inSupport™

Glossary of Insurance Terms

- **Coinsurance:** The percentage of costs of a covered health care service you pay after you've paid your deductible.[1]
- **Copayment:** A fixed amount you pay for a covered health care service after you've paid your deductible.[1]
- **Coverage Gap:** A period of time in which you pay higher cost sharing for prescription drugs until you spend enough to qualify for catastrophic coverage. The coverage gap (also called the “donut hole”) starts when you and your plan have paid a set dollar amount for prescription drugs during that year.[2]
- **Deductible:** The amount you pay for covered health care services before your insurance plan starts to pay. After you pay your deductible, you usually pay only a copayment or coinsurance for covered services. Your insurance company pays the rest.[1]
- **In-Network Coinsurance:** The percent you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network coinsurance usually costs you less than out-of-network coinsurance.[1]
- **In-Network Copayment:** A fixed amount you pay for covered health care services to providers who contract with your health insurance or plan. In-network copayments usually are less than out-of-network copayments.[1]
- **Medicare:** A federal health insurance program for people 65 and older and certain younger people with disabilities.[1]
- **Medicare Part D:** A program that helps pay for prescription drugs for people with Medicare who join a plan that includes Medicare prescription drug coverage.[1]
- **Network:** The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.[1]
- **Out-of-Network Coinsurance:** The percentage you pay of the allowed amount for covered health care services to providers who don't contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.[1]
- **Out-of-Network Copayment:** A fixed amount you pay for covered health care services from providers who don't contract with your health insurance or plan. Out-of-network copayments usually are more than in-network copayments.[1]
- **Out-of-Pocket Costs:** Your expenses for medical care that aren't reimbursed by insurance. Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services plus all costs for services that aren't covered.[1]
- **Out-of-Pocket Estimate:** An estimate of the amount that you may have to pay on your own for health care or prescription drug costs. The estimate is made before your health plan has processed a claim for that service. [1]
- **Out-of-pocket maximum/limit:** The most you have to pay for covered services in a plan year. After you spend this amount on deductibles, copayments, and coinsurance, your health plan pays 100% of the costs of covered benefits. The out-of-pocket limit doesn't include your monthly premiums. It also doesn't include anything you spend for services your plan doesn't cover.[1]
- **Prior Authorization:** Approval from a health plan that may be required before you get a service or fill a prescription in order for the service or prescription to be covered by your plan.[1]
- **Secondary Payer:** The insurance policy, plan, or program that pays second on a claim for medical care. This could be Medicare, Medicaid, or other insurance depending on the situation.[2]

If you have questions about your insurance benefits, please contact your insurance provider or INSUPPORT at 844-INSPPRT (844-467-7778), Monday – Friday 8:00 AM - 8:00 PM ET.

References:

1. Healthcare.gov Glossary of Insurance Terms https://www.healthcare.gov/glossary/
   Accessed October 24, 2017
2. Medicare.gov Glossary https://www.medicare.gov/glossary/c.html
   Accessed October 24, 2017

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