Definitions

Deductible: This is the amount you pay toward covered expenses in a calendar and/or plan year before the plan pays benefits.

Coinsurance: This is the percentage of covered expenses the plan pays after the deductible is met (e.g., for an 80/20 plan, the health plan member's coinsurance is 20%).

Point of Service (POS) Plan: Plan allows a choice of receiving services from a provider in or out of network. You receive the highest level of benefits from providers in the network.

Health Maintenance Organization (HMO) Plan: Providers contract with the HMO to provide the most cost-effective medical services to members. Contracted providers must be used for services to be covered. Emergency care and approved out-of-network care are also eligible.

Health Savings Account (HSA): HSAs allow individuals to pay for health expenses and save for future qualified medical expenses on a tax-free basis. To be eligible for an HSA, you must be covered by a High Deductible Health Plan (HDHP), not covered by other health insurance, not eligible for Medicare, and not claimed as a dependent on someone else's tax return.

Primary Care Practitioner (PCP): A Practitioner who practices in the area of family practice, internal medicine, pediatrics, general practice, or obstetrics/gynecology. When a member first becomes eligible for coverage under this Plan, he or she must designate a Primary Care Practitioner. The member may designate a different Primary Care Practitioner at any time by notifying Arise Health Plan. Each member may select a different Primary Care Practitioner.

Specialty Care Practitioner: A Practitioner whose primary practice is other than family practice, internal medicine, pediatrics, general practice, or obstetrics/gynecology.

In-network: Describes a provider or health care facility that is part of a health plan's network. Insured individuals usually pay less when using an in-network provider.

Out-of-network: Describes a provider or health care facility that is not part of a health plan's network. Insured individuals usually pay more or services may not be covered when using an out-of-network provider.

Pre-Service Authorization: This is the process of receiving written approval from the health plan for certain services or products in advance of the service or product being provided.

Annual Maximum: This is the maximum amount the plan pays for each covered person for covered expenses during a year.