Insurance Definitions

- "In-Network" refers to medical providers that are part of a health insurance plan's network of providers with which it has negotiated a discounted contractual rate.

- "Out-of-Network" refers the providers that are seeing patients who do not have a contractual rate with the insurance payor. Often, expenses from out-of-network providers are higher than if the provider was in-network.

- A "Deductible" is a specified amount of money that you as the insured must pay before an insurance company will begin to pay towards therapy services.

- A "Copay" is a fixed amount of money that you pay for a health care service, usually at the time the service is received.

- "Coinsurance" is your share of the costs of a health care service and is typically calculated as a percentage of the amount charged for services after you have met your deductible and before you have reached your out-of-pocket maximum.

- An "Out-of-Pocket-Maximum" is the most money you have to pay for a covered service within a plan year. After you spend this amount on deductibles, copayments, and coinsurance, your health plan generally pays 100% of the remaining costs of covered benefits.

- A "Pre-Certification Requirement" is a plan-imposed condition that must be met prior to the plan paying for a covered service. This is also known as "Preauthorization"

- "Exclusions," also known as policy restrictions or limitations, are plan-imposed conditions that limits services you may receive as part of the coverage within your policy. These restrictions may include visit limitations, restrictions on the locations of services provided, certain conditions (pre-existing, congenital abnormalities, autism, etc.), or restrictions based on the qualifications of the provider who would be seeing the patient.

- A "Covered Service" is a service that is covered according to the terms provided in your health care benefits plan. If you receive a therapy service that is a "non-covered service," you will be required to pay out of pocket; non-covered services do not go towards your deductible or out-of-pocket maximum

- An "Explanation of Benefits," also known as an EOB is created by your insurance company after a claim payment has been processed by your health care plan. It explains

the actions taken on a claim, such as the amount that will be paid, the benefit available, discounts, reasons for denying payment and the claims appeal process.

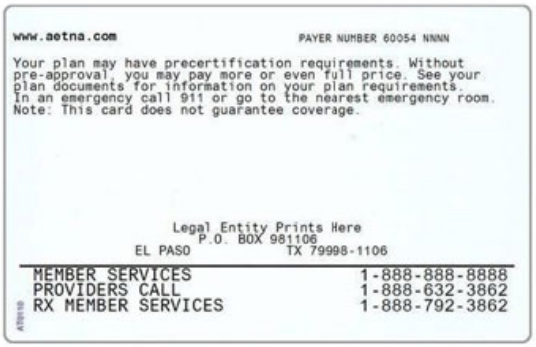
- A "Referral" from a doctor may be required if you have a specialized plan. A referral is a written authorization from a member's primary care physician (PCP) to receive care from a different contracted doctor, specialist, or facility.

- A "Member" refers to the person whom health care coverage has been extended by the policyholder (generally their employer) or any of their covered family members. Sometimes this is referred to the insured person.

- "Family Coverage" is often part of health care coverage for a primary policyholder and his or her spouse and any eligible dependents. Family deductibles and out-of-pocket maximums may be different than individual deductibles or out-of-pocket maximums.

Looking at Your Health Insurance Card

Here's an example insurance card that demonstrates an Aetna policy for the Q Family.



In this example:

- Primary policy holder: Jonathan Q
- Dependents: Jocelyn Q, Grayson Q, Danielle Q
- Member number: W1234 56789
- Group number: 111111-11-101
- Type of plan: Open Choice PPO
- Member services number: 1-888-888-8888