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 o f 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.

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