or "plan".

Overalls Open Enrollment Glossary

Health Savings Account: Similar to a FSA, a HSA is a pre tax savings account to help you pay for health care expenses. In order to enroll in an HSA you must be enrolled in a high deductible health plan. The HSA account is owned and managed by you.. There is no requirement to use the funds in the plan year and if you leave your employer, you take your HSA with you.

Liability: Coverage for accidental property damage or bodily injury that you cause to someone else.

Loss of use coverage: Specific to renters and homeowners insurance, this is coverage in the event that you have a loss that causes you to move out of your home for a period of time. Your loss of use limit is typically 20% of your contents limit (i.e., for $10K in contents coverage you would have $2K in loss of use coverage).

Maximum Out-of-pocket Limit: Yearly amount the federal government sets as the most each individual or family can be required to pay in cost sharing during the plan year for covered, in-network services. Applies to most types of health plans and insurance. This amount may be higher than the out-of-pocket limits stated for your plan.

Medical payments: Specific to renters and homeowners insurance, these are payments in case a guest gets injured at your house.

In-Network Provider (Preferred Provider): A provider who has a contract with your health insurer to provide services to members of a plan. You will pay less if you see a provider in the network. Also called “preferred provider” or “participating provider.”

Overalls Open Enrollment Glossary

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

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

Out-of-network Provider (Non-Preferred Provider): A provider not contracted with your plan. If your plan covers these services, you'll typically pay more compared to in-network providers. Your policy will detail the costs. They may also be referred to as "non-preferred" or "non-participating."

Out-of-pocket Limit:: The maximum amount you pay for covered in-network services in a year. Once this limit is reached, the plan usually covers 100% of costs. It doesn't include premiums, balance-billed charges, or non-covered services. Some plans may exclude certain expenses from this limit.

Preauthorization: A decision by your insurer that a service, treatment, drug, or durable medical equipment (DME) is medically necessary. Also known as prior authorization, prior approval, or precertification, it may be required before receiving certain services (except in emergencies). Preauthorization doesn't guarantee coverage.

Premium: The cost of your health insurance or plan. You and/or your employer usually pay it monthly, quarterly, or yearly.

Overalls Open Enrollment Glossary

Preventive Care (Preventive Service): Routine health care, including screenings, check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

Primary Care Physician: A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who provides or coordinates a range of health care services for you.

Primary Care Provider: A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the plan, who provides, coordinates, or helps you access a range of health care services.

Out-of-pocket Limit:: The maximum amount you pay for covered in-network services in a year. Once this limit is reached, the plan usually covers 100% of costs. It doesn't include premiums, balance-billed charges, or non-covered services. Some plans may exclude certain expenses from this limit.

Provider: An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The plan may require the provider to be licensed, certified, or accredited as required by state law.

Referral: An order from your primary care provider for you to see a specialist. Many health maintenance organizations (HMOs) require a referral before you can get health care services from anyone except your primary care provider. If you don't get a referral first, the plan may not pay for the services.

Overalls Open Enrollment Glossary

Specialist: A provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Specialty Drug: A type of prescription drug that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a formulary.

UCR (Usual, Customary and Reasonable): The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount is sometimes used to determine the allowed amount.

