



Health Coverage Terms: Quick Guide

Short definitions of the main health-coverage terms.

Short, plain-language definitions of common health-coverage terms. Specific plan rules vary; check your plan documents for how each term applies to you.

Term	What it means
Allowed amount	The amount a plan recognizes for a covered service. It may be lower than the amount a provider bills.
Balance billing	When a provider bills you for the difference between what they charge and the plan's allowed amount. It may happen in some out-of-network situations.
Claim	A request for payment sent to the health plan for services you received.
Coinsurance	A percentage of the allowed cost of a covered service that the member may pay, often after the deductible.
Copay	A fixed amount that may apply to certain covered services, such as a visit or a prescription.
Cost-sharing	The share of costs for covered services that the member pays, such as deductibles, copays, and coinsurance.
Deductible	An amount you may need to pay toward certain covered services before the plan begins paying its share for those services.
EOB (Explanation of Benefits)	A statement from the plan that explains how a claim was processed. An EOB is not a bill.
EPO	Exclusive Provider Organization. Usually covers in-network care only, except in certain situations such as emergencies.
Formulary	A plan's list of covered prescription drugs, often grouped into cost-sharing levels.
HMO	Health Maintenance Organization. Usually focuses on in-network care and often requires referrals to see specialists.
In-network	Providers that have an agreement with your specific plan to provide covered services at negotiated rates.
Out-of-network	Providers that do not have an agreement with your specific plan. Care may cost more or may not be covered.
Out-of-pocket maximum	An annual limit on applicable member cost-sharing for covered in-network services. Premiums generally do not count.
PPO	Preferred Provider Organization. Usually allows in-network and out-of-network care, often with higher costs out-of-network.
Premium	The amount paid to maintain health coverage, often monthly.



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Prior authorization	A process in which a plan may require approval before certain services or medications are covered. It does not necessarily guarantee payment.
Referral	Direction from a primary care provider to see a specialist. Often required by HMOs.
Summary of Benefits and Coverage (SBC)	A standard document that summarizes a plan's costs and coverage in a consistent format.

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