Health Plan Terminology

Benefits:

Benefits

Items or services covered by a health insurance plan. Items and services that are covered and excluded are defined by the health plan and explained in the health plan coverage documents.

Emergency Services

Conditions that are considered life-threatening or a sever sickness and may require immediate attention. Emergency services are usually received in the emergency room of a hospital facility.

Excluded (Non-covered) Services

Health care services that your health insurance or plan doesn't pay for or cover.

Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Preventive Services

Routine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems.

Urgent Care

Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe it requires emergency room care.

Essential Health Benefits

A list of benefits that group health plans must provide under the health care law. This includes many basic services, such as doctor visits and hospital stays. Benefits will also include preventive care, maternity care, and mental health services. **Note:** Specific services may vary based on your state's requirements

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Cost-sharing:

Aggregate

For family coverage, it means the entire family deductible or out-of-pocket amounts must be met before copayments or coinsurance are applied for each individual family member.

Allowed Amount

The maximum amount a plan will pay for a covered health care service. May also be called “eligible expense,” “payment allowance,” or “negotiated rate.” If your provider charges more than the plan’s allowed amount, you may have to pay the difference.

Annual Deductible Combined

The total amount that family members on a plan must pay out-of-pocket for health care or prescription drugs before the health plan begins to pay.

Balance Billing

When a provider bills you for the difference between the provider’s charge and the allowed amount. For example, if the provider’s charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30.

Coinsurance

The percentage of costs of a covered health care service you pay (20%, for example) after you've paid your deductible.

Let's say your health insurance plan's allowed amount for an office visit is $100 and your coinsurance is 20%.

- If you've paid your deductible: You pay 20% of $100, or $20. The insurance company pays the rest.
- If you haven't met your deductible: You pay the full allowed amount, $100.

Cost-sharing

Also known as out-of-pocket costs, it’s the amount of money you pay for a health care service, in the form of copays, deductibles, and coinsurance. This is in addition to the premium or monthly rate you pay to be a plan member.

Copayment

Copayments (sometimes called "copays") are a flat fee you pay when you see a doctor or receive other covered medical services. For example, a copayment could be $20 to see a doctor or $100 to go to the emergency room.

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Deductible

The amount you pay each year before your health plan starts paying for services. For example, if your plan has a $1,000 deductible, you will need to pay the first $1,000 of the costs for the health care services you receive. Once you have paid this amount, your insurance will begin to pay a portion or all of your health care costs, depending on the plan. After you pay your deductible, you usually pay only a copayment or coinsurance for covered services. Your insurance company pays the rest.

Embedded

Embedded means each covered family member only needs to satisfy his or her individual out-of-pocket maximum, not the entire family out-of-pocket amounts. This can apply to the deductible and/or out-of-pocket maximum.

Fee for Service

A method in which doctors and other health care providers are paid for each service performed. Examples of services include tests and office visits.

High Deductible Health Plan (HDHP)

A health plan that has a high minimum deductible that a plan member must reach before the health plan begins to pay for covered services. HRAs and HSAs may be paired with these plans to help offset the costs of the high deductible. These plans typically offer a lower monthly premium and give plan members more control over their health care dollars.

Network

The doctors, hospitals, labs, and other health care providers who contract with a health insurance company to deliver services to plan members. They usually charge discounted rates for their services, so you'll save the most money by visiting in-network providers. Facilities, providers, and suppliers that are not contracted (or non-participating) with the health plan are considered Out-of-Network (ONN) and usually have a higher cost than In-Network.

Premium

The amount you pay for your health insurance every month. In addition to your premium, you usually have to pay other costs for your health care, including a deductible, copayments, and coinsurance.

Out-of-Pocket (OOP) maximum

The maximum dollar amount you or your family could pay for covered health care services. Out-of-Pocket maximum may include Copayments, Coinsurance, and/or Deductibles.

Health Plan Terminology

Prescriptions:

Brand-name (Drugs)

A drug sold by a drug company under a specific name or trademark and that is protected by a patent. Brand name drugs may be available by prescription or over the counter.

Formulary

A formulary is a list of drugs covered by the health plan. The list may change as drugs are added or removed. This list may also change based on coverage limitations on certain drugs, or how much you pay for a drug. The formulary list may also vary by plan.

Formulary (or Preferred) Brand Drugs

Formulary (Preferred) Brand medications is a list of brand-name drugs covered by the health plan. These drugs generally do not have generic equivalents.

Generic Drugs

A prescription drug that has the same active-ingredient formula as a brand-name drug. Generic drugs usually cost less than brand-name drugs. The Food and Drug Administration (FDA) rates these drugs to be as safe and effective as brand-name drugs.

Non-Formulary (Non-Preferred) Brand Drugs

Non-Formulary (non-preferred) medications are brand-name drugs that are not included on the plan's approved list of brand-name medications. These generally have one or more generic alternatives or preferred brand options within the same drug class. They may also have a high out-of-pocket cost.

Prescription Drugs

Drugs and medications that, by law, require a prescription.

Specialty Drugs

A medication that meets certain criteria including, but not limited to:c3

- The drug is used in the treatment of a rare, complex, or chronic disease.
- A high level of involvement is required by a healthcare Provider to administer the drug.
- Complex storage and/or shipping requirements are necessary to maintain the drug's stability.
- The drug requires comprehensive patient monitoring and education by a healthcare Provider regarding safety, side effects, and compliance.
- Access to the drug may be limited.
- Some Generic Drugs are included in this category and are subject to the Specialty Drug cost-sharing.

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Types of Health Plans:

Exclusive Provider Organization (EPO) Plan

A managed care plan where services are covered only if you go to doctors, specialists, or hospitals in the plan's network (except in an emergency).

Health Maintenance Organization (HMO)

A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage. HMOs plan require the member to select a Primary Care Physician and obtain referrals for services to Specialists, and often provide integrated care and focus on prevention and wellness.

Preferred Provider Organization (PPO)

A type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. You pay less if you use providers that belong to the plan's network. You can use doctors, hospitals, and providers outside of the network for an extra cost.

Point of Service (POS):

A type of plan where you pay less if you use doctors, hospitals, and other health care providers that belong to the plan's network. POS plans may require you to get a referral from your primary care doctor in order to see a specialist.

Types of Providers:

Primary Care Provider

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, to assist you with your primary medical needs. Primary Care Providers can help you coordinate your overall medical care with specialists and hospitals.

Specialist

Specialists are highly trained and skilled providers that focus on a specific area of medicine or condition in order to prevent, treat, and/or manage your health care. They can help you treat symptoms and manage your conditions.

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Additional Terminology:

Appeal

When plan members ask health insurers to reconsider a decision, such as to not pay a claim.

Authorized Representative

An authorized representative is someone you choose, like a family member or other trusted person, to act on your behalf when contacting the health plan about your medical needs. Some authorized representatives may have legal authority to act on your behalf.

Coordination of Benefits (COB)

A review to decide responsibility for paying a medical claim when 2 or more insurance plans are involved.

Designated Site

Providers that a Primary Care Provider (PCP) are required to choose and send their patients to for services such as radiology, physical and occupational therapy, and laboratory.

Explanation of Benefits (EOB)

An explanation of benefits is a statement sent by a health insurance company to covered individuals. It explains what medical treatments and/or services were paid for on their behalf. Pharmacy and Spending Account claims display a Proof of Claim (POC).

Grievance

A complaint that you communicate to your health insurer or plan.

Limitations

A limit on the amount of covered services that you are eligible for under your health plan. Limitations may apply to all covered services or selected types of services. They may be based on a number of days, the number of services or a specified dollar amount within a certain period of time. Limitations for services can be found in your health plan coverage documents.

Open Enrollment Period (OEP)

The yearly period when people can enroll in a health insurance plan. The dates for Open Enrollment vary by health plan or employer.

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Plan Year

A 12-month period of benefits coverage under a group health plan. This 12-month period may not be the same as the calendar year. You can view your plan year on the Medical tab under Coverage and Benefits.

Preapproval/Preauthorization

A decision by your health insurance plan about a health care service, treatment plan, prescription drug or durable medical equipment. Your plan decides if it is medically necessary. It is sometimes called prior authorization, prior approval or precertification. Your health insurance plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance plan will cover the cost.

Special Enrollment Period (SEP)

A period of time outside of the Open Enrollment Period (OEP) when you can sign up for health insurance. You may qualify for an SEP based on certain life events. These life events include getting married, having a baby, or losing other health coverage.