Lehigh Valley Association of Independent Colleges

TERMS TO KNOW ABOUT

HEALTH INSURANCE

PLAN

A benefit your employer provides to you to pay for your health care services. Your employer usually covers a portion of your plan, and each employee covers a portion of the plan.

PREMIUM

The amount you pay for your health insurance every month – i.e. the amount that comes out of your paycheck to pay for the *plan* provided by your employer.

Example: Jane chose the PPO plan and the premium is $280 per month. She gets paid twice per month, so $140 is taken from each paycheck to pay for that plan.

CO-PAYMENT

A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of service.

For example: Jane went to her primary care physician and looked at her insurance card to find she has a $15 co-pay for this type of appointment.

CO-INSURANCE

Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance after you've paid your *deductible*.

i.e. If you've hit your deductible already and visit a doctor and the allowable charge is $100, with 20% co-insurance you would pay $20.

DEDUCTIBLE

The amount you pay for covered health care services before your insurance plan starts to pay for them. With a $2,000 deductible, for example, you pay the first $2,000 of covered services yourself. After you pay your deductible, you usually pay only a co-payment or co-insurance for covered services. Your insurance company pays the rest. Many plans pay for certain services, like a checkup or disease management programs, before you've met your deductible. Check your plan details. Some plans have separate deductibles for certain services, like prescription drugs. Family plans often have both an individual deductible, which applies to each person, and a family deductible, which applies to all family members. Generally, plans with lower monthly premiums have higher deductibles. Plans with higher monthly premiums usually have lower deductibles.

OUT-OF-NETWORK CO-INSURANCE

The percent you pay of the allowed amount for covered healthcare services to providers who do not contract with your health insurance or plan. Out-of-network co-insurance usually costs you more than in-network co-insurance.

For example: Jane was visiting a friend out-of-state and had to visit a doctor for an illness. Since this doctor was out-of-network, her plan charged her 40% co-insurance instead of the 20% she was used to when using in-network doctors.

IN-NETWORK CO-PAYMENT

A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network co-payments usually are less than out-of-network co-payments.

PRIMARY CARE PHYSICIAN

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

OUT-OF-POCKET LIMIT

The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium.

PRESCRIPTION DRUG COVERAGE

Health insurance or plan that helps pay for prescription drugs and medications. This coverage can either be included in your plan – i.e. the information will be included on your insurance card – or it can be covered by a separate plan where you will receive a separate card with your coverage information.

URGENT CARE

Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care. This is usually a less expensive option than going to an emergency room.

PREFERRED PROVIDER ORGANIZATION (PPO)

A provider contracted with your health insurer or plan to provide services to you at a discount. Check your policy to see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but you may have to pay more.

ALLOWABLE 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.

APPEAL

A request for your health insurer or plan to review a decision or a grievance (a complaint that you communicate to your health insurer or plan) again.

HEALTH SAVINGS ACCOUNT (HSA)

A type of savings account that lets you set aside money on a pre-tax basis to pay for qualified medical expenses. By using untaxed dollars in a Health Savings Account (HSA) to pay for deductibles, copayments, coinsurance, and some other expenses, you may be able to lower your overall health care costs. HSA funds generally may not be used to pay premiums. While you can use the funds in an HSA at any time to pay for qualified medical expenses, you may contribute to an HSA only if you have a High Deductible Health Plan (HDHP) — generally a health plan (including a Marketplace plan) that only covers preventive services before the deductible.

EMERGENCY SERVICES

Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

NETWORK

The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

HEALTH INSURANCE

A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

HOSPITAL OUT-PATIENT CARE

Care in a hospital that usually doesn't require an overnight stay.

FLEXIBLE SPENDING ACCOUNT (FSA)

An arrangement through your employer that lets you pay for many out-of-pocket medical expenses with tax-free dollars. Allowed expenses include insurance copayments and deductibles, qualified prescription drugs, insulin, and medical devices.You decide how much to put in an FSA, up to a limit set by your employer. You aren't taxed on this money.

SPECIALIST

A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

PROVIDER

A physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

CLAIM

A request for payment that you or your health care provider submits to your health insurer when you get items or services you think are covered.

EXCLUSIVE PROVIDER PLAN (EPO)

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).

Jane's Plan Deductible: $1,500 | Co-insurance: 20% | Out-of-Pocket Limit: $5,000

Jane Pays 100%	Her Plan Pays 0%

Jane hasn't reached her $1,500 deductible yet.
Her plan doesn't pay any of the costs.

- Office visit costs: $125
- Jane pays: $125
- Her plan pays: $125

Jane Pays 20%	Her Plan Pays 80%

Jane reaches her $1,500 deductible, co-insurance begins.
Jane has seen a doctor several times and paid $1,500 in total. Her plan pays some of the costs of her next visit.

- Office visit costs: $75
- Jane pays: 20% of $75 = $15
- Her plan pays: 80% of $75 = $60

Jane Pays 0%	Her Plan Pays 100%

Jane reaches her $5,000 out-of-pocket limit.
Jane has seen a doctor often and paid $5,000 total. Her plan pays the full cost of her covered health care services for the rest of the year.

- Office visit costs: $200
- Jane pays: $0
- Her plan pays: $200

Check with your Human Resources Office for more information.

Visit https://www.healthcare.gov/glossary/