

Know your health insurance jargon



Do you know your copay from your coinsurance? How about the difference between your out-of-pocket limit and your deductible? There's no doubt about it—health insurance is complicated. It has its own language and you can get lost if you aren't aware of what the jargon means. Take some time to learn the lingo so you don't panic when you have a question. Let's walk through a few more common health insurance terms to help you understand your health coverage better.

Benefit. Sometimes you'll hear about a health plan “paying a benefit.” This is the amount paid by the insurance company for an insured person's medical costs. Usually, the insurer pays the health care provider directly for covered services.

Claim. For every medical service you receive, you or your health care provider (usually the provider) must submit a claim. This is a request for the insurance company to pay for medical services. The insurance company processes the claim and either approves or denies it based on the terms of your policy.

Coinsurance. Some health plans require you to share in paying the cost for certain covered services. The percentage you pay is the coinsurance amount. For example, if the health plan pays 80%, that makes you responsible for paying the remaining 20% for your covered service.

Copayment. This is a flat fee you pay for a covered service. You might pay a \$50 copay for every doctor visit, for example.

Deductible. This is the amount of money you must pay each year to cover your eligible medical expenses before your insurance policy starts paying.

Explanation of Benefits. Those in the know call these “EOBs.” This document is the health insurance company's written explanation of how a claim was processed. It offers detailed information about what the insurer paid and what portion of the costs are your responsibility. It's not a bill. [Here's how you read a WPS EOB.](#)

Health maintenance organization (HMO). A health care financing and delivery system that provides comprehensive health care services for enrollees in a particular geographic area. HMOs require the use of specific, in-network plan providers.

Note: These are general definitions meant for informational purposes only. Always read and follow the definitions in your policy.

Network. This is the group of health care providers and facilities that a health insurer has contracted with to provide you with health care services at discounted rates. You will generally pay less for services from providers in your network.

Out-of-pocket maximum. Sometimes abbreviated as “Max. OOP” or “MOOP,” it includes the amounts that you pay to satisfy your deductible, copayments, and coinsurance requirements. What you pay for your premium does not count toward your out-of-pocket maximum. Once the MOOP for the calendar year is met, you will not have to pay any further deductible, copayment, or coinsurance amounts for that year. There may be other expenses, however.

Point-of-service (POS). A type of managed care plan that allows customers to use both in-network and out-of-network providers for their health care. Benefits for covered services received from out-of-network providers are usually lower than benefits for services received from in-network providers.

Preferred provider organization (PPO). A health insurance plan that offers greater freedom of choice than HMO (health maintenance organization) plans. Customers of PPOs are free to receive care from both in-network or out-of-network (non-preferred) providers, but will receive the highest level of benefits when they use providers inside the network.

Premium. The amount you and/or your employer pays each month in exchange for insurance coverage.

Prior authorization. There are certain services that might be covered, but that require you to ask for approval ahead of time. You can [view some examples](#) online.

Provider. This can be any person (i.e., doctor, nurse, dentist) or institution (i.e., hospital or clinic) that provides medical care.

There are, of course, [many more health insurance terms](#) you may run across. Armed with this knowledge, you're now more prepared to ask good questions and take a more active role in your health insurance and health care decisions.

If you have any questions, we are here to help. You can call us at the number on the back of your WPS customer ID card and we'll be happy to talk!

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