BENEFITS 101 – BENEFITS TERMINOLOGY

UNDERSTANDING BENEFITS TERMINOLOGY CAN BE CHALLENGING. WHETHER YOU'RE NEW TO INSURANCE OR HAVE BEEN IN THE INDUSTRY FOR A WHILE, THIS GUIDE WILL HELP YOU BETTER UNDERSTAND THE TERMS AND CONCEPTS:

1. **POLICY:** A policy is a legal contract between an insurance company and the policyholder. It outlines the terms and conditions of the insurance coverage, including what is covered and what is not covered.

2. **PREMIUM:** The premium is the amount you pay the insurance company to maintain your policy. The employee usually pays a portion of the premium via payroll deductions, while the employer pays the rest. Keep in mind that policyholders must pay their monthly premiums regardless of whether they visit a doctor or use any healthcare service.

3. **DEDUCTIBLE:** A deductible is an amount you must pay out of pocket before your insurance kicks in. For example, suppose you have a $500 deductible, and you incur $1200 in medical expenses. In that case, you'll be responsible for paying $500, and the rest will run through your insurance plan, subject to copays and co-insurance.

4. **CO-PAY:** A co-pay is a fixed amount you pay for a specific medical service, such as a doctor's visit. Your insurance company will typically cover the remaining cost.

5. **CO-INSURANCE:** Co-insurance is the percentage of covered medical costs you are responsible for paying. For example, if you have 80/20 co-insurance, your insurance company will cover 80% of the cost, and you'll be responsible for the remaining 20%.

6. **OUT-OF-POCKET MAXIMUM:** An out-of-pocket maximum is the most you'll have to pay for covered medical expenses in a given year. Once you reach the maximum, your insurance company will cover the remaining costs.

7. **CLAIM:** A claim is a request for payment from your insurance company for a covered medical expense. These could be for things such as routine doctor's visits, emergency medical care, including sickness, injury, and mental health treatment, or bloodwork, x-rays, and other lab work.

8. **IN-NETWORK/OUT-OF-NETWORK:** Most health plans provide access to a network of doctors, facilities, and pharmacies. To be considered in-network, these doctors and facilities must meet certain requirements and agree to accept a discounted rate for covered services under the health plan. If a doctor or facility has no contract with your health plan, they're considered out-of-network and can charge you the full price.