

- **Benefit year or coverage year** – A year of health insurance coverage. For example, a plan starting January 1 will end December 31. You must re-enroll each year and, starting January 1, begin paying out-of-pocket costs to meet your plan deductible again.
- **Benefits** – The health care services or items, such as medicines or medical equipment, your health insurance plan covers.
- **Claim or insurance claim** – A request for payment that you or your health care provider send to your health insurance company when you visit a doctor, hospital, or pharmacy.
- **COBRA coverage** – If you lose your job, you can temporarily keep your employee health insurance – but you must pay all of the monthly premiums yourself, including the share the employer used to pay.
- **Co-insurance** – Your share of the cost for health care services after you have paid your deductible each year (see “Deductible”). Once you reach your deductible, the insurance plan will start sharing the cost of health care with you. For example, if you go for a doctor visit that costs \$100, your share may be \$20 and your insurance plan’s share may be the remaining \$80.
- **Copayment** – A fixed amount you may pay at the time you receive a health care service – for example, you may pay \$15 when you go for a doctor visit.
- **Deductible** – The amount you must pay out of your own pocket for your covered health care services each year – for example, \$1,000. Once you reach your deductible, your insurance plan will begin sharing the cost with you (see “Co-insurance”).
- **Employer-sponsored insurance plan** – Insurance you get through your job. Employers that offer an insurance plan pay a share of their employees’ monthly premiums.
- **Essential health benefits** – The 10 kinds of health care services most insurance plans must now cover, including care to help prevent disease, care for children, emergency care, prescription drugs and more.
- **Excluded services** – Health care services that are not covered and not paid for by your insurance plan.
- **Explanation of Benefits (EOB)** – A written explanation your insurance company sends you after you get a health care service. The EOB shows how much money the insurance company paid and how much money you must pay (if any) for the covered health care service or item. The EOB is not a bill. If you owe any money, you will get a bill from your health care provider.
- **Flexible Spending Account (FSA)** – An account that lets you set aside money from your paycheck to pay for qualified medical expenses, deductibles, copays, and certain over-the-counter (OTC) items if you have a doctor’s prescription for that item. The advantage to you is that the money you put into the account is not taxed by the federal government. You must enroll each Option Period or you lose the account. For an estimate of how much you could save, use the FSA Savings Calculator at: <https://www.ebd.ok.gov/flexible-spending/Pages/FSA-Calculator.aspx>.
- **Formulary or drug formulary** – A list of the prescription medicines or drugs that are covered under your insurance plan. Most formularies group the drugs into tiers (levels) to control costs. Your plan may pay less for the drugs in some tiers.
- **Health Insurance Marketplace** – An online marketplace where you can buy a Qualified Health Plan (Bronze, Silver, Gold or Platinum) or Catastrophic coverage from private insurance companies.
- **Health Savings Account (HSA)** – A savings account available to people who enroll in a high deductible health plan. The money you put into the account can only be used to pay for qualified medical expenses, such as doctor visits or medicines. The advantage to you is that the money you put into the account is not taxed by the federal government.
- **Medicaid** – A government health insurance program for Americans who have a low income

or a disability. Oklahoma provides separate programs for adults and for children up to age 20.

- **Medicare** – A government health insurance program for Americans who are age 65 or older, certain younger people with disabilities and people who have end-stage renal disease (kidney failure).
- **Network providers or in-network providers** – Health care providers, including doctors, hospitals and other suppliers, who contract with your insurance plan to give you health care services to you at a lower cost. In-network providers are also called “preferred” providers.
- **Option Period** – A period of time when you can enroll in or change an insurance plan with your employer.
- **Out-of-network providers** – Health care providers, including doctors and hospitals, who have not contracted with your insurance plan. You’ll pay more for their services. Out-of-network providers are also called “non-preferred” providers.
- **Out-of-pocket costs, also known as cost sharing** – Money that you pay for health care services yourself, out of your own pocket. These costs include deductibles, copayments and coinsurance. They do not include monthly premiums and may not include costs for services you get outside your provider network.
- **Out-of-pocket maximum** – A limit on your out-of-pocket costs – for example, \$5,000. After you have reached your out-of-pocket maximum for the year, your insurance company will pay

100 percent of your covered essential health benefits. Out-of-pocket maximum costs differ from plan to plan.

For example, your deductible may or may not count toward your out-of-pocket maximum. Check the Summary of Benefits and Coverage (SBC) for your insurance plan to see which out-of-pocket costs count toward your out-of-pocket maximum.

- **Premium** – The cost you pay for your health insurance. Premiums may be paid by you, your employer or a combination of both. It is usually paid monthly.
- **Primary care doctor** – A doctor who gives care for common health problems and for preventing illness. They can help you get access to specialists and special care services if you need them.
- **Specialist or special care doctor** – A doctor who gives health care for a specific medical problem – for example, a foot doctor or heart doctor. A doctor who gives care for common illnesses or injuries is called a primary care doctor.
- **Summary of Benefits and Coverage (SBC)** – A written summary that shows its costs and benefits. When you’re shopping for health insurance, you can compare the costs and benefits of different plans by reading their SBCs. You can see SBCs for the plans available to you at: [https://www.ok.gov/sib/Member/Summary\\_of\\_Benefits\\_and\\_Coverage/index.html](https://www.ok.gov/sib/Member/Summary_of_Benefits_and_Coverage/index.html). When you enroll in a health insurance plan, your insurance company will send you the SBC for your plan.

## Learn more

- Oklahoma Employee Benefits Department: [www.ebd.ok.gov/Benefits/Pages/default.aspx](http://www.ebd.ok.gov/Benefits/Pages/default.aspx)
- Oklahoma State Benefits Coordinators: [www.ebd.ok.gov/Benefits/State-Benefits-Coordinators/Pages/OK-State-Agency-BCs.aspx](http://www.ebd.ok.gov/Benefits/State-Benefits-Coordinators/Pages/OK-State-Agency-BCs.aspx)

