

Health Insurance Glossary

Term	Definition
Claim	A request by the health care provider for the insurance company to pay for medical services.
Composite/Supercomposite	(Used interchangeably) A term used to describe the health insurance premium when it is the same rate whether or not dependents are enrolled.
Copay	A fixed amount you pay for a covered health care service or prescription, usually when you receive the service. The amount can vary by the type of covered health care service.
Coinsurance	Your share of the costs of a covered health care service, calculated as a percent (for example, 20%).
Deductible	An amount you owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. The deductible requirement does not apply to preventive services.
Explanation of Benefits (EOB)	An EOB is created after a claim payment has been processed by your health plan. It is the health insurance company's written explanation of how a medical claim was paid.
Flexible Spending Account (FSA)	An employee benefit that allows you to set aside money on a pre-tax basis to pay for certain out-of-pocket health care costs.
Hospitalization	Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some plans may consider an overnight stay for observation as outpatient care instead of inpatient care.
In Network	Facilities and health care provider with a contractual agreement with the insurance company.

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Out of Network	Services are considered out of network when you use a facility or health care provider that does not have a contract with your health plan.
Out of Pocket Maximum (OOPM)	The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100%.
Premium	The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly, or yearly.
Tier	A structure used to determine the health insurance premium based on the number of people enrolled in the plan.

Health Insurance Plans & Types

Health Maintenance Organization (HMO)	An HMO delivers all health services through a network of healthcare providers and facilities. Members have a primary care doctor to manage care. Out of network care is typically not covered.
Preferred Provider Organization (PPO)	A PPO has a network of preferred providers. You pay less if you go to these providers. Preferred providers are also called in-network providers. With a PPO, you can go to a doctor or hospital that is not on the preferred provider list. This is called going out-of-network. However, you pay more to go out-of-network.
Health Savings Account (HSA)	An investment account available only to members who are enrolled in a High Deductible Health Plan (HDHP) that lets you set aside money on a pre-tax basis to pay for qualified medical expenses. These accounts earn interest and roll over any remaining balance from year to year. The funds are yours to keep whether you change plans, jobs or retire.