Medical Insurance Definitions 101

Copay, coinsurance and deductible—what do these unfamiliar words mean?

Although these terms may seem as if they belong in a foreign language dictionary, this guide will help you better understand some common medical insurance terms. See contact information at the end of this document for additional information and assistance with understanding these definitions.

If you want to learn more about healthcare basics and terms, listen to a podcast in English/Spanish thislifeatsodexo.transistor.fm/

Understanding Your Plan

Preferred Provider Organization (PPO)—with a PPO, you can choose any doctor you want to see from a large national list of primary care and specialty doctors. You do not need a referral to see a specialist with a PPO.

A PPO may cover some costs if you see an out-of-network doctor, but you will pay more to see them. If you choose to see a doctor who is not in your plan's network, you may need to pay for the services at the time of the visit and file a claim to be reimbursed.

Health Reimbursement Account (HRA)—with the CareFirst HRA, Sodexo deposits funds into your account that are used to pay for covered health care services for you and your dependents. The level of coverage you enrolled in will determine the amount of money contributed to your account annually by Sodexo.

As claims are processed, money in your HRA is automatically used to pay for these claims. Once your HRA funds are spent, you are responsible for paying for your portion of the claims until you have met your annual deductible. If you remain enrolled in the HRA plan, any money remaining in your account at the end of the year will be rolled over for you to use the following year. If you stop participating in the HRA Plan for any reason, the remaining money in the HRA is forfeited.

Health Maintenance Organization (HMO)—with an HMO (such as with the Kaiser Permanente plan) you are required to choose a primary care physician (PCP) who's part of the plan's group of local participating providers. With an HMO, you are almost always required to see your PCP first and get a referral before you can see a specialist. If you see a PCP outside the HMO plan network, your costs are not typically covered, except for emergency services.

Understanding Your Network

In-Network—your health insurance carrier's approved group of health care providers—including doctors, hospitals, pharmacies and labs—where you can receive medical services. When you use in-network providers you will almost always pay less than if you use an out-of-network provider.

Out-of-Network—health care providers who do not agree to participate in your insurance carrier's network are out-of-network. You will pay more if you receive care from a provider who does not participate in your plan's network.

Primary Care Physician (PCP)—the doctor you select from your health insurance carrier's approved list to handle your health care needs like annual check-ups and sick visits. Your PCP will also help coordinate additional care you may need such as a visit with a specialist, X-rays or lab work. A PCP is required for HMO plans and not required for PPO plans.

Understanding Your Healthcare Costs

Allowed Benefit—is the highest amount in-network providers are allowed to charge for covered services, regardless of their actual charge. For example, if the doctor's visit is $200 and the allowed amount is $100, all you'll have to pay is $100; even less if you only owe a copay or you've met your deductible.

If a provider you use is not part of your plan's network, that provider can charge more than the allowed benefit and you may have to pay the difference (see balance billing).

Annual Deductible—a set dollar amount that you pay out-of-pocket every plan year before the insurance carrier begins to pay its portion of your claims. Your actual deductible depends on the health plan you choose. Premiums and copays do not count toward your deductible.

Certain services may not require you to meet your deductible first such as services that have a copay or preventive care. That means you do not have to reach your deductible before the insurance carrier will pay its portion of the preventive services. Preventive services are provided at no cost to you as part of the Affordable Care Act.

Annual Out-of-Pocket Maximum—the most you will pay for medical expenses during your health plan year. Once you have paid this amount out-of-pocket, the insurance carrier will pay 100% of your covered medical expenses for the remainder of the plan year. Premiums do not count toward your out-of-pocket maximum.

Balance Billing—when a provider charges you the difference between the amount they charged and the amount the insurance carriers paid for a claim. For example, if the out-of-network provider charges $100 and the allowed benefit is $70, the provider may bill you for the remaining $30.

It is important to know that in-network providers have agreed to accept the allowed benefit as payment in full and will not balance bill you. It's best to use in-network providers as much as possible to help keep your costs down.

Coinsurance—is the percentage owed for certain covered services. You have a certain percentage you are responsible for and your medical plan pays the rest. If your plan coverage requires you to pay 20% coinsurance then your medical plan will pay 80% of the cost.

For example, if the allowed benefit is $100, and you have met your deductible, the insurance carrier will pay $80 and you will owe $20. Your coinsurance depends on the health plan you choose and whether you use in- or out-of-network providers.

Coordination of Benefits (COB)—occurs when you or your dependents are covered by more than one medical plan (for example, you are covered under the Sodexo plan as well as your spouse's plan). If you are covered by more than one medical plan, one plan is considered to be the **primary** plan and the other is the **secondary** plan.

The primary plan pays what it will pay on the claim first, and the remaining balance is then considered for payment by the secondary plan. If approved, the amount of this payment will not exceed: the secondary plan's responsibility, the patient liability or the full cost of the service. Benefits are thus "coordinated" between the two medical plans, and you will be responsible for any remaining unpaid balance.

If the CareFirst coverage is secondary, Carefirst will pay the patient balance after the primary insurance pays or the amount after benefits and cost share is applied, whichever is less.
Not all medical plans have a COB provision. If they do not have a COB provision, benefits will be paid by your Sodexo medical plan. You can find the COB provisions of your medical plan in the Summary Plan Description found at SodexoBenefitsCenter.com

Copay—the fixed amount (for example, $30) you owe for certain covered health care services, such as doctor office visits. You pay this amount at the time you receive the services. Not all plans have copays.

Premium—the amount you pay out of your paycheck for your health insurance benefits.

For more information about medical plan coverage, see your Summary Plan Description under "Benefits Resources" at SodexoBenefitsCenter.com.

You may also call Advocacy Services if you need help understanding this terminology. Get the help you need at 866-888-3203 between 8 a.m. and 7 p.m. ET, Monday through Friday.