# ***Glossary of Insurance Terms***

Here are a few basic terms from the health insurance industry that you should be familiar with. Understanding these will allow you to make more informed decisions regarding coverage for you and your family.

**Co-Insurance**: A percentage that the individual is required to pay after a deductible is met. For example, a plan might require 20% co-insurance, meaning the employer or insurance company pays 80%, while the individual pays 20%. Co-insurance is applied to covered services only. For example, if you had a deductible of $1,500, with 80-20 co-insurance, and you received covered services in the amount of $5,000, you would pay the first $1,500 plus 20 percent of the remaining $3,500, or $700, and the plan would pay $2,800. Note also that such plans have ceilings on what they will pay for certain services, so you may be responsible for all costs above those ceilings. Co-insurance is typically associated with PPO plans, in which you pay a lower monthly premium than a co-payment plan, but pay more when you actually need services.

**Co-Payment**: A flat fee that an individual pays for health care services typically at the time service is provided. The Kaiser and San Luis Valley HMOs and the INO-30 and INO-40 plans use co-payments. Co-payments are specific amounts and apply to covered services only. They are typically associated with plans where you pay a higher monthly premium in exchange for less money out of your pocket when you go to the doctor.

**Deductible**: The amount an individual must pay for covered health care expenses before insurance begins to cover costs. Deductibles apply only to services covered by the plan. The PPO-1500, PPO-3500 and PPO-H plans all have varying deductibles. Deductibles in health insurance work the same as deductibles in auto or home insurance.

**Exclusions**: Services that are not part of the health or dental plan. Experimental and cosmetic procedures are examples of services that are often not covered by health plans. Individuals are responsible for the charges associated with these exclusions. Excluded services cannot be used to satisfy deductibles or out-of-pocket maximums.

**Flexible Spending Accounts (FSA)**: An account that allows you to set aside money on a pre-tax basis, lowering your taxable income. You can then use the money to cover health care or dependent care expenses. Typically, they operate as a reimbursement to the individual once proof of the expense has been provided. An FSA will not directly lower or control your health care or dependent care costs, but instead it puts more money into your pocket to pay for these costs. Money in an FSA that is not spent at the end of a plan year is forfeited; it does not roll forward.

**Formulary**: A listing of prescription medications that are covered by a health plan. A formulary often fosters the use of generic medications with equivalent therapeutic value to provide more cost-effective treatment. Medications that fall outside the formulary are typically more expensive.

**Health Maintenance Organizations (HMO)**: A prepaid medical group practice plan that provides a comprehensive, predetermined medical care benefit package. Employees select their primary care physician (PCP) from the HMO network. The PCP provides referrals to specialists within the participating HMO network. Doctors outside of the network are not covered. Kaiser Permanente and San Luis Valley HMO are examples of HMOs.

**Health Savings Accounts (HSA)**: A mechanism for saving money to pay for health care. Participants can pay for current health expenses while saving for future qualified medical health expenses on a tax-free basis. HSAs must be used in conjunction with a High Deductible Health Plan (HDHP). Participants control the money in an HSA, deciding how to spend it and how to invest it. Unused funds in an HSA at the end of a plan year may be rolled forward.

**In-Network Only (INO)**: A plan with a group of hospitals and physicians that contract with insurance companies, third-party administrators or employers to provide comprehensive medical coverage for a predetermined package of benefits. The INO plan does not provide out-of-network coverage, except in emergencies. The INO plan does not use primary care physicians (PCPs), but are otherwise similar to HMOs.

**Limitation**: A limit on the maximum amount payable for a specific benefit. For example a plan might limit the number of visits allowed for physical therapy or the dollar amount paid for durable medical equipment. The individual is then responsible for charges that exceed this maximum benefit.

**Maximum out-of-pocket expenses** – The maximum amount of money a person will pay for covered health claims, which is in addition to premium payments. Both co-payment plans and PPO plans can have out-of-pocket maximums. These maximums are usually the sum of deductibles and co-insurance payments or the sum of all co-payments. For example, the PPO-1500 plan has an individual, in-network deductible of $1,500 and, for FY07, a $3,000 individual, in-network out-of-pocket maximum. After the deductible is met, the plan pays 80% of costs, while the individual pays 20%. The $1,500 deductible *plus* the claims for which a person pays 20% of the cost both count towards out-of-pocket expenses. When $3,000 is reached, the plan then pays 100% of costs of *covered services*. Note that the plan does not pay for non-covered services.

**Pharmacy Benefits Manager (PBM)**: A third-party administrator of a prescription drug program that manages the prescription drug benefits. A PBM develops and maintains the formulary list of prescription drugs. It also negotiates

discounts with drug manufacturers and contracts with pharmacies. Typically, a PBM is contracted in conjunction with a health plan insurance carrier, a third-party administrator or directly with a self-funded plan. PBMs also can provide disease management programs that help control medical costs by providing incentives for patients to take prescribed medication for a particular condition.

**Preferred Provider Organization (PPO)**: A group of hospitals and physicians that contract on a fee-for-service basis with insurance companies, third-party administrators or employers to provide comprehensive medical coverage. Using in-network providers and services allows more of an individual's costs to be covered by the plan because the provider charges are discounted and the plan pays a greater share of those reduced costs. An individual can go out-of-network for care, but usually at a higher cost. PPOs do not use primary care physicians (PCPs).

**Reasonable and Customary Fees**: The average fee charged by a particular type of health care practitioner within a geographic area. The term is often used by medical plans as the maximum amount of money they will approve for a specific test or procedure. When out-of-network fees are higher than the approved amount, the individual receiving the service is responsible for paying the difference. Sometimes, however, if an individual questions his or her physician about the fee, the physician may reduce the charge to the amount the insurance company has defined as reasonable and customary.

**Third-Party Administrator (TPA)**: An organization that is responsible for claims administration services of a self-insured group's benefits programs. In addition to claims administration, other services may include eligibility management, provider network management, medical management, claims review and claims processing. Unlike an insurance company, a TPA does not assume any risk associated with the programs.